Prevocational Education and Training Accreditation Survey Report

Northern Beaches Hospital

2019

This report assessed the Prevocational Training Provider, their Prevocational Education and Training Program and their terms.

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This document replaces: Accreditation Standards for Junior Doctor Education and Supervision: Guidelines for the Accreditation of Junior Medical Staff Posts in Public Hospitals and Associated Health Services - Version 4.4 (2011)

Acknowledgments

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CONTENTS

ACCREDITATION REPORT 4
ACCREDITATION DECISION LETTER 5
SUMMARY OF RESULTS 6
ACCREDITATION SURVEY RATING 7
SURVEY SYNOPSIS 9
GENERAL INFORMATION 16
ACCREDITATION STANDARDS 18
RESOURCES 60
GLOSSARY 61

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ACCREDITATION REPORT

SURVEY DATE	25 Sep 2019
TEAM LEADER	Dr Bruce Way
SURVEYORS	Dr Mirna Hunter Ms Jeanette Chadban Dr Vasco De Carvalho Ms Lynda Schorer
DATE REPORT APPROVED BY HETI	
ACCREDITATION EXPIRY DATE	
ACCREDITATION DECISION	years accreditation without conditions

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HEALTH EDUCATION & TRAINING

WHERE INNOVATION DRIVES EXCELLENCE IN EDUCATION AND TRAINING FOR IMPROVED HEALTH OUTCOMES

SUMMARY OF RESULTS

THEME	STANDARD NUMBER	STANDARD TITLE	ACHIEVEMENT RATING THIS SURVEY Low / Moderate / Extensive
Governance and Leadership	1	Prevocational Education and Training Program Governance	Moderate Achievement
	2	Prevocational Education and Training Program Management	Low Achievement
	3	Trainee Workload and Safe Working with Patients	Moderate Achievement
	4	Facilities and Infrastructure for Education and Training	Moderate Achievement
Education and Training	5	Program Coordination and Integration	Moderate Achievement
	6	Prevocational Education and Training Program	Moderate Achievement
	7	Trainee Orientation	Low Achievement
	8	Trainee Handover	Moderate Achievement
	9	Clinical Supervision	Moderate Achievement
	10	Term Training, Supervision and Trainee Learning Experience	Low Achievement
	11	Trainee Assessment, Feedback and Remediation	Moderate Achievement
	12	Training Program Monitoring and Evaluation	Moderate Achievement
Trainee Welfare	13	Trainee Advocacy, Welfare and Support	Moderate Achievement

ACCREDITATION SURVEY RATING

Accreditation Rating Scale

The Prevocational Training Provider will be assessed against each of the thirteen standards. Each Standard is assessed against a three point Accreditation Rating Scale. The level to which a standard has been addressed is dependent upon whether the Provider meets the Critical Criteria and Criteria within the standard. The survey team will assess whether a Prevocational Training Provider has successfully addressed the Critical Criteria and Criteria.

Low Achievement (Standard not met)

The Provider has failed to meet the standard by not demonstrating it has addressed all Critical Criteria within a standard.

Moderate Achievement (Standard met)

The Provider has met the standard by demonstrating it has addressed most of the Criteria, including all Critical Criteria.

Extensive achievement (A leader)

The Provider has met the standard and demonstrated it has addressed the Critical Criteria and Criteria to a higher than average level through innovation and leadership.

Prevocational Training Provider Self – Assessment

The Provider is asked to assess their own performance against the Prevocational Education and Training Accreditation Standards using the rating scale detailed below. The same rating scale is used by the survey team. Providers also have an opportunity to make comment about their self-assessment, however this is not mandatory.

It is important to recognize that self-assessment should not be restricted to preparation for the survey process once every four years. Providers are encouraged to use the self-assessment tool annually to review their performance as part of their overall approach to continuous improvement. This process may be managed by the General Clinical Training Committee or the Prevocational Training Provider management to enable the early identification and remedy of problems. The Prevocational Education and Training Accreditation Standards can be accessed at HETI's Prevocational Accreditation Program webpage.

The Survey Team

The survey team assesses Prevocational Training Providers against each standard and gives the Provider a rating on the Accreditation Rating Scale.

A low achievement rating or extensive achievement rating should be accompanied by comments and recommendations from the survey team. Where the surveyors' rating differs from the provider's rating, a comment should also be provided. Commendations can also be made where there is extensive achievement. When assessing a Prevocational Training Provider, the survey team will take into account both the intent of the standard and the context of the Provider's facility.

The survey team rating is determined by simultaneous assessment across five variables.

	Low Achievement	Moderate Achievement	Extensive Achievement
Strength of evidence	There is little documentary evidence or documentary evidence is poor quality. Verbal evidence supports some achievement.	A range of corroborating documentation is available.	Range of documentation available including evidence of improvements.
Consistency of application	Number of circumstances where the Critical Criteria not achieved at all.	There is consistent application in all circumstances.	There is consistent application in all circumstances.
Maintenance over time	Most achievements the result of recent efforts.	Hospital has achieved basic requirements of the Critical Criteria and most of the Criteria for some time.	The provisions of the standard / criterion are fully met and have been for some time.
Sustainability infrastructure	Basic infrastructure is in place.	Infrastructure to support continuous achievement is in place.	Hospital has provided significant resources and infrastructure to support achievement.
Quality improvement	Little evidence of ongoing performance review and no evidence of improvement actions.	Reviews of performance are conducted with evidence of continuous improvement and effort to strive for best practice.	Hospital reviews its own performance and outcomes against the Standard/Criteria. A degree of excellence with significant innovations and improvements evident.
Summary	Requirements of Standard/ Critical Criteria scarcely met. Minimal effort made by the hospital to address the Standard/ Critical Criteria.	The requirements of the Standard/ Critical Criteria are met and most Criteria are generally met majority of circumstances and have been for some time.	The requirements of the Standard / Critical Criteria and Criteria are fully met in all circumstances and have been for some time. Innovation and improvement are evident.

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SURVEY SYNOPSIS

Northern Beaches Hospital is a new hospital which has been operating for twelve months. It has 488 beds and most specialities are represented. It has a busy emergency department with a co-located general practice. It is a public/private enterprise and employs CMOs as well as junior doctors on secondment. There are 18 PGY1s and 18 PGY2s and it has provisional accreditation as a 3-term hospital. The 'home hospital' within its Network is Hornsby but most of its communication with the network is through the JMO unit still in existence at Mona Vale. This was its first full accreditation survey.

The survey team would like to express its thanks to the hospital for the efficient organisation of the visit - and particularly to Cathy Dixon for her assistance throughout the survey and her support of prevocational trainees (PVTs). The DDMS, Dr Marco Metelo and the DPET, Dr Ben Taylor were also very helpful. All our requests were met and everything or everyone we asked to see was provided.

The general feedback from the PVTs was that they enjoyed their experience at NBH, and were being provided with good education and training in a supportive and well supervised environment. We were able to speak to some PVTs who had done terms at the start and were back there now. They were able to reassure the team of the extensive improvements made since the hospital opened. Most PVTs would be happy to do further terms at NBH.

The survey team was happy to support full accreditation for the listed terms with the following exceptions:

1. General surgery D/ENT - had not had PVTs in it and the hospital requested it be withdrawn from accreditation.

2. Paediatrics - had not had any PGY2s in it but we met one of the Paediatricians who was supportive of the idea and the survey team did not feel it was an inappropriate term for a PGY2 - recommend it retain provisional accreditation

3. Obstetrics & Gynaecology - had only had a PVT in it for the current term but seemed suitable - recommend it retain its provisional accreditation

The survey team was happy that due to the ongoing input from HETI and the hard work of the hospital staff (administrative, consultant and junior doctors) the hospital has made significant progress towards compliance with the accreditation standards.

Given that the hospital has only being operating for 12 months it was difficult to give 'extensive' ratings for any standards. Those which were marked 'low' were done so mainly because of areas of significant concern rather than complete lack of compliance.

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There were three main areas of concern which the survey team would like to draw to the attention of the committee and the hospital:

1. Workforce/workload - much work has been done in terms of recruitment and re-development of team structures with a view to reducing workload to manageable levels but this work is not finished. NBH has problems with workforce stability - they have a CMO group and a seconded group of junior doctors (PVTs and registrars). There seem to be significant problems with the stability of the allocated numbers and gaps then have to be filled with locums. This creates uncertainty and unreliability in supervision and teaching. Many JMOs (particularly in surgical terms) are still working long hours to ensure patient safety. The hospital reported it is reviewing its workforce model. The workforce needs to be stabilised in terms of numbers and roles - both in and out of hours.

2. Network - communication problems within the network contribute to the workforce issues but also create problems around rosters, leave, pay and data sharing - particularly with regard to evaluations and workload monitoring, The use of different information systems compound these problems. The hospital needs to find ways to collect its own data and where not possible, improve communication within the network.

3. PVTs not being part of a 'rapid response' - it is important that PVTs get exposure to the assessment and management of deteriorating patients and that where possible the patient's own team are involved in their management (for patient safety reasons). This needs to change.

It is an unusual situation to have a 3 term secondment hospital which is so large and has so many junior doctors. Many of its issues could potentially be addressed by it becoming a five term home hospital. The survey team felt that the clinical exposure to merit such a change is probably available. Whether this happens in the future will probably depend on what workforce model they decide to employ.

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Commendation(s)

Standard 2 - Prevocational Education and Training Program Management

The JMO unit is commended for its support of PVTs.

Standard 2 - Prevocational Education and Training Program Management

The hospital is commended for its development and staffing of a new JMO unit, including the appointment of a DDMS.

Standard 3 - Trainee Workload and Safe Working with Patients

Morning handover is working well and promotes collegiality amongst the clinical staff.

Standard 3 - Trainee Workload and Safe Working with Patients

Orthopaedic term is highly valued within the PVT group with trainees gaining access to theatres.

Standard 4 - Facilities and Infrastructure for Education and Training

Education precinct and access to Wi-Fi.

Standard 8 - Trainee Handover

The formal Night-to-day handover seems to be effective as a tool for not just safe handover but also for raising grievances, education opportunities and for the response to workload surges.

Standard 9 - Clinical Supervision

Term supervisors are commended for their support for and training of PVTs.

Standard 13 - Trainee Advocacy, Welfare and Support

The DPET is commended for his commitment to setting up a successful program for JMOs and all aspects of the role he has taken on.

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Recommendation(s)

Standard 1 - Prevocational Education and Training Program Governance

It is suggested that the hospital should develop a better process for communicating policies and procedures to prevocational trainees.

Standard 2 - Prevocational Education and Training Program Management

After a suitable period of time, there should be a review of the JMO unit with particular regard to staffing and processes. This should include the administrative support for the DPET.

Standard 2 - Prevocational Education and Training Program Management

The GCTC needs to develop a better process(es) for communicating with PVTs and term supervisors.

Standard 3 - Trainee Workload and Safe Working with Patients

The hospital needs to continue to work with the PVT group to streamline processes for PVTs claiming unrostered overtime so that they can be used as an accurate reflection of hours actually being worked.

Standard 3 - Trainee Workload and Safe Working with Patients

The hospital needs to continue to work with the PVT group to streamline processes in relation to diagnostic testing.

Standard 3 - Trainee Workload and Safe Working with Patients

Effective structured processes for monitoring workload need to be developed which allow both responses to short-term surges and the need for long term structural change. The GCTC needs to monitor that these processes are working.

Standard 3 - Trainee Workload and Safe Working with Patients

Team structures and staffing need to be optimised to allow PVTs to achieve their educational outcomes within safe working hours. Efforts should focus on those terms mentioned in the comments. The GCTC needs to monitor that this is happening.

Standard 3 - Trainee Workload and Safe Working with Patients

The hospital needs to stabilise the model for medical staffing structure - this should include clear guidelines on roles and responsibilities for all staff grades both in and out of hours, for both private and public patients, where differences exist. These guidelines should be communicated and tested.

Standard 4 - Facilities and Infrastructure for Education and Training

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The hospital should consider providing the DPET with a private office whilst he is conducting DPET duties.

Standard 4 - Facilities and Infrastructure for Education and Training

The hospital should explore options for more network based education opportunities (such as grand rounds) via videoconferencing

Standard 4 - Facilities and Infrastructure for Education and Training

The hospital should ensure all PVTs are aware of how to access overnight accommodation.

Standard 4 - Facilities and Infrastructure for Education and Training

The hospital should explore further options for giving PVTs access to public health records.

Standard 5 - Program Coordination and Integration

It is recommended that the hospital develop a new Memorandum of Understanding with the network which provides consistency of workforce numbers and equal responsibility for managing workforce shortages.

Standard 5 - Program Coordination and Integration

The hospital needs to ensure that all PVTs get access to career guidance and education on career development - this could be network based.

Standard 5 - Program Coordination and Integration

It is recommended that the Network Committee improve its communication processes and review them on a regular basis.

Standard 6 - Prevocational Education and Training Program

It is recommended that the hospital should provide a PGY2 education and training program.

Standard 6 - Prevocational Education and Training Program

It is recommended that the hospital consider introducing more local learning which could be multi-disciplinary, simulation-based, and involve PVTs in both its development and delivery.

Standard 7 - Trainee Orientation

The hospital needs to develop processes to ensure all PVTs are aware of how to access local policies and procedures and ensure there is also an ongoing evaluation process.

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Standard 7 - Trainee Orientation

The hospital should consider whether its current orientation process might be improved by doing the following:

- Providing to all PVTs dated and updated ROVER documents
- Ensuring all PVTs and registrars working after-hours are aware of their roles and responsibilities, particularly with regard to what patients they are caring for and in what wards.
- Considering the needs of Aboriginal or Torres St Islander PVTs when planning orientation
- Involving a PVT who is familiar with the NBH EMR systems in delivering the orientation to those systems

Standard 7 - Trainee Orientation

The hospital needs to ensure that all PVTs starting after term commencement receive an adequate orientation - this needs to be evaluated.

Standard 7 - Trainee Orientation

The GCTC need to have a process for regularly reviewing all terms and this needs to include a review of the term orientation and the term description.

Standard 8 - Trainee Handover

The hospital should consider whether the following changes to handover would allow PVTs to improve the safety of patient care:

- a more structured process for term handover
- a formal day-to-evening handover
- an electronic handover support tool

Standard 9 - Clinical Supervision

The hospital should consider providing professional development in supervision and teaching - possibly using network resources

Standard 9 - Clinical Supervision

The hospital needs to stabilise its workforce numbers and structure, to minimise the use of locums.

Standard 10 - Term Training, Supervision and Trainee Learning Experience

The hospital should ensure that PVTs are part of the team called for 'rapid responses'.

Standard 10 - Term Training, Supervision and Trainee Learning Experience

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The hospital should review the practice of not allocating interns to the subacute area of ED and also consider providing formal teaching for interns in ED.

Standard 10 - Term Training, Supervision and Trainee Learning Experience

The GCTC needs to include term specific teaching as part of its term reviews and publicise terms who are doing it well.

Standard 11 - Trainee Assessment, Feedback and Remediation

The hospital should ensure that in the management of PVTs with performance issues, all supervisors (both in and out of hours) have the knowledge required to provide appropriate support.

Standard 12 - Training Program Monitoring and Evaluation

It is recommended that the hospital take ownership of the processes used to evaluate the PVT experience at NBH and cease to rely on information provided by the network.

Standard 12 - Training Program Monitoring and Evaluation

The GCTC should develop a structured process to review all terms on a regular basis which involves the relevant term supervisors and PVTs.

Standard 13 - Trainee Advocacy, Welfare and Support

The hospital needs to negotiate with the LHD a mechanism that allows the DPET access to the nominated training funds.

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GENERAL INFORMATION

Local Health District	NSLHD
Chief Executive	

Hospital Executive staff

Executive Director	N/A
Chief Executive	Mr Richard Royle
Director of Nursing	Ms Fiona Allsop
Chair of the Medical Staff Council	Dr Michele Franks
Chair of the General Clinical Training Committee	Dr Andrew Evans
Director of Prevocational Education and Training	Dr Ben Taylor
Director of Clinical Services	Dr Simon Woods
JMO Manager	Ms Debra Roberts

Prevocational Training Providers in the Prevocational Training Network

	PGY1	PGY2
Hornsby & Brooklyn GP Unit	0	0
Hornsby Ku-ring-gai Health Service	0	0
Manly Hospital	0	0
Mona Vale Hospital	0	0
Sydney Adventist Hospital	0	0

Prevocational Training Provider: Medical Workforce

	Previous Survey	This Survey
Number of Medical Administrators	-	
Number of Attending Medical Officers	-	
Number of Staff Specialists	-	28
Number of accredited Registrars	-	54
Number of non-accredited Registrars	-	49
Number of Total Registrars	-	103

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Speciality	Staff Specialist	VMO	Clinical Academic	REG (accred)	REG (non accred)
Anaesthesia	0	106	0	10	2
Cardiology	0	21	0	2	0
Ear Nose and Throat	0	12	0	0	0
Emergency medicine	20	32	0	9	16
Intensive care medicine	0	7	0	0	10
Medical Oncology/Haematology	0	7	0	1	0
Obstetrics & Gynaecology	2	19	0	3	7
Opthalmology	0	7	0	0	0
Paediatrics and child health	2	7	0	4	7
Palliative medicine	0	3	0	0	0
Physician - General medicine	4	44	0	10	2
Physician - Gastroenterology	0	12	0	1	0
Psychiatry	0	20	0	9	0
Surgery - General surgery	0	17	0	4	0
Surgery - Neurosurgery	0	10	0	0	0
Surgery - Orthopaedic surgery	0	21	0	1	4
Surgery - Paediatric surgery	0	2	0	0	0
Surgery - Urology	0	10	0	0	1
Surgery - Vascular surgery	0	5	0	0	0
TOTAL	**28**	**362**	**0**	**54**	**49**

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ACCREDITATION STANDARDS

Governance and Leadership

STANDARD 1

Prevocational Education and Training Program Governance

The Prevocational Training Provider has a clear system of governance for the overall management of the Prevocational Education and Training Program for prevocational trainees.

Critical Criteria

1.1 The Program is incorporated into the Prevocational Training Provider's organisational planning with appropriate priority relative to other responsibilities.

1.2 There is a system of clinical governance with clear lines of responsibility for the overall quality of medical practice undertaken by trainees.

1.3 The Prevocational Training Provider has an appropriate process for management of grievances.

Criteria

1.4 The governance of the Provider is clearly defined.

1.5 There are documented processes, to support trainees raising their concerns about the Program and supervision. These processes should maintain prevocational trainee confidentiality.

Guidelines

- A Delegated manager (such as the DMS, General Manager or equivalent) has executive accountability for the Provider meeting the Prevocational Training and Education Standards and has a line of reporting to the Chief Executive of the Local Health District.
- Providers consider and manage impacts on Prevocational Education and Training when making decisions.
- Policies/processes cover the Program governance, orientation, education and training, supervision, trainee welfare, workload, protected training time, feedback, assessment, and grievance management.
- Trainees are informed of the process for resolving grievances which should include

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timely resolution and communication of outcomes.

Evidence

23. The Prevocational Training Provider grievance procedures.
24. Evidence of formal communication mechanisms/structures between the Provider and their trainees.
33. A copy of the organisational/executive structure of the hospital (i.e. organisational chart). Including reporting lines to the GCTC and NCPT.

Provider's Comments or Additional Evidence (Optional)

The governance structure of the hospital is depicted in the organisation chart. The Medical Director is responsible for medical staff as well as having a primary role in clinical governance within the hospital.

The Medical Director is supported by a Deputy Medical Director who has direct responsibility for oversight of the JMO Unit. A permanent Deputy Medical Director commenced with Northern Beaches Hospital in mid-August 2019.

Processes supporting trainees raising concerns are documented in the JMO grievance policy which supplements and is aligned to information provided in the hospital grievance policy. Central to the policy is the principle of confidentiality.

Regular meetings have occurred between hospital management and junior doctors (including prevocational trainees) since the hospital commenced operations, providing opportunities for trainees to raise issues. This is in addition to the formal GCTC and Network Governance Committees, both of which have prevocational trainee representation.

Achievement Rating

	Low / Moderate / Extensive
Prevocational Training Provider Self-Assessment	Moderate Achievement
Survey Team Assessment Rating	Moderate Achievement

Survey Team's Comments, Commendations and Recommendations

Comment(s)

The survey team agrees that governance procedures are in place within the hospital to support safe practice and allow grievances to be addressed.

There are some network governance issues which will be discussed later.

Clinical policies and procedures have been developed but their communication to prevocational trainees is still an issue. Although they are available on the intranet, many JMOs seemed unaware of how to access them. The hospital is considering developing an 'APP'

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which may help in this regard.

Recommendation(s)

It is suggested that the hospital should develop a better process for communicating policies and procedures to prevocational trainees.

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STANDARD 2

Prevocational Education and Training Program Management

The Prevocational Training Provider has a clear management structure in place with the responsibility, authority and capacity to direct, plan, implement, review and evaluate the Prevocational Education and Training Program.

Critical Criteria

2.1 There is adequate funding and infrastructure to plan, deliver and evaluate the Program including staff with the required administrative, clinical and educational expertise.

2.2 The Prevocational Training Provider has effective organisational committees including a site based GCTC, network based NCPT and prevocational trainees are fully informed of the role of these committees.

2.3 The Prevocational Training Provider has operational structures (DPET/JMO Unit) to manage and support the prevocational trainees.

Criteria

2.4 The Prevocational Training Provider documents and advises HETI of any significant changes to the Program.

Guidelines

- The JMO management unit is staffed to ensure it has the capacity to provide support for all trainees.

Evidence

2. Minutes of the five most recent General Clinical Training Committee meetings or equivalent
3. Minutes of the five most recent Network Committee meetings.
5. Terms of reference of GCTC, NCPT, Assessment review committee
6. Documentation of other relevant committees terms of reference, meeting schedules and minutes.
10. Details of the Provider's infrastructure for providing the formal and clinical term prevocational education and training programs.
25. Evidence of the support and welfare services available to trainees.
26. Process for workload monitoring including regularly reviewing patient numbers and the level of overtime (both rostered un-rostered).
27. Evidence that the Provider has rigorous processes in place to ensure safe clinical

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supervision.

Provider’s Comments or Additional Evidence (Optional)

The NBH JMO Unit is comprised of the permanent Deputy Medical Director who has direct oversight and leadership of the unit; an A/JMO Manager, two JMO Coordinators and a part time A/Recruitment Officer.

While the A/JMO Manager is new to the role, she has previously been the practice manager of the NBH Medical Centre and is therefore familiar with working with medical staff. The two JMO Coordinators have been working within the JMO Unit since opening and are increasingly gaining experience in the management of junior medical staff.

Although the JMO unit is not yet 12 months old, with many processes still to fully implement, JMO Unit staff are committed to building a culture which promotes the support and wellbeing of all junior doctors working at NBH.

At the time of submitting the survey documentation, an experienced medical administrator is working on a contractual basis with NBH to assist and support the transition of the Deputy Medical Director to the role and support the further development of the JMO Unit.

The NSLHD retains some responsibilities for rotating NSLHD doctors including prevocational trainees from Network 6. These responsibilities primarily relate to recruitment, leave management and payroll functions and are undertaken by the previous Manly Mona Vale (MMV) JMO Management Unit. The staffing of this unit comprises a JMO Manager and two JMO Coordinators, all contributing services to NBH on a fractional and primarily remote basis.

All prevocational trainees are provided information and relevant contact details regarding the roles and responsibilities of the two JMO units and staff located on site at the NBH are in regular contact with the MMV team (who retain sole access to the NSW Health roster system) to ensure that any issues raised by prevocational trainees (for example payroll) are followed up promptly.

The DPET is employed on a fractional basis (0.375FTE) for the 31 prevocational trainees on rotation. The DPET also works as an emergency physician at the Northern Beaches Hospital. His combined fraction at the hospital is 0.625 FTE. The fractional allocation is in recognition that additional time would be required to fully establish and implement the prevocational education and training program within the newly opened hospital.

The DPET has office space located within the JMO Unit on Level 4 and access to administrative support to fulfil the role, in addition to regular contact with the JMO Manager and Deputy Medical Director.

The GCTC is chaired by one of the senior physicians in the hospital and has been meeting regularly since the hospital commenced operation.

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STANDARD 2

Staff from the NBH, including the Director of Prevocational Education and Training and the interim Deputy Medical Director, have been active participants at the Network Governance Committee and this has been a valuable forum for strengthening communication across Network 6 including sharing expertise in the management, training and education of prevocational trainees.

Systems for monitoring workload continue to be established and implemented. There have been challenges in managing the equitable distribution of workload across teams, as new clinical services have been introduced, resulting in a number of changes to team structure (particularly in medicine) since the hospital opened. The team structure in medicine (and the senior physician roster) has now stabilised and is supported by daily workload monitoring collected during morning handover. Likewise, work continues to be undertaken in the surgical terms to monitor and manage workload.

Achievement Rating

	Low / Moderate / Extensive
Prevocational Training Provider Self-Assessment	Moderate Achievement
Survey Team Assessment Rating	Low Achievement

Survey Team's Comments, Commendations and Recommendations

Comment(s)

One of the challenges facing the new hospital was the development of a new JMO unit and as described this has included the recruitment of a new DDMS and a new acting JMO Manager who have only been in the job for a short time, and 2 JMO co-ordinators. One of the challenges for this unit is that since they are a secondment hospital, they rely on the network for co-ordination of JMO allocation. Most of this occurs through Mona Vale JMO unit which still seems to influence this part of the network. This has resulted in frustrating inconsistency of JMO numbers at NBH which results in problems with rosters and workforce management. Communication of changes in allocations and rosters does not always occur smoothly. The survey team had concerns about how sustainable this was given the large number of PVTs at NBH.

Lack of access to NSW health department information systems has also made their job difficult - particularly with regard to data gathering, and co-ordination of rosters and payrolls.

It will be important that once the JMO unit has had time to develop its processes, an evaluation should be carried out to ensure staffing and resources are adequate. This should include whether there are adequate administrative resources to support the DPET's role as he currently seems to do a lot of things himself which may be more efficiently done by an administrative support person.

The GCTC is functioning effectively but needs to develop a better communication process. Many PVTs and term supervisors seemed unaware of the role, what discussions occurred

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and what outcomes were achieved. This will be important when the committee starts to take on a more consistent evaluation role. Examples of how this might be done include newsletters, specific invites to particular meetings where specific terms are reviewed, term supervisor functions, presentations at grand rounds, regular distribution of accumulated term evaluation data.

The Network committee meets but there are several issues around network co-ordination which have not been addressed there. This will be discussed later.

Commendation(s)

The JMO unit is commended for its support of PVTs.

The hospital is commended for its development and staffing of a new JMO unit, including the appointment of a DDMS.

Recommendation(s)

After a suitable period of time, there should be a review of the JMO unit with particular regard to staffing and processes. This should include the administrative support for the DPET.

The GCTC needs to develop a better process(es) for communicating with PVTs and term supervisors.

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STANDARD 3

Trainee Workload and Safe Working with Patients

The Prevocational Training Provider monitors the workload and ensures trainees safely work with patients.

Critical Criteria

3.1 The Prevocational Training Provider is responsible for ensuring trainees meet their education outcomes and service delivery requirements within safe working conditions.

3.2 The Prevocational Training Provider monitors and ensures the prevocational trainees have reasonable duties and workload.

Criteria

3.3 Trainees are provided with rosters that meet both the organisational service delivery needs as well as their education and training requirements.

3.4 The Prevocational Training Provider ensures all trainees complete the training required to work safely as an employee of NSW Health, including all mandatory training.

Guidelines

- The procedures for trainees to access leave are published, fair and practical.
- Trainees are provided with an accurate roster in a timely manner at a minimum in accordance with the award.
- The trainee's roster has flexibility and prevocational trainees are aware of the Training Provider's process for negotiating roster changes.
- Patient numbers should be of a range that provides a safe work environment and is conducive to education and training, and ensures safe patient care.
- HETI Online identifies the mandatory training to be completed by trainees.

Evidence

7. De-identified reports from HETI Online of training completion by JMOs.
16. Current shift rosters for the whole hospital where prevocational trainees work.
20. Evidence of the hospital orientation program.
26. Process for workload monitoring including regularly reviewing patient numbers and the level of overtime (both rostered un-rostered).

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STANDARD 3

Provider's Comments or Additional Evidence (Optional)

Priority is given to prevocational trainees to ensure that they meet education outcomes while providing clinical services. This includes ensuring that they can attend formal education sessions for Network 6.

Rosters for prevocational trainees are now solely completed by the NBH JMO Unit, although the MMV Unit retains responsibility for leave management. Rosters are published and provided to prevocational trainees as per requirements. Prevocational trainees are not rostered on nights while on rotation at NBH.

NSW Health mandatory requirements are completed by prevocational trainees during orientation week. The MMV Unit provides a report to the NBH JMO Unit on the mandatory training completed by rotating prevocational trainees.

Northern Beaches Hospital provide additional mandatory training during hospital orientation.

Achievement Rating

	Low / Moderate / Extensive
Prevocational Training Provider Self-Assessment	Moderate Achievement
Survey Team Assessment Rating	Moderate Achievement

Survey Team's Comments, Commendations and Recommendations

Comment(s)

There has been a lot of work done to try and re-structure teams with a view to creating safe working hours which also allow PVTs to meet their education outcomes. This work is not finished.

Many of the Surgical terms are very busy with PVTs working long hours and struggling to attend enough operating theatre time to meet their educational needs. This does not seem to be the case with Orthopaedics which is highly valued by the trainees.

The busy medical terms are Cardiology 1, Gastroenterology, Geriatrics and Renal 2.

Workload monitoring is challenging. Attempts are made at morning handover to share the load on a day to day basis but this is ad hoc and not structured.

There is not a culture amongst the clinical staff of not claiming unrostered overtime but there are issues around the processes - although the hospital is working on this.

The survey team was informed that the hospital was trialling a click-on/click-off KRONOS application in an attempt to monitor actual hours worked. The PVTs were very reluctant to

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use this system as they felt it may be used in a punitive fashion. The JMO group also provided the survey team with a copy of a submission they had made to the hospital executive in July 2019 which detailed their concerns regarding the hospital's overtime policy. In that document they expressed three main areas of concern:

1. Kronos - how it will be accessed and used
2. Systemic issues - under-staffing; access to policies and procedures; safety and quality of patient care (JMOs redistributing work amongst themselves and working late to assist colleagues)
3. Unrostered overtime without prior approval - reason (usually simply too much work); need for senior clinician to sign (not achievable); early shift starts (required on surgical terms); oversight mechanisms

Further workload issues are created by problems backfilling leave due to network communication issues. This can affect registrars also and thus supervision. This also has implications for rosters.

After-hours workload is also problematic and there is confusion amongst both PVTs and registrars about their roles and responsibilities. The hospital has CMOs who work predominately on the private surgical wards. Although the team was told that the PVTs are not supposed to have responsibilities for these patients this is not always clear to the PVTs, the CMOs and the nursing staff.

The hospital seems to be still in a process of evolution regarding its staffing structure - how to use PVTs, registrars and CMOs - both in hours and out of hours and the distinctions between private and public patients.

One of the other issues which concerned PVTs with regard to workload and safe patient care related to problems around diagnostic testing. Some of the issues included ordered tests 'falling off the EMR' and abnormal results being missed. Extra work was created by PVTs having to do work arounds to deal with these faults in the system.

Commendation(s)

Morning handover is working well and promotes collegiality amongst the clinical staff.

Orthopaedic term is highly valued within the PVT group with trainees gaining access to theatres.

Recommendation(s)

The hospital needs to continue to work with the PVT group to streamline processes for PVTs claiming unrostered overtime so that they can be used as an accurate reflection of hours

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actually being worked.

The hospital needs to stabilise the model for medical staffing structure - this should include clear guidelines on roles and responsibilities for all staff grades both in and out of hours, for both private and public patients, where differences exist. These guidelines should be communicated and tested.

Team structures and staffing need to be optimised to allow PVTs to achieve their educational outcomes within safe working hours. Efforts should focus on those terms mentioned in the comments. The GCTC needs to monitor that this is happening.

Effective structured processes for monitoring workload need to be developed which allow both responses to short-term surges and the need for long term structural change. The GCTC needs to monitor that these processes are working.

The hospital needs to continue to work with the PVT group to streamline processes in relation to diagnostic testing.

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STANDARD 4

Facilities and Infrastructure for Education and Training

The Prevocational Training Provider will provide appropriate facilities and infrastructure to enable the Prevocational Education and Training Program to be conducted effectively.

Critical Criteria

4.1 The Prevocational Training Provider has appropriate facilities for education and training.

4.2 Where necessary for trainee safety, the Prevocational Training Provider provides trainees with accommodation including overnight and term accommodation.

Criteria

4.3 The Prevocational Training Provider provides trainees with access to safe physical amenities, including a common room where trainees can support each other and debrief with colleagues.

4.4 The Provider collaborates with the DPET to ensure the trainees have access to appropriate facilities and infrastructure on wards to perform their role effectively.

Guidelines

- HETI *Network Principles for prevocational medical training (2012)* provide guidance on facilities and infrastructure needed for Prevocational Education and Training Programs and prevocational trainees.
- Educational facilities include teaching rooms with the necessary equipment, libraries, computers with internet access, e-learning capabilities and access and simulation opportunities;
- Training needs to be provided for trainees regarding the use of the educational resources.
- Education facilities can be hospital based or coordinated across the prevocational training network and must be accessible by all prevocational trainees.
- Computer access should allow trainees to complete their work tasks, access educational activities, complete their training requirements of HETI Online, as well as mandatory orientation and term assessments.
- The common room should be of sufficient size for the Provider's prevocational trainee numbers and safely accessible for the trainees particularly after hours.
- Overnight accommodation should be provided where the trainee is on-call and/or rostered on for after-hours work and is unable to go home due to safety concerns.
- Where long-term accommodation is required (generally due to secondment for a term to a Provider distant from trainee's home hospital) this should include as a minimum a single room with a desk, phone and internet access provided, bathroom

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facilities with privacy; kitchen; lounge area with television; and security and options for parking of a vehicle.

Evidence

8. Details of the physical amenities provided to the trainees including overnight accommodation for after-hours shifts and term accommodation for trainees on rotation.
10. Details of the Provider's infrastructure for providing the formal and clinical term prevocational education and training programs.

Provider's Comments or Additional Evidence (Optional)

There is a purpose built Education Centre located on Level 4 of the hospital which houses the JMO Unit (including offices for the Deputy Medical Director, DPET, JMO Manager and JMO Coordinators), in addition to a simulation centre, computer training room and a range of rooms dedicated for education and training functions. All class rooms are fitted with relevant education resources, including IT.

In close proximity and also located on Level 4, are the JMO Lounge, JMO Workroom, and 4 overnight rooms with a collocated shower/bathroom.

The JMO lounge is a dedicated space with a generous outdoor area, solely for the use of junior medical staff. Bathrooms are located across the corridor as are a bank of lockers. A kitchen area with coffee machine, fridge and microwave is located nearby within the entrance to the education centre.

Morning and evening handover is held in the JMO lounge and additional resources (IT screen) are on order to enhance the clinical handover function. There are a number of computers within the JMO lounge itself and a further 8 located in JMO workroom down the corridor.

Given that NBH is based within the Sydney metropolitan area, long term accommodation is not required.

On the ground floor there is a large food court with a separate staff area offering a range of meal options which operates extended hours. Throughout the hospital there are staff beverage stations, including access to coffee machines, water fountains and fridges as well as vending machines with drinks and snacks.

While prevocational trainees do not have access to HETI /NSW Intranet while on rotation to NBH (an issue which has been raised with the NSLHD), they do have access through the Healthscope intranet to a range of online clinical resources including:

- Therapeutic Guidelines Online – eTG Complete
- MIMS Online
- Australian Medicines Handbook
- BMJ best practice
- TGA – Updating medicine ingredients names

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STANDARD 4

- The Merck manual Online
- UpToDate
- DynaMed Plus
- Electronic library providing access to journals and texts.

Achievement Rating

	Low / Moderate / Extensive
Prevocational Training Provider Self-Assessment	Extensive Achievement
Survey Team Assessment Rating	Moderate Achievement

Survey Team's Comments, Commendations and Recommendations

Comment(s)

The hospital has an excellent precinct which includes in one area, well-resourced education spaces, a simulation centre, common and kitchen spaces, learning spaces, administrative spaces for the JMO unit, the DDMS and the DPET. PVTs have access to Wi-Fi.

The DPET shares an office with an education officer. Although we were told there were private spaces where the DPET could conduct a private interview with a PVT the team had some concerns about PVT privacy - both in terms of interviews and record keeping. It was felt that the DPET needs to always have a private space available immediately to conduct private interviews with PVTs.

PVTs or the hospital do not have access to Health department sites such as MY Health Learning or CIAP. As with many things, the hospital relies on getting reports from the network. Some of the components of CIAP are available and the PVTs generally thought they had what they needed to do their jobs, with the exception of access to public medical records. There was limited access via only 1 or 2 computers.

Overnight accommodation is available but not well publicised to PVTs who rarely need it.

PVTs also expressed a need for better videoconferencing facilities to access other network teaching opportunities.

Commendation(s)

Education precinct and access to Wi-Fi.

Recommendation(s)

The hospital should consider providing the DPET with a private office whilst he is conducting DPET duties.

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STANDARD 4

The hospital should explore further options for giving PVTs access to public health records.

The hospital should ensure all PVTs are aware of how to access overnight accommodation.

The hospital should explore options for more network based education opportunities (such as grand rounds) via videoconferencing.

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Education and Training

STANDARD 5

Program Coordination and Integration

The Prevocational Training Provider ensures there is a coordinated and integrated Prevocational Education and Training Program.

Critical Criteria

5.1 The Prevocational Education and Training Program is planned, coordinated and delivered across the Prevocational Training Network and allows for addressing individual gaps in learning.

5.2 The PGY1 term allocations and the Program are structured to reflect the requirements of the current Medical Board of Australia's Registration Standard and provide learning experiences as described in the AMC's Intern Training – Guidelines for Terms.

Criteria

5.3 There is a clear structure and processes in place for planning and coordinating the Program at the training provider site level.

5.4 All trainees have access to career advisory services. (Career advisory services are publicised to the trainees, their supervisors and other team members.)

Guidelines

- See HETI's *Network Principles for Prevocational Medical Training Section 1* which outlines a prevocational trainee learning model.

Evidence

3. Minutes of the five most recent Network Committee meetings.
17. Term allocations for all prevocational trainees between terms and network hospitals.
19. Documentation detailing the formal education and training program for PGY1 and PGY2
20. Evidence of the hospital orientation program.
25. Evidence of the support and welfare services available to trainees.
28. Evidence that the Provider delivers clinical learning experiences and clinical training in each term.

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STANDARD 5

Provider's Comments or Additional Evidence (Optional)

As a Level 5 hospital, NBH offers trainees clinical experience within a supervised setting across a range of terms, including emergency medicine, general medicine, geriatrics, respiratory, cardiology, neurology, general surgery and orthopaedics.

Term allocations are undertaken by the MMV JMO Unit in collaboration with HKH staff and ratified by the Network Committee.

Career advice is provided through the DPET during mid-term meetings who then arranges access to relevant senior medical staff/ external resources. This is an area for development in the next 12 months, with a plan to host a career evening for prevocational trainees in early 2020.

Achievement Rating

	Low / Moderate / Extensive
Prevocational Training Provider Self-Assessment	Moderate Achievement
Survey Team Assessment Rating	Moderate Achievement

Survey Team's Comments, Commendations and Recommendations

Comment(s)

There is network based PGY1 education program which is well attended and valued by PVTs.

The unique development of NBH has created some network co-ordination issues which need to be addressed. These include issues around PVT allocations, responsibility for filling in gaps in allocations, late changes to rosters (resulting in heavy use of on-call to fill gaps), accuracy of pays, lack of information sharing, lack of access to different information systems. The survey team was told that allocation numbers are not consistent.

There is an MOU but this does not appear to address these issues.

Some of the problems are difficult to address because of the difficulty for NBH accessing NSW Health information systems. Hornsby hospital is the 'home hospital' of the network but most of the network co-ordination with NBH seems to occur through an isolated JMO Office at Mona Vale. This seemed to cause some confusion and the survey team had doubts concerning whether this was a sustainable model.

Now that NBH is up and functioning, it is time for the network to review how it functions.

It was unclear to the survey team whether all PVTs in the network were getting career development advice or education (e.g. CV writing, interview techniques, tips for different

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specialties) as this did not appear available at NBH.

Recommendation(s)

It is recommended that the hospital develop a new Memorandum of Understanding with the network which provides consistency of workforce numbers and equal responsibility for managing workforce shortages.

It is recommended that the Network Committee improve its communication processes and review them on a regular basis.

The hospital needs to ensure that all PVTs get access to career guidance and education on career development - this could be network based.

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STANDARD 6

Prevocational Education and Training Program

The Prevocational Training Provider and term supervisor together ensure that prevocational trainees have an effective learning program with an emphasis on blended workplace based learning that equips them for their role in delivering effective patient care.

Critical Criteria

6.1 The Prevocational Training Provider organises an education and training program that meets the learning and training needs of both PGY1 and PGY2 trainees.

6.2 The Prevocational Training Provider provides a blended learning approach, with focus on providing clinical and non-clinical based teaching, training, feedback and assessment.

6.3 Trainees are engaged in decisions regarding the quality and content of the Prevocational Education and Training Program.

6.4 The Provider allocates time exclusively for formal education and training, which is quarantined from service responsibilities.

Criteria

6.5 The Program delivers clearly documented learning outcomes that are aligned with the Australian Medical Council's Intern Outcome Statements for PGY1s, the Australian Curriculum Framework for Junior Doctors, and any HETI authorised curriculum.

6.6 The term specific education sessions are designed to support the achievement of the terms learning objectives and the intern outcome statements.

Guidelines

- See HETI's *Network Principles for Prevocational Medical Training* section 1 which outlines a prevocational trainee learning model.
- Participation in the prevocational training is monitored and facilitated.
- The Prevocational Training Provider can access another Provider's education and training program to provide learning opportunities for their trainees.
- The Program includes specific training in delivery of health care to Aboriginal people and the role of all staff in upholding cultural safety and respect.

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STANDARD 6

Evidence

19. Documentation detailing the formal education and training program for PGY1 and PGY2
24. Evidence of formal communication mechanisms/structures between the Provider and their trainees.
28. Evidence that the Provider delivers clinical learning experiences and clinical training in each term.
34. Evidence of any other workplace based assessments/feedback mechanisms

Provider's Comments or Additional Evidence (Optional)

The intern education program is run on a fortnightly basis every Thursday from 08.00 to 10.00 and rotated between sites (Hornsby Hospital, Northern Beaches Hospital and the SAN). Attendance lists and evaluations of the education program are collated by the ESO/DPET assistant located at Hornsby Hospital and circulated to NBH. The education program is coordinated with input from all DPETs and the Network Committee.

In addition, the DPET has run a number of education and simulation sessions for prevocational trainees on a range of topics, including cannulation and interdisciplinary high-fidelity simulation sessions. Future additional training sessions planned include communications training and palliative care sessions. Prevocational trainees have regular opportunities to provide input into the education program through both meetings with the DPET as well as the General Clinical Training Committee.

Achievement Rating

	Low / Moderate / Extensive
Prevocational Training Provider Self-Assessment	Moderate Achievement
Survey Team Assessment Rating	Moderate Achievement

Survey Team's Comments, Commendations and Recommendations

Comment(s)

There is a network based PGY1 program which rotates around the network hospitals. This is protected time and seems to function well.

There is no specific education program at NBH for PGY2s. This needs to be addressed.

The DPET has started organising some local teaching on an ad hoc basis and there is some simulation based education but this could be extended.

Other opportunities for developing the teaching program could include more multi-disciplinary teaching; and more PVT involvement, both in terms of developing and delivering local teaching.

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STANDARD 6

Recommendation(s)

It is recommended that the hospital should provide a PGY2 education and training program.

It is recommended that the hospital consider introducing more local learning which could be multi-disciplinary, simulation based, and involve PVTs in both its development and delivery.

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STANDARD 7

Trainee Orientation

The Prevocational Training Provider provides a comprehensive effective orientation to its prevocational trainees, which ensures the trainees practice safely and are well prepared to commence their prevocational training.

Critical Criteria

7.1 The Provider delivers a comprehensive orientation program which ensures that trainees are adequately prepared to conduct/commence their duties safely and are aware of committees with oversight of the Program.

7.2 The Prevocational Training Provider provides an effective formal orientation to all prevocational trainees at the start of each clinical year, term and when on rotation from another Prevocational Training Provider.

7.3 The Term Supervisor has primary accountability for the effective orientation of the trainee at the commencement of the clinical term.

7.4 The trainees receive a written term description before the clinical term commences. It defines the skills and procedures to be achieved and the nature and range of clinical experiences available to meet the outcomes.

Criteria

7.5 The Prevocational Training Provider considers the needs of trainees from Aboriginal background in planning and delivering the trainee orientation program.

7.6 The Provider through the GCTC is responsible for the regular review of term description's to ensure their accuracy.

7.7 At the commencement of the clinical year and each term, the Prevocational Training Provider in collaboration with the Term Supervisor will assess the trainee's ability to practice safely. Where necessary, additional supervision and training is to be provided to ensure safe medical practice.

Guidelines

Orientations would normally include:

- general information on the hospital/facility/LHD
- introduction to relevant Provider staff and supervisors

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STANDARD 7

- roles and responsibilities of the trainee as a junior doctor
- clinical and procedural skills training and verification
- clinical term structure and services
- trainee supervision
- feedback and assessment processes
- administrative arrangements; and
- location of resources and relevant policies

All term descriptions should be reviewed on an annual basis by the GCTC.

Evidence

1. Term descriptions for all prevocational terms on the current HETI term description template.
2. Minutes of the five most recent General Clinical Training Committee meetings or equivalent
7. De-identified reports from HETI Online of training completion by JMOs.
9. Any ROVER or equivalent term handover documentation is given to the trainees.
20. Evidence of the hospital orientation program.
21. Evidence of term specific orientation.
32. Prevocational Trainee Handbook (one hard copy only).

Provider's Comments or Additional Evidence (Optional)

Interns attend the orientation program for Network 6 at HKH. When rotated to the NBH, prevocational trainees attend the hospital-based orientation (half day) in addition to term-based orientation. A copy of the hospital orientation program is provided. Given that there are different clinical IT systems at NBH compared with NSW Health counterparts, orientation for all junior medical staff includes a two-hour EMR training session. There is close monitoring of this by JMO Unit staff to ensure that all prevocational trainees have quarantined time to attend this training at the commencement of term.

The position description for term supervisors includes responsibility for term orientation.

There is a term description for each accredited term which outline the roles and responsibilities as well as expected learning objectives for the prevocational trainee. These are circulated to prevocational trainees prior to the commencement of term. This information is supplemented by ROVER forms as well as, in some cases, additional written information.

Achievement Rating

	Low / Moderate / Extensive
Prevocational Training Provider Self-Assessment	Moderate Achievement
Survey Team Assessment Rating	Low Achievement

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STANDARD 7

Survey Team's Comments, Commendations and Recommendations

Comment(s)

Intern orientation is network based. There is a half-day hospital orientation. One of the major issues for orientation is the different EMR systems. One of the PVTs suggested that it would be helpful to have a PVT who knows the system involved in that part of the orientation.

Term orientation is not consistent. ROVERs were seen by the team but they were not dated, updated or always provided.

Some PVTs who started during a term reported not getting adequate orientation.

Term descriptions need regular review.

PVTs and registrars reported they were not adequately orientated to their roles and responsibilities when working after-hours - particularly on who covered what and variations between public and private patients.

Orientation did not include any special needs for PVTs with an Aboriginal or Torres St Islander background.

Much work has been done on developing NBH policies and procedures and improving their availability but many PVTs are still unaware of this. The next phase of this process needs to be ensuring PVTs are aware of the existence of these policies and procedures and how to access them. Then, there will need to be an evaluation process.

The hospital is considering using an 'APP' and the survey team would be supportive of this as a way of facilitating orientation and access to policies and procedures.

Recommendation(s)

The hospital needs to develop processes to ensure all PVTs are aware of how to access local policies and procedures and ensure there is also an ongoing evaluation process.

The GCTC need to have a process for regularly reviewing all terms and this needs to include a review of the term orientation and the term description.

The hospital needs to ensure that all PVTs starting after term commencement receive an adequate orientation - this needs to be evaluated.

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STANDARD 7

The hospital should consider whether its current orientation process might be improved by doing the following:

- Providing to all PVTs dated and updated ROVER documents
- Ensuring all PVTs and registrars working after-hours are aware of their roles and responsibilities, particularly with regard to what patients they are caring for and in what wards.
- Considering the needs of Aboriginal or Torres St Islander PVTs when planning orientation
- Involving a PVT who is familiar with the NBH EMR systems in delivering the orientation to those systems

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STANDARD 8

Trainee Handover

The Prevocational Training Provider provides effective handovers to prevocational trainees that enable them to provide safe patient care.

Critical Criteria

8.1 The Prevocational Training Provider has a documented and available, well defined process in place for handover at the commencement of each clinical term and when transferring care responsibility of patients.

Criteria

8.2 The roles and responsibilities of the clinical and non-clinical staff involved in term handover are clearly defined and understood.

Guidelines

- The Provider facilitates an effective term handover consisting of both formal and informal processes.
- The process for term handover should include an up to date ROVER like form or discussion for trainees to be aware of an individual consultants' practices and preferences.
- The Prevocational Training Provider has a written, well defined process that is implemented for handover between all shifts (including day, evening and weekend shifts), patients transferred from other areas within the same health facility or other health facilities.

Evidence

9. Any ROVER or equivalent term handover documentation is given to the trainees.

22. Documentation outlining the handover processes between terms and individual responsibilities at the beginning of terms.

Provider's Comments or Additional Evidence (Optional)

Formal clinical handover occurs in the JMO lounge at 08.00am and 10.30pm on weekdays and at 8.00am and 8.30pm on weekends. Day to evening handover processes are undertaken by junior medical staff as required.

The structure and processes to ensure effective clinical handover have been an area of focus supported by written documentation, including information about handover, expectations of staff (with suggested script), sign on sheets and written handover sheets.

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STANDARD 8

Weekday morning handover is attended by the Deputy Medical Director and JMO Manager (or one of the JMO Coordinators). Generally, one of the senior physicians or the DPET also attends. Given the infancy of the hospital, this will remain an area for continued focus and support as the systems and culture supporting effective clinical handover are firmly established.

Handover at the end of term is supported by the JMO unit staff who coordinate this process and encourage the JMOs to use a standardised handover sheet.

Achievement Rating

	Low / Moderate / Extensive
Prevocational Training Provider Self-Assessment	Moderate Achievement
Survey Team Assessment Rating	Moderate Achievement

Survey Team's Comments, Commendations and Recommendations

Comment(s)

The hospital has a well-established Night to day handover which seems to be working well, not just for handover but also for education and redistribution of workload.

There is no formal day to evening handover and no electronic handover tool and these may be something they might want to consider.

Term handover is not structured.

Commendation(s)

The formal Night-to-day handover seems to be effective as a tool for not just safe handover but also for raising grievances, education opportunities and for the response to workload surges.

Recommendation(s)

The hospital should consider whether the following changes to handover would allow PVTs to improve the safety of patient care:

- a more structured process for term handover
- a formal day-to-evening handover
- an electronic handover support tool

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STANDARD 9

Clinical Supervision

The Prevocational Training Provider and its supervisors ensure a high standard of clinical supervision and training is provided at all times for prevocational trainees.

Critical Criteria

9.1 Trainees have accessible and effective supervision and support at all times, adjusted as required to their individual needs and levels of experience.

9.2 The Provider ensures that Supervisors understand their roles and responsibilities associated to supervision.

Criteria

9.3 Each term has clear, explicit supervision arrangements that are documented in the term description.

9.4 All supervisors demonstrate a commitment to ongoing professional development in their role as a supervisor and have access to training where required

9.5 The Prevocational Training Provider through the GCTC evaluates the quality of all supervision at both a program and individual level and makes the necessary adjustments to improve performance in this area and ensures the AMC requirements for supervisors are met.

9.6 The quality of supervision is consistent across the program and terms with processes in place to manage any temporary change of supervisor's circumstances.

Guidelines

- The Prevocational Training Provider has written, clear, accessible processes, that outline the duties, responsibilities and authority of doctors supervising/training prevocational trainees.
- The Provider provides supervising doctors with feedback on their performance and opportunities to develop supervisory and teaching skills.
- The Prevocational Training Provider understands that all medical staff above the level of prevocational trainee are potential supervisors and should receive appropriate training in supervision from a range of sources.
- The Prevocational Training Provider ensures that supervisors are allocated appropriate time and resources to participate in the Program.
- PGY1 trainees must be supervised at all times by a medical practitioner who is

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STANDARD 9

PGY3 or above and who is both on-site and awake.

- The PGY2 trainee cannot be the most senior doctor on site at anytime
- The Term Supervisor position description fits the guidelines contained in HETI's Network Principles for prevocational medical training (2012)
- The supervision provided complies with HETI, the AMC and relevant guidelines on clinical supervision including the HETI *Superguide: A Handbook for supervising doctors in training*(2013)*.
- Trainees have been made aware of state-wide and local policies and guidelines in relation to supervision.
- The Prevocational Training Provider provides levels of clinical supervision that not only ensures support for the prevocational trainee but ensures safe patient care.

Evidence

1. Term descriptions for all prevocational terms on the current HETI term description template.
12. Documentation of the process for providing feedback to supervisors about their term/skills as a supervisor
13. Position descriptions of supervisors outline the competencies, duties, responsibilities and accountabilities of doctors' responsible for supervising prevocational trainees.
14. Documentation of training opportunities provided to/and taken up by supervisors (including any College training), including evidence of completion of appropriate courses via HETI Online.
27. Evidence that the Provider has rigorous processes in place to ensure safe clinical supervision.
31. Documentation of the Providers process for managing trainees in difficulty. If appropriate include examples of how individual trainees have been managed (i.e. Improving Performance Action Plans).

Provider’s Comments or Additional Evidence (Optional)

Prevocational trainees are in accredited terms supported by a registrar and term supervisor. The majority of term supervisors fulfilled the role in Manly / Mona Vale Hospitals and are aware of requirements. Each term supervisor has a written position description (which they have signed). The DPET has regular contact with individual term supervisors to provide information and support. Term supervisors are all invited to the GCTC meetings and there is a reasonable attendance to this which allows them to remain in the loop with JMO concerns and changes to hospital processes.

Achievement Rating

	Low / Moderate / Extensive
Prevocational Training Provider Self-Assessment	Moderate Achievement
Survey Team Assessment Rating	Moderate Achievement

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STANDARD 9

Survey Team's Comments, Commendations and Recommendations

Comment(s)

Generally, PVTs felt that they were well supervised and supported at NBH.

Term supervisors seemed knowledgeable and committed to PVT education and supervision.

The main concern the team had regarding supervision related to the use of locums to fill registrar vacancies. PVTs had concerns regarding the variability of these locums in terms of their capacity for effective supervision. This again often relates to the hospital not having control over numbers of doctors allocated or ability to fill vacancies. The hospital needs to strive for a more stable workforce model which does not rely so much on the use of locums.

Another opportunity for improvement would be to offer training on supervision and education to term supervisors, registrars and PVTs, e.g. via Teaching on the Run or similar. This could be done on a network basis.

There were some issues around supervision with regard to Palliative care patients as there is only one Pall care consultant who is not on call all the time. The hospital is aware of this issue and working to address it.

Commendation(s)

Term supervisors are commended for their support for and training of PVTs.

Recommendation(s)

The hospital should consider providing professional development in supervision and teaching - possibly using network resources

The hospital needs to stabilise its workforce numbers and structure, to minimise the use of locums.

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STANDARD 10

Term Training, Supervision and Trainee Learning Experience

The Prevocational Training Provider ensures that terms provide broad practice-based clinical experiences and training to meet prevocational trainee's learning outcomes.

Critical Criteria

10.1 The Provider has processes for appointments of trainees to terms based on published criteria that are transparent, rigorous and fair.

10.2 The Provider ensures that PGY1 trainees' clinical and learning experiences enable them to develop the knowledge and skills outlined in the AMC's 'Intern training – Intern Outcome Statements' and 'Guidelines for terms' to enable trainees to meet the MBA requirements for general registration.

10.3 The supervisor ensures trainee participation in a range of clinical experiences and responsibilities relevant to the clinical term.

Criteria

10.4 The Provider takes individual trainees' future career objectives into account in their term allocation.

10.5 The term training opportunities are planned and support the specific term's learning objectives.

10.6 All medical staff are actively involved in supervising, teaching, evaluating and providing feedback to prevocational trainees.

Guidelines

In identifying terms for training, the Prevocational Training Provider considers:

- the complexity and volume of the units workload
- the trainee's workload
- the breadth of experience the trainee can expect to gain
- how the trainee will be supervised and who will supervise them

Term training opportunities can include:

- multidisciplinary meetings,
- term or department based activities such as mortality and morbidly audits, quality assurance activities, case presentations, seminars and journal clubs

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STANDARD 10

- group and one to one training sessions with senior medical/health practitioners
- developing and practising clinical skills within a simulation environment
- medical, surgical or hospital wide grand rounds.

The terms enable prevocational trainees to become team members and allow team members to make reliable judgements on the trainees' abilities, performance and progress.

Where additional learning goals have been requested, the term supervisor supports the trainee to develop a learning plan The learning plan should consider:

- The individual trainee's career goals
- Specific learning needs related to meeting the intern outcome statements
- Clinical experiences and opportunities available in the term.

Where specific learning needs have been identified in previous terms, the term supervisor supports the trainee to develop a learning plan with realistic goals. The learning plan should consider:

- The individual trainee's career goals
- Specific learning needs related to meeting the intern outcome statements
- Issues identified in previous terms
- Clinical experiences and opportunities available in the term.

HETI *The Superguide: A Handbook for supervising doctors in training (June 2013).*

Evidence

17. Term allocations for all prevocational trainees between terms and network hospitals.
18. Documentation of the Process for term allocations.
28. Evidence that the Provider delivers clinical learning experiences and clinical training in each term.
29. Evidence of completed mid and end of term NSW Prevocational Assessment forms for all Prevocational Trainees. *to be supplied at the survey only
30. Evidence of the Provider supporting trainees who have requested specific learning opportunities in addition to the term description

Provider's Comments or Additional Evidence (Optional)

Term allocations are undertaken by the MMV JMO Unit in collaboration with HKH. NBH is advised of which prevocational trainees will be rotated to the hospital on a term to term basis. The process by which Network 6 term allocations are undertaken are published and available to both prevocational trainees and NBH JMO Unit staff.

Prevocational trainees are afforded a range of clinical experiences while at NBH in a supported and well supervised environment. Although the hospital is not yet 12 months old, most units have well-established unit and multidisciplinary meetings. There is a published document of unit-based teaching activities which is circulated to the prevocational trainees.

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STANDARD 10

The DPET meets each prevocational trainee formally a minimum of once per term and this provides an opportunity to ensure that individual trainees are meeting the requirements, including gaining relevant clinical, procedural, communication and professional experiences in their term. The DPET also welcomes prevocational trainees to see him at any time, in addition to these planned mid-term meetings and has an informal open door approach.

Achievement Rating

	Low / Moderate / Extensive
Prevocational Training Provider Self-Assessment	Moderate Achievement
Survey Team Assessment Rating	Low Achievement

Survey Team's Comments, Commendations and Recommendations

Comment(s)

Term specific teaching is variable. Some terms such as Geriatrics do it well. This needs to be part of the term review process and evaluations fed back to term supervisors.

There is no intern teaching program in Emergency and interns are not rostered to the subacute part of the department. This has an impact on the range of ED experience.

Something which concerned the survey team greatly in terms of learning experience was that the PVTs are not required to attend 'rapid responses'. This removes a major opportunity for them to develop their skills in assessing and managing the deteriorating patient. It also means that the responding team does not have immediate access to information that the in-patient team would be able to provide. This is a potential patient safety issue.

Recommendation(s)

The hospital should ensure that PVTs are part of the team called for 'rapid responses'.

The GCTC needs to include term specific teaching as part of its term reviews and publicise terms who are doing it well.

The hospital should review the practice of not allocating interns to the subacute area of ED and also consider providing formal teaching for interns in ED.

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STANDARD 11

Trainee Assessment, Feedback and Remediation

The Prevocational Training Provider provides effective feedback and assessment of a trainee's performance in clinical practice development and achieving learning outcomes.

Critical Criteria

11.1 The intern assessment process is consistent with MBA registration requirements and AMC's publication 'Intern training – Assessing and certifying completion'.

11.2 The Prevocational Training Provider undertakes assessment of PGY2 trainees consistent with the process for PGY1 trainees.

11.3 Trainees are provided with both regular formal documented feedback and timely progressive informal feedback from their supervisor. Formal feedback includes formative mid-term appraisal and summative end of term assessments.

11.4 The Provider has in place an Assessment Review Committee that reviews the progress of all prevocational trainees in order to identify, support and manage trainees experiencing clinical training or practice difficulties, ensuring their early identification and intervention.

11.5 The Provider has an appeals process in place for individual trainees, who wish to appeal an unsatisfactory term assessment report.

Criteria

11.6 The Prevocational Training Provider assesses PGY1 and PGY2 trainees to provide feedback on their progress and determine their ability to practice safely.

11.7 The JMO Management Unit collaborates with the DPET to monitor trainee performance.

11.8 The Provider maintains confidentiality when dealing with trainees in difficulty whilst balancing the need to gain additional support for the trainee and ensure safe patient care.

Guidelines

All trainees should be assessed and provided with constructive feedback during every term. Information that informs the appraisal and assessment can include:

- direct observation
- reports from supervisors

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STANDARD 11

- Improving Performance Action Plans (IPAP)
- Feedback from patients and other team members
- audit of medical records, pathology and radiology requests

The term supervisor encourages trainees to:

- Reflect on and critically appraise their clinical experiences
- Seek feedback from their supervisors
- Take responsibility for their performance

Assessment can include discussions between the term supervisor and the trainee about their previous clinical experiences, training and specific skills; observation; tools used; and reviews of patient cases and clinical notes.

Supervisors communicate their concerns about the trainee to the organisation and collaborate on trainee remediation strategies and monitoring the trainee's progress.

The organisation has processes to:

- immediately address patient safety concerns related to trainee performance
- provide early identification, support and remediation of trainees in difficulty
- inform a trainee when a concern exists with their performance
- establish trainee assessment review groups to advise on complex remediation decisions where satisfactory trainee assessment isn't achieved
- support trainees whose progress after remediation remains unsatisfactory
- communicate with clinical and term supervisors and other prevocational network training facilities about the trainee's performance issues, whilst ensuring anonymity outside relevant stakeholders with a need to know

HETI's *Trainee in difficulty: a management guide for Directors of Prevocational Education and Training 2nd edition 2012.*

Supervisors assessing trainees will have the relevant capabilities and understand the trainee assessment processes.

The DPET is notified when any trainee receives a less than satisfactory assessment or appraisal and ensures an Improving Performance Action Plan (IPAP) is implemented.

The Assessment Review Committee will have clearly documented processes for monitoring trainees in difficulty including their progress on their Performance Improvement Action Plans.

Evidence

4. De-identified minutes of the Assessment Review Committee.
15. Documentation of an appeal process for assessment and registration decisions.
29. Evidence of completed mid and end of term NSW Prevocational Assessment forms for all Prevocational Trainees. *to be supplied at the survey only
31. Documentation of the Providers process for managing trainees in difficulty. If

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appropriate include examples of how individual trainees have been managed (i.e. Improving Performance Action Plans).

34. Evidence of any other workplace based assessments/feedback mechanisms

Provider's Comments or Additional Evidence (Optional)

Term supervisors meet with prevocational trainees at the mid and end of term and complete the progress review forms. This is closely monitored by the DPET who will follow up as required. Completed forms are scanned and returned to HKH.

There is a Network based Assessment Review Committee which is attended by the NBH DPET as well as JMO Unit staff. There is close collaboration between the JMO Unit staff and DPET in managing prevocational trainees identified as requiring additional support.

In addition, the DPET has been in regular contact with the Chair of the HETI PVTC who has provided support and advice as required.

Achievement Rating

	Low / Moderate / Extensive
Prevocational Training Provider Self-Assessment	Moderate Achievement
Survey Team Assessment Rating	Moderate Achievement

Survey Team's Comments, Commendations and Recommendations

Comment(s)

The survey team found evidence that this standard is largely being achieved. Term assessments are done and feedback received,

There seemed to be a culture of information sharing which allows the identification and then support of PVTs requiring extra assistance. The DPET was active in this regard and several examples were cited.

The survey team did hear a case from one of the registrar's which did provide an opportunity for improving the process. A PVT with performance issues had been rostered on a weekend shift under the registrar's supervision but the issues had not been communicated to the registrar.

Recommendation(s)

The hospital should ensure that in the management of PVTs with performance issues, all supervisors (both in and out of hours) have the knowledge required to provide appropriate support.

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STANDARD 12

Training Program Monitoring and Evaluation

The Prevocational Training Provider regularly monitors and evaluates the Prevocational Education and Training Program and uses the feedback for continuous improvement.

Critical Criteria

12.1 The Provider through the GCTC regularly evaluates the Program and uses the findings for continuous improvement.

Criteria

12.2 A quality assurance system has been established, that seeks feedback from Prevocational Trainees, the DPET, Clinical and term supervisors, JMO Management and Consumer perspectives and utilises the feedback to improve the Program.

Guidelines

Provider through the GCTC should evaluate all areas of the Program including:

- The performance of the DPET
- Program orientation
- workload across all terms
- the content and effectiveness of the formal education and training program
- prevocational trainee governance and management
- identification and management of trainees with difficulties
- safety of working conditions
- trainee assessment
- range and access to information resources
- self-care programs
- supervisors
- consumer representative/patient feedback

The Prevocational Training Provider should have a structured process for the evaluation of all its terms across the clinical year. This should include the evaluation of:

- term orientation
- access and effectiveness of the term based training and experiential learning
- access to and range of information resources
- accessibility and effectiveness of supervision
- trainee working hours and workload
- feedback from trainees and supervisors

The Provider should utilise outcomes of evaluation for continuous quality improvement activities.

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STANDARD 12

Evidence

2. Minutes of the five most recent General Clinical Training Committee meetings or equivalent
11. Evidence that the Provider has a system for evaluation and is being used to inform and implement continuous quality improvement of the Program (in both the whole of program and in specific terms).

Provider's Comments or Additional Evidence (Optional)

Although many of the evaluation systems are still in their infancy (given it is less than 12 months since the hospital opened) there are clear structures being established to support evaluation of the prevocational education and training program. Term evaluations are completed by prevocational trainees and currently returned to HKH. As the systems mature, it is planned that these will be collected and retained at NBH and presented to the NGC.

The formal education sessions are evaluated and feedback collated by HKH staff for Network 6. Information arising from these sessions is also presented to the NGC.

All educational sessions undertaken at the hospital are documented with attendance records and evaluated with post-session evaluation forms. Each individual presenter for Intern teaching is sent an email thanking them and given feedback consisting of a summary of the speaker feedback evaluation forms.

Achievement Rating

	Low / Moderate / Extensive
Prevocational Training Provider Self-Assessment	Moderate Achievement
Survey Team Assessment Rating	Moderate Achievement

Survey Team's Comments, Commendations and Recommendations

Comment(s)

Evaluation processes are in place but much of the collection is done by the network which creates delays in any actions which might need to be done by NBH - as they rely on reports from the network.

The GCTC has been reviewing terms but needs to develop a structured process to review all terms on a regular basis. One way to do this is to nominate certain terms to be discussed at each GCTC meeting, with evaluation data being presented to the relevant term supervisors who should be required to attend that meeting and PVTs who have done the term(s).

The other area for improvement is in communication of the outcomes of term reviews (both good and bad) as was mentioned in Standard 2,

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STANDARD 12

Recommendation(s)

It is recommended that the hospital take ownership of the processes used to evaluate the PVT experience at NBH and cease to rely on information provided by the network.

The GCTC should develop a structured process to review all terms on a regular basis which involves the relevant term supervisors and PVTs.

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Trainee Welfare

STANDARD 13

Trainee Advocacy, Welfare and Support

The Prevocational Training Provider ensures that trainee welfare and support is built into all aspects of the Prevocational Education and Training Program. The Prevocational Training Provider ensures that all trainees have access to people who provide support and advocacy.

Critical Criteria

13.1 The Provider has clear and documented processes to ensure that all trainees are supported and that trainee welfare is prioritised.

13.2 The Provider must enable the DPET and JMO Management to provide advocacy and support for trainees.

Criteria

13.3 The Provider ensures appropriate support structures are in place for trainees which includes a DPET and JMO management unit.

13.4 The Provider has systems for providing counselling and support for prevocational trainees.

13.5 The Provider demonstrates compliance with the NSW Health policy directive to prevent and combat workplace bullying in all workplaces. Trainees are aware of mechanisms to manage any incidences of Bullying and Harassment.

Guidelines

The DPET:

- directs the education and training of trainees
- is available for consultation with trainees
- actively monitors the wellbeing of trainees
- regularly communicates with trainees and supervisors about their performance

It may be appropriate to have a second DPET appointed in some circumstances.

DPETs work collaboratively within their Training Network to ensure that all trainees are supported and have equitable access to learning opportunities, career advice, feedback, supervision and welfare.

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STANDARD 13

The Provider ensures that culturally appropriate support systems are in place to support Aboriginal trainees.

The DPET should meet face to face with each trainee twice per year to monitor their progress, assist with their career development and to gain feedback to improve the Program.

All trainees have access to both personal counselling (i.e. Employee Assistance Programs) and career advisory services. These services are publicised to trainees, supervisors and other team members.

Trainees should be encouraged and supported in having their own GP.

Mentors should be available to trainees who want or need this assistance.

PGY2 trainees have access to appropriate professional development leave and the procedures to access professional development leave are published, fair and practical.

HETI's *The DPET Guide (2012)*

HETI's *JMO Manager's Guide (2013)*

HETI's *Network Principles for Prevocational Medical Training (2012)*

Evidence

25. Evidence of the support and welfare services available to trainees.
35. Evidence of the implementation of appropriate strategies to prevent workplace bullying.

Provider’s Comments or Additional Evidence (Optional)

The DPET, supported by the Interim Deputy Medical Director, has been instrumental in creating a culture where prevocational trainees are supported and their well-being prioritised within the organisation. This has included working with the senior medical staff, as well as members of the hospital executive, to give visibility to the needs of prevocational trainees within the hospital.

Central to the establishment of the JMO Unit at NBH has been promoting a culture of support to prevocational (and other) trainees. Staff within the JMO Unit, although new to their roles, are engaged and committed to providing a service or ‘customer’ focussed approach to the management of junior doctors.

Although there remains much work to be done in fully establishing systems and processes, feedback from prevocational trainees indicates that they find the staff of the NBH JMO Unit approachable and responsive to addressing issues.

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STANDARD 13

Achievement Rating

	Low / Moderate / Extensive
Prevocational Training Provider Self-Assessment	Moderate Achievement
Survey Team Assessment Rating	Moderate Achievement

Survey Team's Comments, Commendations and Recommendations

Comment(s)

The DPET is committed and is well respected by both supervisors and PVTs. As mentioned in previous standards, there needs to be a review of the administrative support for the DPET and the available office space. The other concern is access to the HETI PVT training funds. This money is sent to the LHD as part of the larger training amount and it is unclear how this is supposed to trickle down to NBH. Enquiries made by HETI seem to imply that this falls under the public/private agreement.

The team felt other areas for improvement which were discussed with the hospital might include:

- Inviting PVTs onto more hospital committees to improve advocacy
- Developing a mentoring program
- More welfare focussed activities

Commendation(s)

The DPET is commended for his commitment to setting up a successful program for JMOs and all aspects of the role he has taken on.

Recommendation(s)

The hospital needs to negotiate with the LHD a mechanism that allows the DPET access to the nominated training funds.

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RESOURCES

The Accreditation Procedure

NSW Prevocational Training Term Description

NSW Prevocational Training Assessment Forms

Prevocational Accreditation- A guide for Hospitals

HETI Unified Education Series

HETI Online https://spzsso.hss.health.nsw.gov.au/hetionline/oam_login.jsp

Network Principles for prevocational medical training (July 2012)

The DPET Guide – A handbook for Directors of Prevocational Education and Training (2013)

The Superguide- a handbook for supervising doctors (2013)

The JMO Managers Guide to managing and supporting prevocational trainees (2013)

Trainee in difficulty- a management guide for Directors of Prevocational Training (2012)

The Doctor's Compass- a guide to prevocational training developed by the NSW JMO Forum (2012)

The Doctor's GPS (2014)

Australian Curriculum Framework for Junior Doctors

Australian Medical Council "Intern training – Intern outcome statements"

Australian Medical Council "Intern training – National Standards for Programs"

Australian Medical Council "Intern training – Guidelines for terms"

Australian Medical Council "Intern training – Assessing and Certifying Completion"

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GLOSSARY

Accreditation status

Whether or not a Provider or term is accredited, provisionally accredited, not accredited or lapsed. Accreditation status can be varied at any time.

Accreditation decision

A decision made by the PAC regarding a Provider's accreditation status, accreditation period, provisos, recommendations and conditions.

Accreditation cycle

The period of time for which a Provider is accredited. A Providers' accreditation cycle can be varied at any time.

Assessment Review Committee

Is a committee responsible for reviewing the progress of all prevocational trainees in order to identify, support and manage trainees experiencing clinical training or practice difficulties. The committee should ensure the early identification and intervention of trainees in difficulty and assist with more complex decisions on the remediation of interns who do not achieve satisfactory supervisor assessments.

Australian Curriculum Framework for Junior Doctors

Outlines the knowledge, skills and behaviours required of prevocational doctors (PGY1, PGY2 and above) in order to work safely in Australian hospitals and other healthcare settings.

Australian Medical Council (AMC)

The Australian Medical Council (AMC) is an independent national standards body for medical education and training. Its purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.

Clinical supervision

Direct or indirect monitoring of prevocational trainees by a more senior medical practitioner (PGY3 or above) to ensure practices are performed safely for both patients and trainees.

Supervisors also provide prevocational trainees with training, feedback and assessment of clinical procedures and patient care.

Clinical team

Facilities are to list all registrars, consultants and clinical team members including their titles, who will be working with the prevocational trainees. This section should include a contact phone number and pager number for each team member.

Core term

A mandatory term required for general registration. There are three core terms - Emergency, Surgery and Medicine. For terms to be accredited as a core term they must meet the specific requirements of a core term. A PGY1 prevocational trainee must complete all three core terms plus an additional two terms to gain general registration with the NSW Medical Board.

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Criteria

The Criteria are elements of a standard that should be addressed in order for a Provider to meet the standard. Where the Provider is deemed to have not addressed the Criteria, they may be judged to have not met the standard.

Critical Criteria

The Critical Criteria are elements of a standard that must be addressed in order for a Provider to meet the standard. Failure to meet a Critical Criteria will result in the standard not being met.

Director Medical Services (DMS)

Is the senior clinician in charge of managing medical services in the hospital and the responsible officer for issues affecting the employment, progression and registration of prevocational trainees.

Director of Prevocational Education and Training (DPET)

Is a medical practitioner appointed by the Provider and approved by HETI to provide medical leadership and oversight of the Prevocational Education and Training Program (Program). This role includes developing, coordinating, promoting and evaluating the PROGRAM. The DPET is responsible for the supervision and welfare of junior doctors (PGY1s and PGY2s) and advocating for trainees. This position communicates with the clinical supervisors, term supervisors, JMO Managers and assists the General Clinical Training Committee (GCTC).The DPET position description can be found in the HETI Network Principles for Prevocational Medical Training.

General Clinical Training Committee (GCTC)

Is a Training Provider based committee responsible for the development, implementation, monitoring and evaluation of the Prevocational Education and Training Program. A suggested Terms of Reference can be found in the HETI Network Principles for Prevocational Medical Training.

Immediate Supervisor of a Prevocational Trainee

Is the medical practitioner with direct responsibility for patient care delegated to supervisor the prevocational trainee on a day to day basis and will be at least a postgraduate year 3 (PGY3) trainee.

JMO Manager

This role may vary between facilities; JMO Managers all have one common responsibility of managing the junior medical workforce of the Training Provider or Network. This role encompasses junior medical officer recruitment, orientation, term allocations, rostering, leave and human resources management, support to trainees in difficulty and managing grievances and complaints involving junior doctors.

Network Committee for Prevocational Training (NCPT)

Provides governance to the prevocational training network. The NCPT coordinates the allocation of terms across the network, ensures safe, high quality prevocational training and ensures equitable agreed distribution of trainees across the network. The NCPT membership includes representatives from each Provider within the network such as Directors of Prevocational Education and Training, senior JMO Management, Directors of Medical Services or their equivalents and Prevocational Trainees. A suggested Terms of Reference can be found in the HETI Network Principles for Prevocational Medical Training.

PGY1

The first year of supervised training following the completion of medical school or AMC graduation. The year is also referred to as internship. PGY1 Trainees are expected to have Provisional Medical Registration from the Australian Health Practitioner Regulation Agency.

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PGY1 trainee

An AMC Graduate, IMG or local graduate undertaking supervised training in their PGY1. PGY1 Trainees are expected to have Provisional Medical Registration from the Australian Health Practitioner Regulation Agency.

PGY2

Is a second year of supervised training following PGY1. This year is also referred to as the resident year. PGY2.

Trainees are expected to have General Medical Registration from the Australian Health Practitioner Regulation Agency.

PGY2 Trainee

A trainee undertaking their second year of supervised training and has attained General Medical Registration from the Australian Health Practitioner Regulation Agency.

Prevocational Accreditation Committee

Is a HETI committee with the delegated responsibility for managing, advising and making decisions on the accreditation and review processes for Prevocational Training Providers, Prevocational Education and Training Program and terms.

Prevocational Education and Training Accreditation Standards (also referred to as Standards)

This refers to HETI's Standards for accrediting Prevocational Training Providers and Terms in NSW.

Prevocational Education and Training Program (Program)

Is a two year generalist education and training program delivered by a Prevocational Training Provider that enables trainees to achieve general registration and provides a foundation for entry into vocational training. The Program provides trainees with the knowledge, skills and supervision to provide safe patient care through appropriate educational and training opportunities. The Program promotes the interests and welfare of trainees. The Program provides opportunities for trainees to meet the AMC's Intern Outcome Statements and the learning outcomes specified in the Australian Curriculum Framework for Junior Doctors. At the Providers accreditation survey they will be assessed on how successfully the Program is being delivered.

Prevocational trainee

A Prevocational Trainee includes PGY1 trainees, PGY2 trainees and AMC graduates undertaking supervised training.

Prevocational Training Council

Is a HETI Council delegated responsibility to ensure state-wide coordination of the prevocational training networks and to develop resources that will improve prevocational training in NSW. The Council also provides expert advice to HETI and NSW Health on prevocational education and training matters and related issues. The Prevocational Training Council is responsible for approving DPET appointments.

Prevocational Training Provider (Provider)

Is the institution where the prevocational trainees work and train. The Provider can be a hospital, general practice, community health centres or other accredited health facility. The Provider governs and or provides some or all aspects of the Prevocational Education and Training Program.

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Primary Clinical Supervisor

Is a consultant or senior medical practitioner with experience managing patients in the relevant discipline (PGY3 or above). The Primary Clinical Supervisor may be the term supervisor.

Provisional Accreditation

An accreditation status granted by the PAC for a limited period to a new Provider or term that has demonstrated its preparedness to meet the Standards. After the period of provisional accreditation the term or Provider may be eligible for accreditation.

Supervisor

A medical practitioner who is responsible for ensuring the clinical supervision of prevocational trainees. A supervisor must be a medical practitioner with general registration with the Medical Board of Australia. At a minimum their clinical experience must be greater than that of a PGY2 trainee and preferably greater than a PGY3 trainee.

Surveyor

A clinician, medical administrator, JMO Manager or a junior medical officer engaged by HETI on a voluntary basis for the purpose of surveying Prevocational Training Providers against the Prevocational Education and Training Accreditation Standards. All surveyors complete training before undertaking a survey.

Team Leader

A surveyor delegated with the responsibility of coordinating the survey team before and during and after a survey. With the survey teams input the team leader produces the final written accreditation report and reports to the Prevocational Accreditation Committee the survey findings. Team leaders are medical administrators or clinicians who are experienced surveyors.

Term

The specific clinical team, service or unit attachment which is accredited for prevocational trainees to work and receive clinical training in. All terms must be accredited prior to prevocational trainees commencing work in the term.

Term description

An orientation document required for each term. All terms must ensure the safety of both patients and prevocational trainees by providing appropriate levels of supervision, workload, hours and clinical practice suitable to the skills of the prevocational trainees performing them. HETI's Prevocational Accreditation Committee (PAC) assesses all term descriptions submitted for their potential to provide safe educational opportunities.

Term Orientation

Provides the trainee with a formal orientation specific to the term, including the clinical experiences and skills development that will be facilitated and the term assessment process.

Term Supervisor

Is a senior medical practitioner responsible for the orientation, supervision and coordination of clinical training and assessment of prevocational trainees attached to the specific term.

Every term must have a dedicated term supervisor that can fulfil the roles, responsibilities and requirements outlined in the HETI Term Supervisor Position Description which can be found in the HETI Network Principles for Prevocational Medical Training.

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The National Standards

Refers to the Australian Medical Council National Internship Framework.

Trainee

This term, where not specified, refers to both PGY1 and PGY2 junior doctors.

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