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CONFEDERATION OF POSTGRADUATE MEDICAL EDUCATION COUNCILS



**Building Supervisory Capacity Project:
National Professional Development Program
for Directors of Clinical Training and
Prevocational Clinical Supervisors**

© Confederation of Postgraduate Medical Education Councils

This report was prepared by Dr Jagdishwar Singh for the Confederation of Postgraduate Medical Education Councils (CPMEC), as part of National Training and Professional Development Program for Directors of Clinical Training and Prevocational Clinical Supervisors Project funded by Health Workforce Australia

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Abbreviation	Description
ACF	Australian Curriculum Framework For Junior Doctors
ADCTC	Australian Directors of Clinical Training Committee of CPMEC
AHPRA	Australian Health Practitioner Regulation Agency
AJMOC	Australasian Junior Medical Officer Committee of CPMEC
AMC	Australian Medical Council
AMEOC	Australian Medical Officers' Committee of CPMEC
ANZAHPE	Australian & New Zealand Association for Health Professional Educators
BSCP	Building Supervisory Capacity Project
CPMEC	Confederation of Postgraduate Medical Education Councils
CSSP	Clinical Supervision Support Program
DCT	Director of Clinical Training or equivalent roles such as DPET
DPET	Director of Prevocational Education and Training
HETI	Health Education and Training Institute of NSW
HWA	Health Workforce Australia
JMO	Junior Medical Officer
MBA	Medical Board of Australia
MEO	Medical Education Officer
NTGPE	Northern Territory General Practice Education
NTPD	National Training Program for Directors of Clinical Training
PAC	Program Advisory Committee for the NTPD project
PDPR	Professional Development Program for Registrars
PMCs	Postgraduate Medical Councils or equivalent agency looking after the accreditation, education and training of the first two years of prevocational training
PMCV	Postgraduate Medical Education Council Victoria
PMCWA	Postgraduate Medical Council Western Australia
PSC	Program Steering Committee for the NTPD project

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1. EXECUTIVE SUMMARY

This Final Report of the National Training and Professional Development Program (NTPD) highlights the outcomes of two pilot programs designed to address a major lacuna in the training of prevocational medical education supervisors, most of whom hold minor fractional appointments to perform their roles. The issue of a national program for Directors of Clinical Training (DCT) and other prevocational training supervisors had been raised a number of times at the DCT workshop held in conjunction with the annual Prevocational Forum. The Confederation of Postgraduate Medical Education Councils (CPMEC) was able to obtain funding from Health Workforce Australia (HWA) to run two pilot programs and if there was support, to establish an online learning platform subsequently.

The report notes that in the establishment of learning needs, design, development and delivery of the pilot programs, DCTs were very closely involved in the process right from the outset. Specialist expertise in professional development was also utilised to ensure that the participants had a very worthwhile learning experience that expanded their repertoire of professional skills but remained largely focused on their DCT roles. This included the development of cases and scenarios based on feedback and discussions with DCTs and others involved in prevocational medical education.

In developing the pilot programs, we were mindful of the significant challenges. Having senior clinicians travel to attend the program meant that the maximum time available for the program was 1.5 days. The target audience was very heterogeneous with experienced and novice DCTs in attendance. As participation was based on self-nomination, the program objectives needed to resonate with the intended target audience. Program facilitators needed to account for these challenges and make in-program adjustments.

The pilot programs surpassed all of CPMEC's expectations. A total of forty DCTs attended the two programs in Sydney and Melbourne drawn from every jurisdiction in Australia and also included a participant from New Zealand. (We were initially targeting 24 to 30). The overall program rating by the participants was 6.5 out of a maximum of 7. Every participant noted that they would recommend the program to other DCTs. Post-program feedback received confirmed the value derived from the programs and that it had been an excellent learning experience. There were a number of suggestions on topics for inclusion on future programs for DCTs. Participants also appreciated the opportunity to network with other DCTs in safe professional learning environment designed specifically for their needs.

Participants also identified the additional insights gained from undertaking the programs with particular mention made of enhanced counselling and mentoring skills, handling conflict and promoting a community of practice. There was a significant agreement that the program would allow them to function more effectively as a DCT. The feedback received from the participants indicated strong support for a website to continue the work done in hosting the pilot programs and create a national vehicle for DCTs to facilitate DCT interactions and foster a community of practice. Work on this website which will be hosted by CPMEC is advanced.

The report makes the following recommendations to ensure that the benefits of this project are sustained:

- 1 That PMCs and jurisdictional health departments continue to provide opportunities for DCTs to undertake professional development programs of this type
- 2 The pilot programs provide a successful template for delivery of professional development programs for DCTs and should be expanded to other prevocational settings
- 3 CPMEC continue to explore mounting national programs to bring together DCTs using the self-learning model adopted for the pilot programs
- 4 Maintain the strong engagement with DCTs through the Australasian DCT Committee to identify ongoing learning and professional development needs and, once the DCT website is online, to communicate this to all DCTs and prevocational training supervisors

CPMEC thanks Health Workforce Australia for funding the project and all the members of the Project Steering Committee and the Program Advisory Committee for their inputs. CPMEC also acknowledges inputs from all the DCTs from throughout Australia who helped in the design and delivery of the pilot programs and provided post-program feedback. Particular mention should go to the contributions of Professor Louis Irving of Royal Melbourne Hospital in the design, development and delivery of the NTPD pilots. CPMEC Executive Officer, Ms Lucy McEwan also provided excellent support work in ensuring the success of this project.

2. PROJECT BACKGROUND

CPMEC has been concerned for some time that little preparation, training, and support has been provided to Directors of Clinical Training (DCTs)¹ and prevocational clinical supervisors (PCSs) who are responsible for the educational supervision, training, and assessment of interns and the prevocational medical workforce. This issue was raised at the 2010 and 2011 DCT Workshops held as part of the Annual Prevocational Forums. The DCTs agreed that a national approach to the professional development of this group was required to reduce unnecessary duplication of effort and resources. The meetings noted the need for DCTs to have the same access to professional development as clinical supervisors in other phases of the medical training continuum. The 2010 DCT workshop noted that CPMEC was 'ideally placed to develop and conduct a national professional development program for DCTs, given its leadership in postgraduate medical education²'. The 2011 meeting made an initial attempt to identify key training needs of DCTs in terms of knowledge and skills requirements; possible program contents; and modalities of delivery.

A perennial hurdle in the prevocational medical training domain has been the absence of commensurate funding to support the expansion of supervisory capacity to keep pace with increased medical graduate numbers. Some PMCs³ have taken sporadic initiatives to develop programs but the overall situation remains rather patchy and highly variable. CPMEC approached Health Workforce Australia (HWA) to fund the development of a national program for DCTs on the basis that development and support for prevocational medical workforce supervisors responsible for the teaching and supervision of junior doctors was a grossly underserved area. CPMEC is grateful that HWA agreed to provide one-off funding of \$150K to CPMEC to develop and pilot a national training and professional development program (NTPD) for DCTs and prevocational clinical supervisors. The funding agreement also had a provision for the development of an online learning platform for DCTs which was contingent on the successful delivery of the NTPDs.

In considering funding due cognisance was taken of the Clinical Supervision Support Program (the Program) of the HWA which has sought to expand clinical supervision capacity and competence across the educational and training continuum by supporting measures to prepare and train clinical supervisors; and support and develop a competent clinical supervision workforce, which delivers quality clinical training.

HWA has also developed the National Clinical Supervision Support Framework to guide and support clinical education activity in the health sector. The Framework informs and underpins projects and activities undertaken as part of the Program. The NTPD supported HWA's achievement of the three key focus areas of the Framework as follows:

¹ "DCTs" is used in this report as a generic term to cover equivalent positions such as Director of Prevocational Education and Training etc.

² Letter from Prof L. Irving, Convenor of 2010 DCT Forum to Prof B. Crotty, then Chair of CPMEC, 29th March 2011

³ PMCs are used as the generic term to cover organisations responsible for the accreditation, education, training and support of prevocational doctors and their supervisors

- **'Clarity'** – the NTPD helped reinforce national consensus amongst DCTs and other relevant prevocational medical workforce agencies about the role, functions, responsibility and accountabilities of DCTs. A key facilitator in this regard was the development of position description guidelines by CPMEC's Australasian DCT Committee (*Appendix 1*).
- **'Quality'** - to improve the quality of clinical supervision of prevocational doctors; help PMCs build local capacity by providing a template and resources for their professional development; and enhance the quality of interaction between DCTs and prevocational medical workforce.
- **'Culture'** - reinforce the role, value and contribution of DCTs and prevocational supervisors and encourage collaboration with other clinical supervisors across the medical training continuum to promote a culture of continuous improvement. Having a dedicated program for DCTs would provide an important signal about the value attached to the role.

a) Project Phases

The Building Supervisory Capacity Project (BSCP) involved designing, developing, delivering and evaluating a national training and professional development program (NTPD) to specifically cater for the learning needs of Directors of Clinical Training and Prevocational Clinical Supervisors in Phase 1 of the Project. Dependent on the outcome of the evaluation of Phase 1, the project would then proceed to the establishment of an online learning platform for DCTs in Phase 2. Details on the aims of the two phases were as follows:

Phase 1 of the project involved the following:

- Establishing the project governance structure.
- Setting up a representative consultation process with DCTs to establish the learning requirements of DCTs and prevocational clinical supervisors and the manner in which current training practices could benefit from improvement.
- Designing and developing the NTPD and ensuring alignment with the HWA Supervision Frameworks.
- Promoting and piloting the NTPD in Melbourne and Sydney.
- Evaluating the NTPD and reporting findings.

Phase 2 of the project:

The results of the evaluation of the NTPD were assessed to be very positive and HWA granted CPMEC approval to proceed with the implementation of the online learning platform as Phase 2 of the project.

The online learning platform has been developed in consultation with HWA. It was agreed that the platform be hosted by CPMEC. Site Zero who are the existing website provider to CPMEC were commissioned to develop the platform based on specified needs. In developing the website, feedback received from DCTs attending the NTPD programs, discussions at the Project's governance groups, and inputs from the annual DCT Forums were the key factors that governed the final shape of the platform.

b) Project Deliverables

The key deliverables for this project are:

- A report on the findings from consultations with DCTs
- Report on the pilot and evaluation of the NTPD
- If approved, establishment of an online learning platform for DCTs
- Final report to the HWA

c) Scope Exclusions

In undertaking this project, CPMEC ensured that there would be little overlap with work being undertaken under the Clinical Supervision Support Partnership Project being managed by the Medical Deans of Australia and New Zealand. It was also agreed that there was no commitment to provide ongoing support for the NTPD by HWA beyond the duration of the project. It was also agreed that CPMEC would not extend the brief of the project beyond the requirements of DCTs.

4. Phase 1: The NTPD Program

a) Project Governance Structure

The BSCP project governance included a national Project Steering Committee (PSC) with responsibility for oversight of the project and a separate Program Advisory Committee (PAC) to provide more specific advice on the program design and development. To avoid unnecessary proliferation of administrative structures, the Australasian DCT Committee (ADCTC) of CPMEC took on the role of the PAC with a few more DCTs also being added to augment the expertise in the group. Albeit varying in degrees, both the PSC and the PAC were closely involved in the development and approval of the program, setting up the pilots, and agreeing on the evaluation methodology. The PSC also included a representative of HWA. The project governance structure is captured in Figure 1 below.

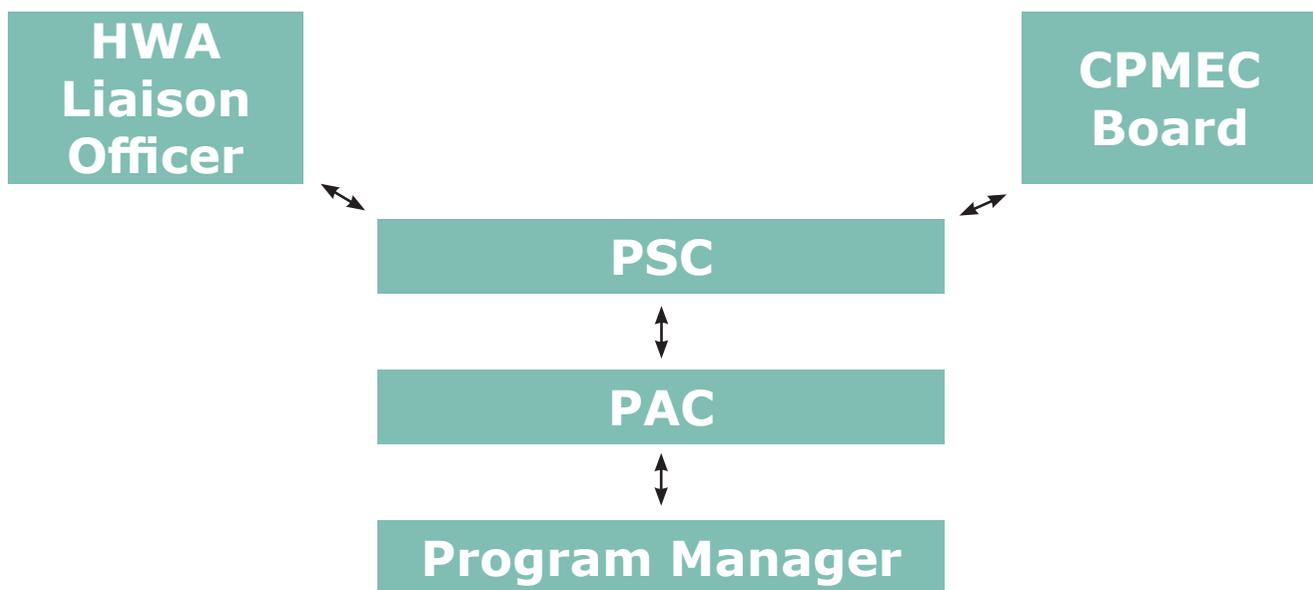


Figure 1: BSCP Project Governance Structure

The Project Steering Committee (PSC) was comprised representatives made up of medical administrators, DCTs or equivalent, PMC reps, junior doctors, HWA representatives, and medical educators. The PSC membership list is included as *Appendix 2*. Its roles and responsibilities included:

- Monitoring approved project plan
- Receive report of the DCT consultation process

- Approve evaluation methodology for the NTPD pilot programs
- Assess results of the NTPD program evaluation and recommend the need or otherwise for an online learning platform for DCTs
- Provide inputs into the development of an online learning platform

The Program Advisory Committee (PAC) was set up to ensure that the program development closely took into account the needs of DCTs as gauged by a wide cross-section of the potential target group. In short, we took the approach of making it a program for DCTs designed by themselves but with the input of educational experts in facilitation of learning. The PAC provided inputs in the following areas:

- Learning needs of DCTs
- Design and development of NTPD
- Identification of pilot sites
- Delivery of the NTPD
- Evaluation of NTPD
- Identification of elements that could be supported by online learning versus those to be delivered in the NTPD

CPMEC was the major project sponsor in conjunction with its member Postgraduate Medical Councils (PMCs). The latter acted as the principal conduits for disseminating information on the project within their jurisdictions with other key stakeholders.

b) Project Management

The project was managed by CPMEC's Chief Executive Officer, Dr Jagdishwar (Jag) Singh and Executive Officer, Ms Lucy McEwan. Other part-time staff were contracted to deliver particular aspects of the NTPD. The technical development of the online platform is being undertaken by Site Zero under instructions from CPMEC.

In addition to project management, oversight and implementation, there was ongoing liaison with HWA, the project governance groups, DCTs participating in the program, and

communication about the project to other key stakeholders. Key risks were monitored and managed regularly to keep the project on track. The principal one related to CPMEC's reputation. The first was the risk of poor participation levels if CPMEC went ahead and organised the program. The second was that if the program did attract sufficient number of participants, it was not considered to have been a worthwhile learning experience by the participants.

The key assumptions for the project included availability of project resources and the expertise of CPMEC to deliver a program that would have support from DCTs throughout Australia. In taking on the project, it was recognised that CPMEC was working under relatively tight timelines and would be able to attract time-poor DCTs to attend NTPD programs if seen as relevant.

c) Establishing DCT Learning Needs

After the initial work undertaken in the 2011 annual DCT workshop, it was agreed that in the 2012 workshop a more systematic process be adopted to establish the learning needs of DCTs. This was part of a multi-tiered process which provided a substantial level of validation of the identified needs. Undertaking the learning needs analysis for the NTPD program was designed to ensure that the program developed was appropriate and relevant. The process helped identify the knowledge, skills, behaviours and capabilities that needed to be addressed in a robust training program. Additionally, it also helped DCTs by providing a tool for self-assessment of gaps in their knowledge and skills.

The attached form (*Appendix 3*) sought feedback on two issues:

- 1.** At the 2011 DCT forum participants were asked to identify and rate the learning needs of DCTs as it is the most representative Australasian gathering of DCTs. DCTs were asked to identify needs as high, medium or low priority.
- 2.** Subsequently, feedback from the Australasian DCT Committee meetings and other DCT forums provided further validation of the identified needs. The feedback not only confirmed the earlier feedback, but also helped in prioritising them. In addition, it also helped identify a few areas that had been missed out earlier.
- 3.** The second part of the feedback sought to establish the preferred delivery modality for each of the topics listed and any others added. This helped the PSC and the PAC identify components of the face-to-face NTPD workshops and separate them from topics that could be delivered through the online learning portal. It was recognised that all topics listed could be delivered in either format or in blended form, but the key element of the feedback was the preferred delivery mode for the topics.
- 4.** *Appendix 4* shows the combined results of the learning need priority rankings and preferred delivery modality. There was very significant overlap between highest priority

learning needs and preferred delivery modality in a face-to-face setting and topics included:

- A** Demonstrating educational leadership
- B** Mentoring skills and techniques
- C** Counselling skills and techniques
- D** Managing performance including the underperforming trainee
- E** Advocacy skills
- F** Handling conflict and difficult individuals
- G** Dealing with stress and distress
- H** Giving and receiving feedback

d) Design & Development of NTPD

As noted previously, the development of the NTPD had been driven by the DCTs themselves with CPMEC playing a key facilitating role in aiming to deliver a worthwhile learning experience. DCTs had helped identify and prioritise learning needs, and preferred delivery modality. The challenge for CPMEC was to put together a program that integrated

The contents and ensured a delivery methodology that would be engaging for the participants. The program design agreed upon had the full support of both project governance groups. As this was the first time that DCTs from all over Australia were being brought together for a professional development program, the following were some of the outcomes that CPMEC hoped would emerge from the pilot programs:

- A** Reaction of a national community of practice for DCTs to share knowledge and experiences about their roles, responsibilities and challenges
- B** Emphasise the role of DCTs as educational leaders and members of an educational team
- C** Develop or augment skills in areas such as counselling, mentoring, conflict management

In considering the program design, the following factors were taken into consideration:

1. Program Duration

The Program Advisory Committee (PAC) advised CPMEC that the maximum duration that DCTs would be available for this program would be 1.5 days. This was in recognition of the limited time allocation for most of these DCT appointments and taken into account in the planning of the program. As the program was offered in a residential format, it did allow for some program activities in the evening as well. However, it was recognised that the format would result in a fairly intensive training program but it was envisaged that the mix of training methodologies utilised would mitigate most of the concerns in this regard.

2. Target Audience

It was agreed that the target audience for the programs would be all DCTs who were interested in attending the programs. There were a number of factors that underpinned this decision. Principal amongst this was that it was one of first opportunities that had been made available to DCTs to attend a professional development program of this nature. Having more experienced DCTs would also help the less experienced members through informal networking and sharing of some of more tacit skills involved in the role. It was also agreed that participation in the program would be on the basis of self-nominations. Enquiries had also been received from DCTs in New Zealand to attend the program. The approach had the full endorsement of PSC, PAC and HWA.

3. Program Objectives

It was agreed that the program would seek to address the following objectives in the allotted duration:

- A** Discuss roles and responsibilities of DCTs
- B** Clarify Medical Board of Australia requirements especially with regard to signing off on completion of internships
- C** Enhance educational supervision skills and techniques
- D** Give and receive feedback more systematically
- E** Understand & apply conflict resolution techniques
- F** Handle difficult trainees more effectively
- G** Augment teaching and leadership skills
- H** Build mentoring and counselling skills
- I** Network with peers

4. Preparatory Activity

Particular attention was paid to ensuring that the program was contextualised to meet the needs of DCTs. The following activities were undertaken in the design and development of the program:

- A** Discussions with a number of experienced DCTs to develop scenarios for discussions (*Appendix 5*). Based on the discussions, a number of key issues and challenges were distilled to provide the basis for discussions on topics in the program.
- B** Developing a program methodology that focused on active, experiential learning that was relevant to their roles. As the nature of the program dealt with “far transfer” issues, it was important that activities could be translated into educational and clinical roles.
- C** Providing full briefings for the presenters who were involved in the delivery of the program on the DCT’s roles and expectations. Presenters included experienced DCTs and experts in leadership development, counselling, conflict and stress management, mindfulness, and education.
- D** Utilising the lessons from numerous professional development programmes that CPMEC had run previously for clinicians engaged in the teaching and supervision of the junior medical workforce. In this regard, experiences from the rollout of the Professional Development Program for Registrars (PDPR) proved particularly valuable.
- E** Identifying a range of resources that would provide background information on the various learning topics identified as priority areas. The resources were drawn from both medical education and the best practices from non-medical sources.

5. Considerations in Program Development

Given that participation in the program had been made open to all DCTs nationally one of the challenges was developing a program and methodology that catered for a heterogeneous group of participants. Using the analogy of a smorgasbord, the NTPD was designed to cover the topics based on the understanding that participants would have different levels of engagement with the topics depending on needs and experience. The challenge in program development was to ensure that the course methodology was devised to ensure that all the participants would be sufficiently immersed in the topics covered. In developing the program, a further consideration was that it would not just cover the organisational role requirements as DCTs but also enhance personal development through reflective activity as clinicians, educators and supervisors on a range of issues dealing with the teaching and supervision of junior doctors. The following were some of the key considerations in the development of the NTPD:

- A** The use of experienced facilitators who could employ a range of training methodologies to account for the varying levels, ability, and prior experience of the group. This included the ability to make in-program adjustments. As we shall highlight later, the mix of participants was different even when comparing the two pilot programs.
- B** As the participants had self-nominated to attend, motivation and readiness to learn was not expected to be an issue. The challenge was to create a safe learning environment that allowed for the active involvement of the participants in an informal setting away from their respective work environments.
- C** Given the program duration constraints, we had to be mindful that the program would be intensive but not result in information overload.
- D** The program logic was based on guided learning with minimal emphasis on telling and prescribing solutions. Program facilitators provided frameworks, cues, prompts, suggestions and feedback on solutions generated by the participants around the structured program topics.
- E** Irrespective of prior experience in DCT roles, the program would help enhance the capabilities of the attending DCTs.
- F** Additional resources could be made available post program through the anticipated online learning platform.

6. NTPD Timetable Outline

As noted previously, the program was run over 1.5 days. The first day was intense and culminated in a dinner that involved a panel on career counselling. The second day of the program concluded after lunch to allow participants to travel back the same day. The following was agreed as the timetable for the program:

Day 1

Welcome & Introductions DCT roles and responsibilities

- Position requirements
- Dealing with ambiguity

Leadership & Advocacy skills

- Key leadership principles
 - Role modelling
- Dealing with transitions

Challenges of educational supervision

- Key learning principles
- Workplace-based learning
- Establishing trainee learning needs
 - Competence and confidence

Giving and receiving feedback

DCT as a member of educational team

- Preferences and learning styles
 - Working in teams
- Implications for supervisory role

Counselling, Coaching & Mentoring

- Effective Skills and techniques

Career Counselling Panel

Overnight work

Day 2

Reflections from Day 1

Stress management and Mindfulness

Perspective from the Medical Board of Australia

Handling conflict and difficult individuals

- Assessing and responding to different scenarios
 - Sources of conflict for DCTs
- Different conflict management styles
 - Handling Difficult individuals
 - o Underperformer
 - o Personality issues
- Having the difficult conversation

Open Consulting Forum

Program review and closure

7. Program Staff

The CEO of CPMEC, Dr Jag Singh, was the Program Director for both the pilot programs and acted as the link between the participants and the facilitators. Presenters who contributed to the pilot programs were:

- a. Ms Jane Austen (HWA – Melbourne)
- b. Prof Louis Irving (Roles of DCT – Melbourne)
- c. Ms Michelle Morrison (Personality; Conflict; Coaching - Melbourne)
- d. Prof Barry McGrath, Dr Laila Rotstein, and Dr Susannah Ahern (Career Counselling - Melbourne)
- e. Dr Craig Hasted – (Mindfulness – Melbourne)
- f. Dr Joanna Flynn (Medical Board of Australia - Melbourne)
- g. Dr George Beltchev (HWA – Sydney)
- h. Mr Richard Jones (Sydney - Personality; Conflict; Coaching)
- i. Dr Alan Gale (Roles of DCTs – Sydney)
- j. Dr Stephen Bradshaw (Medical Board of Australia – Sydney)
- k. Dr Di Khursandi (Educational Roles of DCTs– Sydney)
- l. Dr Belinda Khong (Mindfulness – Sydney)
- m. Prof Simon Willcock and Dr Ros Crampton (Career Counselling – Sydney)

Appendix 6 includes a set of key PowerPoint slides used during the two pilot programs.

e) Development of Evaluation Methodology

It was agreed that the NTPD program would be evaluated using a combination of approaches including:

- A** End of program reaction feedback from the participants on the program objectives, content and processes used; expertise and facilitation skills of the presenters; and the format of the program and resources provided. Participants provided both quantitative and qualitative ratings. The latter was particularly encouraged given that these were pilot programs.
- B** Self-assessment by the participants at the end of the program on the increases in learning as a result of undertaking the program.
- C** Participants providing feedback on the need for an online learning platform to further support and identifying resources and materials for inclusion on the platform, if considered warranted.
- D** Online post-program surveys with individual follow up. Whilst a formal post-program form was developed (*Appendix 7*), it was felt that formally administering the questionnaire would be an overkill given the amount of post-program feedback that was received on the program and in the shaping of the online platform. Nevertheless, targeted post-program follow up has been continuing.

As these were the first national programs targeting DCTs, the following were agreed as critical success measures for the NTPD in advance of the pilots being developed and trialled:

- A** That each of the pilot programs would have a minimum of 12 and a maximum of 16 participants.
- B** The program had support of jurisdictional Postgraduate Medical Councils willing to be involved in hosting the pilot programs.
- C** Achieve post-program follow with at least 80% of the pilot participants.
- D** Establish the need for, and clearly identify contents that could be supported through an online learning platform for DCTs.

f) Piloting of NTPD

There were several expressions of interest for the hosting the two pilot programs. Eventually, it was agreed to host the pilot programs in Sydney and Melbourne at the Sebel in Surry Hills and Bayview on the Park respectively. The Melbourne program was run on 2-3 May 2013 and the Sydney program on 17-18 May 2013.

It was agreed that the programs would host DCTs from states and territories as follows:

- The Melbourne pilot program would host DCTs from VIC, SA, TAS, WA and NT.
- The Sydney pilot would host DCTs from NSW, QLD, ACT and NZ

A brochure outlining the program objectives was circulated to DCTs throughout the country through the PMCs (*Appendix 8*). Members of the Project Steering Committee and the Program Advisory Committee also helped disseminate information about the program. The NTPD was also advertised through CPMEC's newsletter and its various Special Interest Group.

Eventually, we had a total of 40 DCTs who attended the program with 16 attending the program in Melbourne and 24 attending the Sydney program. There were three late withdrawals (one in Melbourne and two in NSW due to unforeseen clinical service commitments). QLD had the highest level of representation on the program followed by NSW. The DCTs represented a wide range of specialities. A list of the DCTs who participated in the pilot programs is included as *Appendix 9*. The breakdown of attendees attending by jurisdictions was as follows:

JURISDICTION	MELB	SYD	TOTAL
QLD	0	12	12
NSW	0	9	9
VIC	7	0	7
WA	3	0	3
SA	2	0	2
TAS	2	0	2
ACT	1	1	2
NT	1	1	2
NZ	0	1	1
TOTALS	16	24	40

Table 1: Breakdown of attendees by jurisdiction

A Program folder containing transcripts of the presentations during the program was made available to all the participants. This was supplemented by additional background materials and resources being made available in an electronic format. All course meals and venue costs were met from the project funds.

Prior to the program, participants were asked for details on experience in roles etc. The cohort who attended the Melbourne pilot was significantly less experienced in their DCT roles than the Sydney group, with a number having just come into the role. Having the different profiles provided for different challenges for the program directors in terms of the pitch of the program. Additionally, because of conflicting commitments presenters, the presenters used on the two programs were largely different although the program contents and timetable remained largely the same.

g) Results of the Pilot Program Evaluation

Quantitative Reaction Feedback

The table below summarises the quantitative feedback of participants to the various items relating to program, its facilitators and general comments included overall rating. A 7-point Likert scale was used. Participants were given the option of identifying themselves or remaining anonymous in providing this feedback. The overall program rating was 6.5 with the Melbourne participants giving it a rating of 6.7 and the Sydney cohort rating it at 6.4.

	ITEM	MELB	SYD	OVERALL
1	Program			
<i>a</i>	<i>Objectives were clearly outlined</i>	6.6	6.0	6.2
<i>b</i>	<i>Content will be useful in my role</i>	6.6	6.1	6.3
<i>c</i>	<i>Content was well organised</i>	6.5	6.0	6.2
<i>d</i>	<i>Examples and illustrations used were very helpful</i>	6.5	6.2	6.3
<i>e</i>	<i>Training processed and methods used were very effective</i>	6.5	6.1	6.3
2	Facilitators			
<i>a</i>	<i>Were always prepared for the sessions</i>	6.4	6.2	6.3
<i>b</i>	<i>Demonstrated subject knowledge</i>	6.6	6.6	6.6
<i>c</i>	<i>Communicated effectively</i>	6.7	6.2	6.4
<i>d</i>	<i>Encouraged trainees' participation</i>	6.7	6.5	6.6
<i>e</i>	<i>Constructive response to questions and comments</i>	6.6	6.4	6.5
3	General Comments			
<i>a</i>	<i>Quality of program folder, hand-outs, etc.</i>	6.4	6.2	6.3
<i>b</i>	<i>Format of the program</i>	6.4	6.0	6.2
<i>c</i>	<i>Training facilities and venue met my need</i>	6.2	6.2	6.2
<i>d</i>	<i>Participants contributed effectively</i>	6.7	6.4	6.5
4	Overall course rating	6.7	6.4	6.5

Table 2: Reaction Program Evaluation – NTPD Pilot Programs (Max = 7.0)

The positive feedback above was echoed in numerous conversations both during the programs and post-program with the participating DCTs. In terms of expectations, the response from the participant exceeded our expectations and it was reciprocated in comments from the participants. These are noted later in this report. It easily surpassed the 5.5 target set by the Program Advisory Committee.

Recommending Program to Others

It is noteworthy that all the participants stated that they would recommend the pilot program to other DCTs and prevocational training supervisors. This has been reinforced by other post-program developments including the organisation of a similar program for medical education staff that stemmed directly from the positive feedback by the participating DCTs.

Most Valuable Sections of the Program

Participants were asked to identify the sections of the program that they found most valuable. The most frequently cited responses to this question were: they found all sections valuable; the sessions dealing with conflict management and resolution; the segment dealing with MBTI, personality preferences and its applications; and the opportunity to network and discuss common issues and the presented scenarios with other DCTs. Other comments related to the mixture of interactive, experiential, and small group program methodologies utilised; the sessions on mindfulness; the practical orientation of the program; acquisition of new skills and techniques on coaching, giving feedback; and the opportunity to discuss issues with the Medical Board of Australia. There was also appreciation about the opportunity to reflect on own and other colleague's skills and styles on a range of teaching and supervision matters. Another similar comment related to the many helpful hints provided throughout the program. The skills and expertise of the program facilitators was also highlighted as being valuable for them.

Program Sections Not Considered Valuable

The most frequent response to this question was that none of the topics fell into this category and that all sections were considered valuable. The other topic that generated multiple responses was the mindfulness session in Sydney. Whereas in the Melbourne program, the response had been overwhelmingly positive, in the Sydney pilot program the feedback was more mixed. Most were very happy with the session whilst a few felt that it had limited impact on their roles.

Other Comments and Suggestions for Improvement

Participants were also given the opportunity to make any further comments about the program format and contents of the program and suggestions to improve its quality if run again in future. These comments have been grouped into the following themes:

i. Excellent learning experience

A number of participants described the program contents and format as excellent. Amongst factors contributing to this were how it had been researched and put together; the choice of facilitators; a safe learning environment created that allowed for honest and open discussions; well-thought out, organised and delivered; felt inspired; well worth the investment of my time; reinforced prior learnings but also provided new insights and strategies; maintaining interest level throughout the program; very helpful; good formula of being "brief and punchy"

ii. Timing and Program Intensity

A number of the participants noted that the program was very intensive but timing and duration was appropriate given resourcing and other constraints. There were some suggestions to expand the program whilst a few others suggested dealing with fewer topics if the program was offered again. Those making the latter suggestion did not

specify what to delete.

iii. Inclusions for Future DCT programs

There were a number of suggestions for additions and changes to any future programs. They included;

- Expanding training models and styles using videoing and tutoring (although this could add to the time pressures)
- Have more ready access to some pre-reading resources and course links
- Include something about structuring the transition as learner moves from novice to expert level
- Need to capture the spontaneous wisdom that arose from discussing the various training scenarios
- Focus on one or two in-depth case discussions
- Ensure that a follow-up session is organised to support these programs
- Spend more time on conflict resolution and feedback
- Would like to access slides used in the program to use in my own teaching
- Introduce change management including managing transitions
- Perhaps include a session on what an exemplar intern training session should look like
- Need to explore funding to ensure that all the work put into this pilot programs are disseminated

iv. Networking

There were several comments on the opportunity to meet and interacting with DCTs from other jurisdictions and with different levels of skills and capabilities. The newer DCTs on the programs highlighted the lessons gained from listening to experienced DCTs on the problems they were facing and possible solutions.

Post-program Feedback

In addition to the feedback at the end of the program, we received a number of unsolicited emails from the participants after the program. Reproduced below are some of these feedback with some minor editing:

I personally experienced a high level of satisfaction. Post conference discussions with some of my colleagues support my view. Thank you indeed for the obvious efforts you expended and the great value we all derived. I believe that such meetings need recurrent support ... as the educational benefit to both novice and to experienced senior DCTs was felt and, in the future, it is imperative in the light of the rapidly evolving medical education space. Please continue to support the DCT role.

Thank you so much for all the time and effort you put into organising this. It was a really great program.

Let me congratulate you on a very successful course - I think everyone really enjoyed it.

Having a functional DCT in each hospital is such an important risk management and human requirement that I hope these courses can continue.

It was one of the most useful, if not the most useful, training programs I have been on in the last 10 years. Well done to all involved. Having a good group of doctors helped the program as well.

Really well organized and presented

Have used some of the information already

A great formula utilised to organise the contents and delivery the program.

Thank you for the presentation. The NTPD program was one of the most helpful professional development programs I have ever attended - spot on for content and delivery and beautifully organised.

Just to touch base and let you know what a great 2 days for the DCT program. I enjoyed the time and got a lot out of it. I would like to be on your mailing list for any other activities and info ...

There was one post-program comment about utilising more medical presenters, and further "medicalising" the presentations. The rationale was that "having doctors presenting to other doctors is so important, and essential for ensuring the best buy-in, and providing "mana". However, gauged by the feedback, this was not seen as a major issue by most others in the two pilot programs. Indeed, some of the anecdotal feedback was to the contrary and that the participants appreciated the methods utilised in the program by

experts in professional development.

h. Program Learnings

In addition to the reaction of the participants, there was an attempt to gauge the additional insights, knowledge, and skills acquired as a result of undertaking the NTPD pilots. Participants were asked to complete a questionnaire to identify perceived changes in their capabilities. A 7-point Likert scale was used again to rate capabilities pre and post program. These information provided CPMEC with further reinforcement on parts of the program that worked well and identify areas with lesser impact. Table 3 below summarises the aggregated percentage changes by topics pre and post program for each of the two programs and the combined improvement. It was anticipated that the rankings would be significantly influenced by the prior experience of the group. As noted earlier, the Sydney pilot had DCTs with significantly more experience in their roles. When combined the areas where the greatest perceived improvements came were in areas relating to counselling, coaching, mentoring, handling conflict and being part of a community of practice.

Topic	MELB	SYD	COMBINED
Creating a community of practice	76.0	36.9	53.9
DCT roles and responsibilities	32.8	26.0	29.3
DCT as a leader	33.3	28.4	30.7
Challenges of educational supervision	25.4	22.7	24.0
DCT as member of an educational team	16.2	19.4	17.8
Counselling, coaching, mentoring	42.2	55.0	48.4
DCTs as career advisors	33.3	46.7	39.8
Stress management and mindfulness	44.4	27.9	36.3
Handling conflict and difficult individuals	34.9	58.9	46.2
Medical Board of Australia perspective	30.8	33.3	32.2
Capabilities to function effectively as DCT	46.7	29.7	37.3

Table 3: Perceptions of Improvements in Capabilities – Pre and Post Program

NB - Figures indicate percentage improvements

In summary, it is clear from the feedback that the HWA-supported BSCP Project to run pilot programs for DCTs was very successful. In support of this contention it is useful to

note that each of the quality criteria for the project was surpassed:

- i.** The overall satisfaction rating for the NTPD was 93% compared with the aim of at least 80%
- ii.** Every participant would recommended that program to others
- iii.** There was extensive post-program interaction with a number of the participants individually and through the Australian DCT Committee meetings
- iv.** The program had the support of all members of the Project Steering Committee and the project Advisory Committee
- v.** There were extensive inputs provided by DCTs from all states and territories in the development, delivery and post-program feedback
- vi.** The report on the evaluation of pilot programs was well received by all stakeholders
- vii.** HWA approved the establishment online platform for DCTs as Phase 2 of the project
- viii.** Final report and deliverables approved by HWA

i. Post-Program Developments of Note

In enumerating the success of the pilot programs, there have been a number of other developments which further reinforce the value of the program. I would like to highlight just a few of these:

- A** Postgraduate Medical Councils have started looking at building on the work undertaken in the pilot programs to offer more structured professional development opportunities for their DCTs. In this regard, CPMEC will be organising the NTPD for WA DCTs in June 2014 in conjunction with the Postgraduate Medical Education Council of Western Australia (PMCWA).
- B** A number of DCTs who attended the program provided feedback to their medical education officer colleagues and CPMEC was subsequently inundated with requests to organise a similar program for them. CPMEC conducted two programs on a fee-paying basis and both of them were extremely well received. The first was organised by the Postgraduate Medical Council of Victoria and the second was a national program organised by CPMEC's Australasian MEO Committee (AMEOC). A total of 44 MEOs attended these two programs.

- C** Another positive externality from the program has been that one of NT participants has asked CPMEC to develop a similar program for general practice registrars based in the Northern Territory. A program is planned for June 2014 in conjunction with Northern Territory General Practice Education (NTGPE).

5. PROJECT COMMUNICATIONS

Apart from reports to meetings of the project governance groups and HWA, communication about the project was widespread and included regular updates to CPMEC's Board, its PMC Principal Officers and Australian DCT Committees. CPMC, Medical Deans, and other key external stakeholders were also kept in the loop about the project. These ongoing communications were designed to demonstrate that project deliverables and reporting requirements under the funding agreement with HWA were being met; that all key stakeholders informed of the status of the project and outcomes and provided opportunities for feedback; and also helped foster long-term sustainability of the program.

Strategies employed for project communications to match different stakeholder target groups included targeted presentations; reporting through CPMEC's newsletter and website; communication through PMC newsletters and websites; and email broadcasts to selected audiences teleconference meetings with key stakeholders. Presentations were made to the **2013 Australian and New Zealand Association for Health Professional Educators 2013; 2013 NSW Health Education and Training Institute Prevocational Forum** and the **2013 Annual Prevocational Forum** (Appendix 10). CPMEC also enlisted the support of clinical champions in each jurisdiction to disseminate information on the DCT project and the pilot programs

A final part of the formal communication process will be the dissemination of final report once approval is granted by HWA. CPMEC has publicly acknowledged at all times the support of HWA in facilitating the development and implementation of the NTPD.

6. PHASE 2: ONLINE LEARNING PLATFORM

a. Online Learning Platform Feedback from DCTs

As part of the national pilot programs, participants had indicated strong support for a website for DCTs. They were asked to identify elements of the national training program and any other supporting resources and training that could be delivered by the creation of an online platform dedicated to DCTs throughout Australia. Their responses helped establish the value that an online learning platform would provide for DCTs and other prevocational training supervisors.

Some of the responses were collected at the end of the training program whilst a significant number of others sent their suggestions post-program via email. Summarised below are some of the responses which broadly fell into broad categories. The first related to general comments about the concept of an online platform, the second focussed on fostering a community of practice for DCTs, and the third covered specific suggestions on topics and resources to be available on the website.

There was overwhelming consensus in the responses that having a platform for DCTs would be a great idea in helping them perform their roles more effectively. It was also highlighted that it was to be not so much a learning platform as a knowledge sharing medium for DCTs which should be easily accessible. CPMEC was seen as the logical host for the website.

To foster a community of practice for DCTs, the following suggestions were offered:

- Having a DCT case of the month which highlighted a problem that a DCT had to deal with and tips/ideas/strategies on how to manage them from respondents
- Provide examples of dealing with important and relevant issues such as the failing intern, poorly performing residents; giving feedback; effective supervision strategies; dealing with conflict of various types. Videos of diagnosis that defined acceptable and unacceptable behaviours would be helpful
- Guidelines for professional development of DCTs, SITs, DPETs to support their expected role, as usually nil is provided by many hospitals and jurisdictions
- Ways of navigating the requirements of MBA registration standards and providing constant updates on any training pathway changes
- Setting up and maintaining educational initiatives and programs

- Establishing mentoring contacts and grooming interested medical officers in these roles
- Advice on dealing with management role including establishing and managing budgets for medical education units; recruiting and training new DCTs;
- Talks by DCTs that have general applicability

With regard to links and resources to populate the online platform, there were a number of suggestions to make available the resources in the NTPD program in an online format. These included making available the training and learning resources provided in the NTPD covering educational theory, leadership principles, feedback, coaching, counselling, mentoring; managing conflict; various uses of the MBTI; mindfulness and self-care. Other topics suggested were:

- A** Links to HWA data on assessing potential future job medical workforce vacancies
- B** Highlighting training pathways and relevant courses for DCTs wanting to learn about medical education
- C** Updated MBA and PMC guidelines for assessment and feedback
- D** Useful links on career planning, and engagement of supervisors
- E** Evaluation of a course / program / lecture / term / rotations including examples of evaluation forms
- F** How to write an education report
- G** More strategies on managing the trainee in difficulty;
- H** DCTs as managers and how to effectively interact with hospital administration. These would include understanding the language of management/administration; balancing advocacy role for JMOs with expectations and requirements for employers
- I** A program that delivered to DCTs in preparation for their roles before commencement: Duties and responsibilities; access to mentors; reporting requirements to MBA/AHPRA; involvement in professional development courses
- J** Tools to promote self-assessment of learning needs

- K** Resources for managing work-based performance assessment, e.g. Mini-CEX
- L** Tips and resources on training supervisors – modules on assessment; feedback; clinical teaching; simple models of learning
- M** Good quality junior doctor self-help sites; practical tips on stress management strategies; junior doctors in distress; performance issues
- N** Understanding needs of PGY1 and PGY2s and what they find useful

The feedback obtained has been invaluable in providing the basis of the website that is being developed for DCTs.

b. Progress on the Online Platform

Progress on this has been steady but a bit slow due to many other commitments of CPMEC. HWA granted approval to CPMEC to proceed with Stage 2 of Building Supervisory Capacity Project which involved the establishment of the online learning platform. Work on this phase of the project began soon after and it was agreed that the platform would be hosted through CPMEC's website. The principal purpose is to create an online community for DCTs and other supervisors who teach, supervise and assess prevocational doctors including IMGs not in vocational training programs.

Based on the feedback received, CPMEC agreed that that website would be designed to share resources, knowledge and good practices amongst DCTs rather than move towards a full-fledged learning management system. It would also help build network of support for experienced and newly appointed DCTs. It was agreed that the website would have flexibility in terms of scope and approach and would be available nationally. It was also agreed that rather than just be a passive source of resources, there would be an interactive component to allow DCTs to discuss role challenges and solutions. To ensure that it was a credible and trustworthy site, there would be a need to ensure that resources made available were properly vetted. This process is continuing. In making the website interactive, we were also mindful of managing access issues to any one engaging in unprofessional and inappropriate comments. The Australian DCT Committee would have ongoing oversight of these matters in conjunction with CPMEC.

In developing the website and generating interest amongst the DCTs, we have to be mindful of its utility value for them; ensure that it is the right forum for them in their roles as DCTs; provide resources that are credible, reliable and current; and allow for a degree of interactivity to engage on relevant issues. CPMEC has been working with Site

Zero to develop a website that will be linked to CPMEC's home page. The DCT website (<http://www.cpmec.org.au/DCT/>) is being structured as follows:

- Home page with welcome message from the CPMEC Chair and log-in details
- The DCT Forum Section to allow DCTs to exchange ideas, strategies, effective practices, etc. on topics that are relevant to their roles. Current topics will include Assessment Challenges for DCTs; Dealing with the Trainee in Difficulty; Fostering Leadership amongst Prevocational Doctors; Building Resilience in the JMO Workforce; and the DCT Case of the Month. We will also have a provision for DCTs to suggest possible topics or contribute cases for the future.
- The DCT Library containing resources and links to key organisations. We will have search facilities by organisation and topics. Choice of the latter has been largely influenced by feedback from the DCTs themselves.

RECOMMENDATIONS AND CONCLUSIONS

Given the exclusions highlighted in section 3.c of this report, the recommendations being made here are based on the premise that there will be no further funding available from HWA for future national DCT programs. Given this scenario, the recommendations are designed to reflect some practical ways of ensuring that the success of the pilot programs is utilised. As it has turned out, there have already been positive externalities from undertaking this project that have been discussed elsewhere in this report.

The following are the recommendations:

1. Provision of Professional Development Opportunities for DCTs

Postgraduate Medical Councils and jurisdictional health departments should continue to provide opportunities for DCTs to undertake professional development programs. The pilot programs have clearly demonstrated the need for these types of program as well as the willingness of the DCTs to participate in the same. It is important that the momentum generated by the NTPD is sustained at the local level.

2. Template for Future Programs

The pilot programs provide a successful template for delivery of professional development programs for DCTs and should be expanded to other prevocational settings. Dissemination of the program can be done through various modalities including face-to-face workshops, train-the-trainer programs and resource manuals.

3. Role of CPMEC

CPMEC should continue to explore mounting national programs to bring together DCTs using the self-learning model adopted for the pilot programs. Whilst there was some suggestions to move towards a credentialing system for prevocational supervisors, it is the predominant view that CPMEC should continue with its "light touch" model based on providing short courses and opportunities for DCTs to interact with each other.

4. Ongoing DCT Engagement

One of the key factors pointing to the success of the pilot programs has been the engagement of DCTs in all facets of the program design and delivery. CPMEC must continue to provide the infrastructure to support knowledge sharing (website portal etc.) amongst these groups. Once the DCT website is online this will need to be communicated to all DCTs and prevocational training supervisors. Similarly, CPMEC needs to maintain the strong links with DCTs through the Australasian DCT Committee to identify ongoing learning and professional development needs.

In summary, the NTPD pilot programs proved to be highly successful in fostering a sense of community amongst DCTs nationally. It reinforced the demand for professional development training for these prevocational medical training supervisors. The pilot programs have also provided a template for successful delivery of future programs. The establishment of the DCT website will augment the support that CPMEC provides to DCTs and other prevocational supervisors.

