General Practice Training Accreditation Project:

Northern Territory Pilot

FINAL REPORT

Managed by Northern Territory Post Graduate Medical Council in partnership with Northern Territory General Practice Education

August 2012
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EXECUTIVE SUMMARY

This report summarises the achievements and challenges of the Northern Territory pilot project of the broader General Practice Training Accreditation Project (GPTAP). The GPTAP aims to integrate and streamline accreditation of vocation and prevocational training in general practice. The motivation for the GPTAP project arose from the need to cater for an expanding number of medical graduates; to ensure quality placements are available. Accreditation is the instrument to ensure quality of the placements, and integrating prevocational and vocational accreditation reduces the burden on general practice of achieving this accreditation. The GPTAP project incorporated State and Territory pilot projects to allow for the variation in accreditation processes between State and Territory postgraduate medical councils and the relevant regional training providers to be explored and tested.

Key points

The Northern Territory pilot has made progress towards integrating accreditation for prevocational and vocational accreditation for general practices including:

- the development of a model to enable general practice to be accredited to Northern Territory Postgraduate Medical Council (NTPMC) standards; and

- the development of a draft single-survey visit tool between NTPMC and Northern Territory General Practice Education (NTPGE) for integrating prevocational and vocational standards.

The NT pilot project has also led to the development of new working relationships between key organisations and a series of formal intra- and inter-organisational discussions to progress the placements of postgraduate year 1 (PGY1 or intern) doctors into general practice placements.

One of the key challenges to completing the project within the allocated timeframe was that no formal dialogue had been initiated within the NT previously on the issue of accrediting general practices for intern placements, so the project was starting from scratch. Working relationships between the key organisations had not ventured into this area before and this proved to take more time than anticipated.

While the integrated accreditation process has been the focus of the pilot project, the underlying impetus is about placing interns into general practice rotations. This aspect of the project has been problematic and has raised some significant challenges that require significant further effort in the NT. The biggest challenge in this area is that the pressure of increasing numbers of medical graduates seeking internships has not yet been realised in the NT. Historically, including the current year, filling intern placements in NT hospitals has been difficult and this legacy remains a heavy influence for future planning.
Recommendations

- NTPMC to continue its proactive role in promoting the placement of interns into general practice in the NT – in partnership with the relevant hospitals and NTGPE.

- NTPMC to seek formal endorsement from the NT Board of the Medical Board of Australia to develop and deliver integrated accreditation of general practice facilities for PGY1 placements, which may require some adjustment of the current accreditation process.

- More formal and regular links between NTPMC and NTGPE particularly at the Board level and to encourage NTGPE to include NTPMC Executive officer on the accreditation committee.

- For further work on the integrated accreditation tool – it is planned in its current form to be tested with accreditation visits including NTPMC. May need to be revised to be satisfactory for all parties and needs to be formally endorsed by both accreditation committees.

- CPMEC / NTPMC to initiate discussions with other state PMCs from States that regularly release PGPPP doctors for placements in the NT – to discuss whether cross-state intern placements are likely to happen and if so, how to accredit etc.

- Northern Territory is different (high turnover, few local doctors, low GP numbers, remote and Aboriginal health, small numbers of interns, only 2 hospitals that train interns) and any national system that will develop for placing interns in GP rotation needs to include flexibility and commitment to take these differences into account.
FINAL REPORT

1. Project Overview

1.1 Project Background and Context

Prevocational placements in general practice have been promoted throughout Australia as a useful and effective program of increasing interest in general practice career paths. South Australia has been placing intern doctors into general practices since 1997 with reported benefits for all parties (Mugford, Worley, Braund & Martin, 2001). One of the benefits of intern general practice placements is that training resources are expanded beyond the hospital boundaries, enabling more intern training positions to be sustained. With an expected surge of medical graduates starting in 2013, the pursuit of regular intern general practice placements throughout all States and Territories is timely.

For intern doctors to be placed in general practice settings throughout Australia as a regular practice, there needs to be assurance for the interns and the public that the resources and support are in place to train and practice safely. This means that the general practices which train interns need a quality assurance system. The Confederation of Postgraduate Medical and Education Councils (CPMEC) meeting in 2010 identified that this would require additional accreditation of general practice facilities to meet the standards of the State and Territory postgraduate medical councils (PMCs).

As highlighted in “Streamlining Training Accreditation in General Practice Discussion Paper” (Australian General Practice Training, 2010) separate accreditation processes are currently applied to General Practice facilities depending on the learner level (medical student, junior doctor or registrar), State/Territory jurisdiction, and/or College affiliation of the practice and learners. The separate accreditation processes place demands on the general practice that are burdensome and not necessary. In the Minister for Health and Aging’s ‘Statement of Expectations 2011’ to General Practice Education and Training (GPET), this issue is identified and GPET has been directed to work towards a streamlined approach to accreditation for practices engaged in prevocational training, with the aim of developing ‘a national approach that could be implemented in the near future.’ (p.4).

The NT has particular challenges that shape the model of streamlined accreditation developed and the outcomes of this pilot (see Table 1). A striking NT challenge is that historically it has been difficult to fill intern placements, most likely due to the lack of a local medical training program. There is now a small medical program operating in the Northern Territory that is well-resourced to produce locally based trainee doctors. The program also has an emphasis on training Indigenous doctors to work in the Northern Territory. This is encouraging for the Northern Territory which currently has the highest turnover rate of GP’s in Australia, more than double the rates of other jurisdictions and 50% more than other rural / remote locations (Auer & Carson, 2010).

Under PGPPP, NTPGE places more junior doctors from interstate than any other State or Territory, and the program is viewed as a mechanism for recruiting doctors to the NT. PGPPP had previously been seen as an experiential placement, but has now
become more accountable particularly concerning accreditation, supervisors and participants and is taking its place as part of the vertical pathway for junior doctors into further general practice training and the rural generalist stream.

Table 1. Specific Northern Territory Characteristics Relevant to the Project

<table>
<thead>
<tr>
<th>Demographic</th>
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<tbody>
<tr>
<td>• Urban, Regional and Remote practices</td>
</tr>
<tr>
<td>• Large proportion of Aboriginal health services</td>
</tr>
<tr>
<td>• A small population base dispersed over 1.3 million square kilometres</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Very high turnover of medical workforce</td>
</tr>
<tr>
<td>• Small medical program providing two year bonded graduates into our workforce</td>
</tr>
<tr>
<td>• Only 2 jurisdictional training hospitals</td>
</tr>
<tr>
<td>• Historical difficulties filling all intern placements</td>
</tr>
<tr>
<td>• Need to attract, develop and retain a supervisory workforce</td>
</tr>
<tr>
<td>• A small resourced PMC to undertake accreditation</td>
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<table>
<thead>
<tr>
<th>Health of Population</th>
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<tbody>
<tr>
<td>• “closing the gap” in health outcomes and life expectancy between Aboriginal and non-Aboriginal NT population</td>
</tr>
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</table>

It is important to understand the broader context of dynamic change in accreditation processes and standards in medical training. In July 2010, the Northern Territory changed to a national registration process for all medical practitioners through the Australian Health Practitioners Registration Authority (AHPRA). During the transition to national registration, States and Territories have retained responsibility for prevocational medical education and training accreditation standards and processes. However, a new registration standard for the internship year will be developed and set by the national Medical Board of Australia (MBA) some time in 2012-13. The Postgraduate Medical Councils are also working to develop and comply with a CPMEC national framework of prevocational medical accreditation policies, principles and standards (CPMEC, 2009). These policy and operational changes are underway but not settled which creates a dynamic environment for exploring new options for junior doctor training, and some uncertainty for how it will evolve.

1.2 Project description

The GPTAP NT pilot project aimed to develop, implement and evaluate a pilot model that integrates prevocational and vocational accreditation processes for Northern Territory general practice facilities providing training. The NTPMC coordinated the project, working in partnership with NTGPE.

The NTPMC pilot project was one component of a national project. The national project has been coordinated and managed by the CPMEC. The national project included two other jurisdictional postgraduate medical councils; Western Australia and Victoria who
delivered concurrent state-based pilot projects. A signed agreement was in place between CPMEC and GPET, which outlined the overarching objectives, deliverables and project term along with the pilot project funding allocation.

The NT project sought to accredit NT general practices for the placement of prevocational doctors through the PGPPP. By using a streamlined and integrated accreditation process that would also cover vocational level standards, it was expected that the model tested during the pilot would be suitable in the future for all training practices.

The project objectives were:

- To provide a documented and evaluated assessment of a streamlined and integrated process of prevocational and vocational accreditation of general practice training facilities;

- To provide an assessment of the applicability and reliability of a single survey and information collection process to support the prevocational and vocational accreditation of training practices by the relevant accreditation bodies in NT for general practice training facilities;

- To advise on the accreditation implications for an expansion of capacity for future general practice training placements in the NT; and

- To further the partnering of primary and acute healthcare training in the NT.

The full project plan is at Appendix A.

The focus of the project was on accreditation for PGY1 placements, but it is noted that as PGY2 placements under PGPPP may also benefit from combining the accreditation standards.

2. Project Achievement

The project began in November 2011 with project planning and initial mapping of the standards which were finalised in December 2011. The project plan was endorsed in January 2012 by the NT Steering Committee and in February 2012 by the National Steering Committee. In March 2012, Royal Darwin Hospital stated that they would not be able to release an intern for the pilot project placements. In May 2012, Alice Springs Hospital also confirmed that they would not be able to release any interns. Difficulties were also encountered with finding appropriate placements within Darwin and Alice Springs. The integration of the accreditation processes between NTPMC and NTGPE was not completed as NTGPE has been undertaking a concurrent review of its vocational accreditation processes during the project period. The following sections outline the progress of the project against the project objectives and project outcomes.
2.1 Achievement of Project Objectives

2.1.1 To provide a documented and evaluated assessment of a streamlined and integrated process of prevocational and vocational accreditation of general practice training facilities

This project objective has been partly met. The NT pilot project has produced a draft streamlined and integrated process with a series of supportive documents for achieving accreditation of general practice facilities. The integration was unable to be completed within the project timeframe. As the process was not able to be piloted, it was also not able to be evaluated.

Substantial progress has been made towards integrating the accreditation processes for both prevocational and vocational doctors:

- Mapping of the NTPMC accreditation standards and combined college standards was completed (Appendix B);
- Desktop analysis of the compatibilities and differences of the two accreditation processes including what evidence is common to both processes and where is additional evidence needed;
- The development of a model of applying NTPMC accreditation processes to general practice training facilities (Appendix C);
- The development of a partnership Memorandum of Understanding (MOU) outlining roles and responsibilities of achieving intern placements and accreditation of general practice (Appendix C);
- Two vocational accreditation visits to local general practices have been undertaken with an NTPMC observer;
- NTPMC and NTGPE have had several iterations of input and feedback on combining accreditation processes;
- Substantial work on a combined instrument for GP visits has been undertaken with the NTGPE accreditation committee approving a combined instrument for piloting (Appendix D); and
- NTPMC has drafted supporting documentation for integrated visits (Appendix D).

There were several reasons for the integration not reaching completion. There is a limited history of collaboration between the relevant organisations in the placement of junior doctors in the NT. This has meant that the project required a substantial ‘start up’ effort. The initial impetus was lost when both Royal Darwin Hospital and Alice Springs Hospitals stated that they were not able to release any interns for placement. The project timing has also been affected by the concurrent review of NTGPE’s accreditation process for the combined GP College’s (Royal Australian College of General Practitioners – RACGP and the Australian College of Rural and Remote Medicine – ACRRM) accreditation. This has meant that the project timing has been dependent on the timing of the NTPGE review.
A further significant difficulty in recruiting interns to the project was the timing of the whole project in relation to hospital intern recruitment. This generally commences midyear, that is to say that NT intern recruitment was completed before the commencement of the project, so that there was limited capacity for the intern pool to include PGPPP placements for the year of the project.

2.1.2 To provide an assessment of the applicability and reliability of a single survey and information collection process to support the prevocational and vocational accreditation of training practices by the relevant accreditation bodies in NT for general practice training facilities;

As mentioned above, the single survey has not formally been finalised and so is not yet able to be assessed. As the accreditation instrument was not finalised within the project period, it was not able to be trialled within the project timeframe.

NTGPE notified NTPMC in mid July that their review of accreditation was finalised and that they are ready to pilot the combined survey tool in collaboration with NTPMC. There is a commitment from both NTPMC and NTGPE to pilot the combined survey in coming months. Once the piloting is undertaken, formal endorsement of the accreditation tool is needed from both NTGPE and NTPMC.

The endorsement process through NTPMC is different to NTGPE. NTGPE is delegated the authority to implement and make decisions on the RACGP and ACRRM accreditation of practices. NTPMC is delegated to implement an improved accreditation process with the decision-making being retained by the NT Board of the Medical Board of Australia. The level of evidence and formality for the different accreditation processes are two aspects of integrating the single survey visits that will be important to monitor.

2.1.3 To advise on the accreditation implications for an expansion of capacity for future general practice training placements in the NT.

Progress has been made towards this objective but without a more complete picture of how the accreditation process will take place, it is premature to be providing formal advice.

The progress that can be reported against this objective includes:

- Preliminary modelling of the accreditation implications has been undertaken within NTPMC (Appendix C);

- The key parties involved have informally discussed the implications including costs, logistics (particularly for remote locations), responsibilities and accountability mechanisms.

- The project is an ongoing agenda item at NTPMC meetings and NTPMC Accreditation meetings;

- The integration of the accreditation processes has been discussed in NTGPE Accreditation Committee meetings;
The pilot project and its importance for the future of intern training in the NT is included in the NTPMC Annual Report 2010-2011;

The NT Board of the Medical Board of Australia has been informed of the project;

The project has been discussed in face-to-face meetings and written briefings between NTPMC and the office of the NT Minister for Health, and between NTPMC and the Chief Executive of the NT Department of Health. This has resulted in a request to keep the Minister and Chief Executive up to date with the progress of potential intern placements in general practice; and

The NT pilot is an ongoing Board item for both CPMEC and GPET.

There is a strong commitment from NTPMC and NTGPE to continue promoting the expansion of general practice training placements in the NT, including the placement of interns.

2.1.4 To further the partnering of primary and acute healthcare training in the NT.

This project objective is important in the Northern Territory and will remain a key driver for future efforts in this area. Reported progress against this objective includes:

- Proposed incorporation of NTGPE representatives and/or GP representatives into the General Clinical Training Committee (RDH) and Medical Training Committee (ASH) to inform, advise and coordinate the prevocational placements in NT general practices.

- Operational relationship between NTGPE and RDH has been seeking improved collaboration for PGPPP placements;

- Strengthened relationship between NTGPE and NTPMC crossing into new areas of collaboration; and

- NTPMC branching out from an acute care facility only focus, to exploring roles for expanding junior doctor placements in the primary care setting.

2.2 Achievement of project outputs

- Project plan – endorsed by both NT project Steering Committee and National Steering Committee

The project plan was prepared in December 2011 and endorsed by the NT Steering Committee in January 2012 and by the National Steering Committee in 2012.

- Project Evaluation Plan – endorsed by both NT project Steering Committee and National Steering Committee
The project evaluation plan was drafted in early March but was put on hold when it became unclear if key project objectives would be able to be pursued. Amendments to the project plan were undertaken in April and May. The evaluation plan remained in draft form but was eventually amended to be sent to the National Steering committee for endorsement in June.

- **NT model and rationale for a streamlined, single survey multi-accreditation process**

  The NT model and rationale were developed into a complete draft form but without formal endorsement or agreement. The outputs included mapping of the vocational and prevocational standards, designing and documenting an NTPMC process for incorporating general practices into facility accreditation processes, development of an integrated accreditation single survey-visit tool and the development of a partnership agreement for all key parties.

  The NT model and associated draft documents are contained in Appendix C.

- **Evaluation of the NT pilot model**

  Evaluation of the NT pilot model is incorporated into the final report with a primary focus on the key lessons from the pilot project which did not progress as planned due to a range of factors. A full evaluation as planned did not take place as the accreditation documentation was not completed, a pilot of the accreditation process did not take place and no prevocational doctors were placed as a part of this pilot.

- **Final project report including project evaluation and recommendations for a future streamlined accreditation process**

  The final project report has been completed (this document) with input from stakeholders and includes several recommendations for progressing integrated accreditations processes in the future.

2.3 **Project Risk Assessment**

As the project did not proceed as planned, it is worth reviewing the project risk management plan. Table 2 is a summary of the project risks as conceived at the beginning of the project, the planned mitigating action and the realisation of some of those risks.
Table 2. Project Risk Management

<table>
<thead>
<tr>
<th>Identified Risk</th>
<th>Risk Level</th>
<th>Proposed Mitigating Action</th>
<th>What actually happened</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeder hospitals unable to provide intern doctors for pilot term</td>
<td>M</td>
<td>Contacting both hospitals in advance to advise of upcoming project – working with the Director of Clinical Training and Medical Education Officers of both feeder hospitals.</td>
<td>This risk was realised despite the mitigating action. Some months into the project, both hospitals advised NTPMC that due to the lack of opportunity to recruit for extra rotations and without confirmed placement availability they were unable to provide intern doctors for the pilot GP placements. While this reduced the ‘real world’ applicability of the pilot project it was not a project ‘stopper’ as the integrated accreditation could still be pursued and trialled. It significantly reduced the impetus for other parties involved in the project.</td>
</tr>
<tr>
<td>Unable to complete project within timeframe</td>
<td>M</td>
<td>Good project planning and a dedicated project officer provides the best chance of keeping the project timing on track.</td>
<td>This risk was realised despite the mitigating action. The problems with completing the project within the timeframe were due to external factors outside the control of project team.</td>
</tr>
<tr>
<td>Northern Territory or National Steering Committee to seek significant changes to the project</td>
<td>M</td>
<td>The Steering Committees involved in the project are a valuable source of advice for the project and have an important endorsement role. Regular contact will be made to keep both Steering Committees appropriately updated on project developments.</td>
<td>This risk was not realised as both Steering Committee’s remained supportive of the project planning, and proposed objectives, outputs, outcomes and processes.</td>
</tr>
<tr>
<td>Delay in the partnership agreement</td>
<td>H</td>
<td>All parties have been contacted early on in the project and the discussions about the content and expectations of the partnership MOU have been clear and transparent.</td>
<td>This risk was realised despite mitigating actions. Progress has been made in the development of the partnership agreement particularly at the informal level. However until the integrated accreditation process is established and intern placements are ‘in the pipeline’ there is little impetus for the partners to progress the agreement further.</td>
</tr>
<tr>
<td>Unable to get parties to agree to proposed accreditation and term arrangements in time for accreditation for term 2 placements.</td>
<td>M</td>
<td>Every effort will be made to get accreditation underway for Term 2 placements, but if it is not possible – the accreditation can still take place before the end of the project – even if the placement itself does not finish within the project timeframe.</td>
<td>This risk was also realised and became the biggest factor in the non-completion of the project within the allocated timeframe.</td>
</tr>
</tbody>
</table>
2.4 Stakeholder Involvement and the Project Steering Committees

The NT pilot was overseen by national level stakeholders engaged primarily through the national project steering committee (the General Practice Training Accreditation Pilot Steering Committee). The national steering committee included representatives from GPET, CPMEC, the Australian College of Rural and Remote Medicine (ACRRM) and Royal Australian College of General Practice (RACGP) and a representative for the Regional Training Providers. Local stakeholders were involved in the project through the NT Steering Committee (see Table 3) and the key partners were involved in discussions and collaboration on specific project objectives. Most of the project work was conducted between NTPMC and NTGPE.

A ‘Partnership Memorandum of Understanding’ (MOU) was developed for signature by all NT project partners; NTPMC, Royal Darwin Hospital (RDH), Alice Springs Hospital (ASH), NTGPE and the participating General Practice – however this was not finalised as it was formed in the context of the specific placements of interns into a general practice rotation.

Table 3. Northern Territory Pilot Project Steering Committee

<table>
<thead>
<tr>
<th>Stakeholder Organisation</th>
<th>Representatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>NT Postgraduate Medical Council</td>
<td>Dr Elizabeth Chalmers, Chair</td>
</tr>
<tr>
<td></td>
<td>Shirley Bergin, Executive Officer</td>
</tr>
<tr>
<td>NT General Practice Education</td>
<td>Nicole Lamb (Manager PGPPP)</td>
</tr>
<tr>
<td></td>
<td>Dr Tamsin Cockayne (Director of Medical and Cultural Education)</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>Dr Kishan Pandithage (also a Medical Educator)</td>
</tr>
<tr>
<td>Junior Medical Officers</td>
<td>Dr Pasqualina Coffey (junior doctor who had completed a PGPPP placement in the NT).</td>
</tr>
<tr>
<td>Royal Darwin Hospital</td>
<td>Dr Barbara Bauert, Director of Clinical Training</td>
</tr>
<tr>
<td>Alice Springs Hospital</td>
<td>Amanda Cawthorne-Crosby, Medical Education Officer</td>
</tr>
</tbody>
</table>
2.5 Project Team

The NT project team was made up of staff of the NT Postgraduate Medical Council (NTPMC) with the support of a project officer contracted through CPMEC (Table 4). The NT project team met regularly during the course of the project, with weekly meetings during the intensive periods of the project. A new project administrative support officer started during the course of the project.

<table>
<thead>
<tr>
<th>Project team member</th>
<th>Project Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shirley Bergin</td>
<td>Project leader, Standards and Accreditation mapping and streamlining, pilot implementation, project coordination</td>
</tr>
<tr>
<td>Dr Elizabeth Chalmers</td>
<td>Project adviser</td>
</tr>
<tr>
<td>Karen Brandt / Vanessa Lewfatt</td>
<td>Steering Committee Secretariat, project administration assistance</td>
</tr>
<tr>
<td>Julia Chalmers</td>
<td>Project planning, project coordination and project evaluation</td>
</tr>
</tbody>
</table>

3. Project Challenges

The major challenge to this project was that formal discussions of placing interns from NT hospitals into NT general practice placements and the associated accreditation processes had not previously been held.

In essence, the process was starting from scratch.

The significance of this is that the time limitations of the project were not appropriate for the ambitious goals of the pilot project. This was considered a key risk at the beginning of the project, yet still worth pursuing as the process needed to be initiated and the project could serve as an impetus for placing NT junior doctors into general practice/primary care. It was also an opportunity to ensure the unique circumstances of the NT could be considered in any further national initiatives in promoting intern placements and integrated accreditation in general practice.

It is worthwhile to consider the key challenging issues of the organisations involved in the project and how this impacted on the achievement of the project objectives. Report Section 5 will then deal with the key learnings that can be extracted from the pilot project and the further issues to be resolved.
Northern Territory Postgraduate Medical Council

The resources of the NTPMC are adequate for the core responsibility of the organisation which are focused on postgraduate year 1 standards and the accreditation of the two NT training hospitals. The staffing is limited (2 full-time staff; one senior manager, one support staff member and part-time Chair). Undertaking this project has been assisted by a part-time project manager, but has required significant work input from the senior manager.

This project challenged the organisation in new directions including:

- expanding from a focus on accreditation to facilitating new partnerships between other organisations;
- expanded interest to include standards suitable for PGY2 placements and integration with vocational standards; and
- expanding from a focus on hospitals to include general practice training facilities.

The project related work has been engaging, relevant and interesting for NTPMC and has highlighted that NTPMC will need to adjust its business and work plans to incorporate these new responsibilities. NTPMC has previously worked with a focus on its endorsed mission, whereas this project has not had official endorsement from the Medical Board or NT Minister of Health. This will be an important consideration when taking this work forward, as official endorsement will be needed.

Royal Darwin and Alice Springs Hospitals

NT Steering Committee members from both Royal Darwin Hospital and Alice Springs Hospital showed initial interest in placing interns into general practice rotations. The operational difficulties of how this would happen soon rose to prominence and it was realised by all parties that a placement in such a short period of planning time offered by the pilot project would not be feasible from either hospital.

It became apparent during the course of this project, that while the ‘tsunami’ of medical graduates seeking internships is an immediate concern for other States and Territories and a key driver for intern general practice placements, the same urgency is absent in the two Northern Territory hospitals. For example, no significant increases in internship numbers are planned for over the next two years. The historical difficulties of filling all intern placements appear to weigh heavily in the forward planning of the hospitals.

Historically, there have been reported difficulties of getting RDH interns into PGPPP placements. The result is that the NT PGPPP placements are predominantly from interstate with a small contingent from NT hospitals. At the beginning of this project, Royal Darwin Hospital representatives stated that they would need to have PGPPP placements confirmed before they would be able to plan for any interns to be released for a general practice term. This is a potential sticking point for future placements, as the hospital needs to factor PGPPP placements early in the planning process whereas PGPPP placements can only be confirmed closer to the actual commencement of the
placement. This could be resolved with the hospital having a regular forward planning process to include PGPPP placements with a risk management process in place to deal with the situation if a suitable placement is not found.

*Northern Territory General Practice Education*

The timing of the pilot project has coincided with a period where NTGPE has been undergoing organisational change processes including staff resignations, new staff recruitments and reviews of processes and programs. For example during the project period the Chief Executive resigned and left the organisation, a temporary replacement Chief Executive from outside the organisation took over and just recently a new Chief Executive has been recruited from Queensland. Times of organisational change are very demanding on staff, including both managers and operational level staff.

During the course of the project, NTGPE was reviewing its vocational accreditation process. This was an opportunity for integrating and streamlining and vocational accreditation processes, but it proved difficult for NTPMC to be included in the review process from the beginning. For example, it would have been beneficial for both parties to include an NTPMC representative on the NTGPE accreditation committee. While NTGPE and NTPMC worked together on a new accreditation process and a single accreditation visit tool, it has not yet been completed to the satisfaction of both accreditation parties.

At the beginning of the project NTGPE stated that they were having difficulties recruiting general practices located within Darwin to take on PGPPP placements. The two reasons put forward for this were the costs of taking on a PGPPP placement, particularly when space within the practice facility is limited and the difficulties in finding appropriate supervision for the PGPPP. This creates a real difficulty for future placement of interns as the hospitals have a strong preference for the interns to be placed locally, not remotely. Additionally, local general practices with reservations of taking on PGY2 PGPPP’s may be less likely to take on intern placements who have greater supervisory needs and less ‘earning’ potential due to not having a medicare provider number.

The NTGPE Director of Training and RDH Director of Clinical Training recently wrote a joint letter to NTPMC Chair to state that intern placements into general practice via PGPPP is not currently viable due to lack of supervisors in Darwin general practices.

In summary, the project challenges were embedded within the key organisations and the dynamics of their working relationships moving into a new area of collaboration. Key learnings from this process are reported in Section 5.
4. Evaluation

As the integrated accreditation process and pilot were not completed by the end of the project timeframe, the evaluation methodology was appropriately altered. In particular the interviews planned with participants in the pilot trial did not go ahead.

The project evaluation methodology proposed to focus on the four aims in table 5 and these aims have been addressed in the sections of the final report as indicated below.

Table 5: Project Evaluation Aims corresponding to Final Report Sections

<table>
<thead>
<tr>
<th>Evaluation Aims</th>
<th>Final Report Section to address the Aims</th>
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<tbody>
<tr>
<td>Comparing the actual project outcomes compared to the planned project outcomes</td>
<td>Section 2. Project Achievements</td>
</tr>
<tr>
<td>Evaluating the tools and process designed during the project period</td>
<td>Section 4. Evaluation</td>
</tr>
<tr>
<td>Identifying key challenges experienced in the execution of the pilot project</td>
<td>Section 3. Project Challenges and Section 5. Key Learnings</td>
</tr>
<tr>
<td>Recommending actions to take the streamlined process forward in the Northern Territory</td>
<td>Section 6. Recommendations</td>
</tr>
</tbody>
</table>

4.1 Project stages

The project evaluation plan identified three project stages to evaluate. The three stages are summarised in Table 6.

Table 6. Evaluation at Pre-, Mid- and Post- Project Stages

<table>
<thead>
<tr>
<th>Project Stage</th>
<th>Evaluation Findings</th>
</tr>
</thead>
</table>
| Pre-project   | During the project planning phase, it was evident that the aims of the pilot project were ambitious for the NT to complete in such a short time period, as formal discussions had not been initiated on this topic. It was agreed that the project would be an important opportunity to initiate formal discussions and action on the placement of interns in general practice in the NT. At the first Steering Committee:  
  - in-principle agreement to the project aims was gained from all Steering Committee members;  
  - concerns were raised by hospital representatives that the timing may not be suitable for placing an intern in 2012;  
  - it was agreed by all parties that placement in a rural or remote general practice for an intern would not be suitable |

GPTAP: Northern Territory Pilot Final Project Report
for the pilot, and so a placement in Darwin or Alice Springs would be needed;

- NTGPE indicated that they were having difficulties finding Darwin-based general practices willing to host PGPPP placements due to a range of constraints;

- The medical educator on the Steering Committee indicated strong support for placing interns in general practice placements;

- The junior doctor representative on the Steering Committee indicated that she thought the placements would be popular and would potentially attract more interns;

- The junior doctor representative highlighted that any junior doctors involved in the pilot be properly supported and not to feel like ‘guinea pigs’.

Mid-project

- Following the Steering Committee meeting, formal letters were written to the hospitals requesting cooperation and interns for pilot placement and responses were received indicating that this would not be suitable in 2012.

- NTGPE Board representatives in informal discussions reiterated support for the placement of interns in general practice in the NT and the streamlining of vocation and prevocational accreditation;

- NTGPE began undertaking a review of their accreditation process;

- NTPMC continued developing the model for accrediting general practices and analysing how this may require an adjustment of NTPMC accreditation processes;

- Late in the project period NTPMC and NTGPE began working collaboratively on a combined accreditation visit tool.

Post project

- NTGPE informed NTPMC that it had endorsed a single survey accreditation tool to pilot with NTPMC;

- RDH and NTGPE provided a letter stating that intern placement was not currently possible due to lack of supervision in local general practices;

- NT Medical Educator indicated disappointment with the lack of progress towards placing PGY1 doctors in general practice;

- The NT Health Minister responded in the media to the national shortage of intern placements by stating that the NT would be keen to take more intern placements and in the same press statement highlighted the low numbers of general practitioners in the NT. This may create some impetus for future progress.
4.2 Key Evaluation Questions

4.2.1 Did the pilot prevocational accreditation process meet all the standards for prevocational training? With particular reference to:

- Sufficiency of evidence provided
- Authenticity of evidence provided
- Reliability of evidence and surveyors findings
- Sustainability of the process

The model developed by NTPMC during the project timeframe incorporates all the prevocational standards of NTMPC's accreditation standards. The standards mapping undertaken by NTPMC in conjunction with NTGPE demonstrates that the standards are compatible to combine into an integrated accreditation process; they have some crossover with additional needs relating to supervision being the biggest difference. The principle 'accreditation visit' tool developed between NTPMC and NTGPE is still being finalised but also allows for both vocational and prevocational standards to be represented in the single survey document.

The critical issue is how this is implemented in practice.

4.2.2 Is the accreditation process used in the pilot suitable for combining with vocational training accreditation?

There is a significant difference in how accreditation visits are undertaken by the two organisations. NTPMC is experienced in accrediting hospitals with large facilities, complex compliance issues and accreditations are multi-week events with numerous documents screened and interviews held with a wide range of staff. The accreditation process for hospitals is rigorous and highly structured. There is also an emphasis on evidence, ongoing monitoring and a quality improvement cycle. This is the level of accreditation that is appropriate for large acute care facilities. The difficulty has been designing a model for accrediting general practice facilities that will not compromise the standards which ensure the safe and supportive learning environment for interns, while avoiding a burdensome accreditation process on the participating general practice.

The draft tool that has been compiled by NTPMC and NTGPE is more aligned to the NTGPE model of accreditation. The NTGPE accreditation visits have been performed more frequently and are less formal and more reliant on self-reporting and professional insight than the highly structured process of NTPMC. NTPMC realises that NTGPE has the experience of working with general practices and knowing what is likely to be feasible and appropriate to expect from an accreditation visit, so it has been appropriate to adjust to the NTGPE model. However the accreditation visit is conducted, NTPMC still has to ensure that its standards are being met. How this will be achieved is yet to be tested.

Some considerations that may be needed are:

- accreditation visits would need to have thorough pre-visit meetings of both NTPMC and NTGPE surveyors to ensure a streamlined presentation to the general practice;
• collection of documents for evidence would be appropriate before the accreditation visits, including time set aside for surveyors to analyse the evidence; and

• NTPMC will likely need to provide its own surveyors to ensure that the different standards are being met.

4.2.3 Was the accreditation process suitable for the general practice / community health service? That is, was the level of effort required to meet accreditation processes and standards fair and reasonable?

This question remains to be explored with a testing and refinement of the combined accreditation tool in coming months.

An important consideration for the NT is the cost of accreditation when remote practices are seeking accreditation. The cost of sending surveyors to remote locations is high and needs further consideration.

4.2.4 Was the partnership agreement a suitable and useful instrument for the necessary collaboration between GP, feeder hospital and training provider?

The partnership MOU also remains to be tested as the draft partnership agreement was not finalised or signed by any parties. It was circulated for consultation and some comments were received but it would need to be agreed to at senior management levels in both hospitals which wasn’t progressed during the course of the pilot project.

The partnership MOU (Appendix C) is a clear and logical document that establishes the different roles, responsibilities and expectations of all parties. For future implementation, the partnership agreement will need to be formal (signed by senior managers in all organisations) and may take some time to develop to the satisfaction of all parties.

The partnership agreement as formed for the pilot project was focused on Northern Territory stakeholders for the placement of NT interns. For future implementation, an appropriate instrument for the placement of interstate interns may need to be considered.

4.2.5 Is it likely that the pilot accreditation process will be suitable for implementation in the NT to make general practice placements a standard option for prevocational junior doctors? What else might be needed to implement this?

The pilot accreditation process has not been developed far enough to determine is suitability for regular placements of interns into general practice.

Dr Kishan Pandithage, an experienced medical educator with NTGPE and a practicing GP based in Darwin, highlights that placing prevocational doctors including interns to general practices in the NT is a great learning opportunity for the doctors, even though the placements would be challenging. He believes flexibility about training standards may be needed to make it happen. He states “These challenging environments will
never be perfect and 100% safe with idealistic supervision goals. Hopefully in the future we will not wait for this and all parties will agree on a plan to guide these young doctors."

4.2.6 Did the pilot project provide a useful model for furthering the partnerships between primary and acute care in the NT?

The model developed by NTPMC for the pilot project does contain several useful mechanisms for further partnerships between primary and acute care in the NT.

- A partnership MOU to clarify all roles and responsibilities of the parties, both Acute and Primary care providers, involved in the PGY1 training.
- NTGPE and general practice representation on the respective hospital’s training committees; and
- Promotion of the benefits to hospitals of general practice rotations for junior doctors.

This is an important area to consider and as implementation progresses there will likely be some resistance, particularly from the acute care sector, to overcome.

4.2.7 Did the junior doctor feel that the experience:

- met the required level of training that they would expect in their hospital rotations?
- provided an opportunity that they would not have got within a hospital rotations?
- was worthwhile as a learning option within the prevocational years?

These questions are not able to be answered as the pilot placement of a junior doctor in a pilot accredited practice did not take place. However, these evaluation questions are critical in any process of accreditation and any trial of interns being placed in general practice settings. It is crucial that the prevocational doctor in the general practice setting is given the best chance to have a good quality and worthwhile learning experience.

5. Key Learnings

The NT pilot project has initiated the process of integrating vocational and prevocational accreditation of general practices to enable the training placements of intern doctors within the NT. While the project has not completed its original aims, there are key learnings that have been highlighted for future work.

Learnings from the development of the NT model of accreditation and standards mapping:

- Mapping of the standards was completed early in the project in collaboration with NTGPE and it was realised that there was significant overlap between the sets of standards. The respective supervision requirements were quite different;
• The development of the model was challenging to maintain the integrity of the NTPMC accreditation process and standards which are currently focused on hospitals rather than smaller and less-well resourced general practices – without creating an unworkable model;

• After several iterations of the model it was agreed that the NTPMC accreditation process would need to be amended to allow for some flexibility in the accreditation of general practices;

• It was decided that the best way was to add the intern GP placement as a secondment term from the training hospital; and

• While amendments are being made to the NTPMC accreditation process, it may also be worthwhile to consider expanding the accreditation to cover all prevocational doctors.

Learning from the integration of NTGPE and NTPMC’s accreditation processes

It is clearly important for both NTPMC and NTGPE to pursue the development of intern placements in general practice. This was confirmed at the strategic level of both organisations during the project. There has been substantial progress in the two organisations working together to first put into place the combined accreditation process. Through the development of this working relationship, the differences between the two accreditation processes have become apparent, as summarised in Table 7.

Table 7. Major differences between NTPMC and NTGPE accreditation processes

<table>
<thead>
<tr>
<th>Accreditation component</th>
<th>NTGPE</th>
<th>NTPMC</th>
</tr>
</thead>
<tbody>
<tr>
<td>regularity of accreditation</td>
<td>rolling 12-month accreditation</td>
<td>4 year terms, with quality assurance monitoring and reporting throughout highly structured accreditation visits</td>
</tr>
<tr>
<td>visits and monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>structure of visits</td>
<td>flexible and informal structure to accreditation visits</td>
<td>highly structured accreditation visits</td>
</tr>
<tr>
<td>formality</td>
<td>less formal</td>
<td>very formal</td>
</tr>
<tr>
<td>evidence</td>
<td>relies on self-reporting, professional insight and established professional relationships</td>
<td>relies on self-reporting, documentation, and triangulation of evidentiary sources.</td>
</tr>
<tr>
<td>recommendations</td>
<td>no formal recommendations made</td>
<td>formally made to NTPMC accreditation committee and to the NT Board of the Medical Board of Australia decisions made by NT Board of the Medical Board of Australia</td>
</tr>
<tr>
<td>decision making</td>
<td>decisions made by NTGPE</td>
<td></td>
</tr>
</tbody>
</table>
Initial discussions have been held with NTGPE where NTGPE surveyors might conduct both accreditation processes. There are several issues to be resolved, for example – is it appropriate for NTGPE to be both the deliverer of and the accrediting body for the PGPPP? Or should the accreditation process be separate?

The previous NTGPE accreditation process did not include specific recommendations, while such recommendations arising from accreditation surveys are considered essential from NTPMC as part of their quality assurance cycle.

There are ongoing difficulties in recruiting and training surveyors and the costs involved are significant. The make up of teams is another varying issue across the two organisations’ accreditation activities – for example, NTPMC survey teams usually include a junior medical officer whereas NTGPE does not.

As always in the NT, the costs associated with rural / remote accreditation visits are significant as are the supervision practicalities from time to time.

**Learnings about NT organisations working together**

The Northern Territory organisations involved in this project had not previously had formal discussions on the placements of interns in general practice nor about the accreditation processes that would need to be in place. An important lesson has been that time has been needed to develop, negotiate and operationalise the partnerships between the key stakeholders, particularly NTPMC, NTGPE and the two training hospitals. The operational relationships are still in development.

The project has highlighted ongoing challenges to be met by the key organisations involved in development of intern placements in general practice in the NT. For example, NTPMC need to formally adjust it’s workplans, seek formal endorsement from its governing bodies (NT Health Minister, Chief Executive of Health Department, NT Board of Medical Board of Australia) and educate key stakeholders on the relevant issues.

There are complexities with the differing accreditation cycles between the training hospitals and the teaching general and primary care practices in the NT. The alignment for hospital intern recruitment with GP intern placements needs careful joint planning. For example, the impact of both the increasing number of interns for placement and the expansion of the PGPPP will be significant in taking the project forward. Ideally, NT interns would have equal / priority access to the range of training opportunities of working in the NT.

There is a further question as to how to align remote practice placements with the training hospital placements based in Darwin and Alice Springs. Developing working partnerships between the training hospitals and training general and primary care practices will require significant organisational change.

It is noted that NTGPE has been in a dynamic organisational stage, with significant staff turnover, new managers appointed, resignation of previous CEO, appointment of interim CEO and recruitment of new CEO, as well as a new manager overseeing PGPPP
and both GP college accreditation functions. In addition NTGPE has been experiencing some difficulties in recruiting Darwin based general practices to provide placements and supervision for interns as part of the NT PGPPP.

**Reinforcement of NT-specific issues**

The Northern Territory was an important pilot to include in the national project as there had not been formal discussions about the placement of interns in GP (and associated accreditation) and the NT has some very different dynamics and characteristics to other States and Territories.

The nature of NT general practices is quite different. It has the highest turnover rate in Australia, with one study documenting a 60% turnover between 2001 and 2006 (Auer & Carson, 2010). The 2010 NT Health Workforce Modelling (Maylon, Zhao & Guthridge, 2010) highlights this high turnover as the biggest issue for future planning for the NT’s medical workforce. In addition to the high turnover, the NT also currently has a much lower ratio of general practitioners to population than the other States and Territories.

Several major investments and initiatives have been undertaken in the last decade to reduce the high turnover rate in general – such as the development of rural clinical training schools in the NT and the recently established NT medical program. The clinical placement of medical students into NT health services does result in students returning as interns, although it takes 122 weeks of placements to lead to one intern (Smedts & Lowe, 2008). The NT medical program had its first graduate level program begin in 2011 with the first cohort currently in their second year. These important initiatives are still in development and will take years to achieve a significant change in the NT medical workforce.

The PGPPP program is ideally placed to reach junior doctors and attract them to work in the NT and in general practice. In 2011, NTGPE reported 71 placements in the NT under the PGPPP program. Most of these junior doctors were from Victoria, South Australia and New South Wales and most of the placements (66 out of 71) were in remote locations.

With a GP workforce with such a high turnover, the implications are significant for training of junior doctors. The highly mobile workforce also includes the doctors who would otherwise be the supervisors of junior doctors.

The NT is a small place and has diverse organisations, remotely located practices, and a strong Aboriginal health sector in both urban and remote settings. Around 30% of the NT population is of Aboriginal descent.

While it sometimes seems from the outside having a small number of players should make things easier, the reality is:

- Small number of players increases the risk that a problem with any one organisation can turn into a show-stopper;
• There is a high turnover of staff in general and difficulties in recruiting new people;

• With smaller numbers of individuals involved, people often have multiple roles which can become problematic; and

• Distance from our hospitals is also an issue for remote placements.

The difficulties that NTGPE is having in recruiting GP supervisors in Darwin, raises the issue of resources for and motivations of general practices taking on interns. The medical profession has a tradition of training the 'next generation', without necessarily requiring substantial financial return. Unlike the PGY2's of the standard PGPPP placements, PGY1's do not have Medicare provider numbers so while they are still a 'free' doctor for the general practice, they also require more resources than PGY 2's and registrars; in particular increased supervision. If a practice is corporate owned or has a business model in place to prioritise financial profits, there may be less motivation to invest these resources in taking on PGY1 placements without a financial incentive to do so. In some rural practices, there is likely to be more consulting space available, a greater need for more doctors and less choice. Opportunities may be more fruitful in more remote locations. This causes difficulties though for intern placements as the current preference is to be based in urban settings near the training hospitals.

With reports that up to 400 medical graduates have missed out on first round offers for 2013 internships ('Govt vows to expand intern places', Australian Doctor, 24 July 2012) there is an immediate need to establish greater capacity for training intern doctors. Placing PGY1 doctors in general practice rotations as a regular feature of internships would have the dual benefit of expanding the capacity for internship positions and increasing training in general practice. In the Northern Territory the NT Health Minister has recently made a similar link, stating to the media that 'The number of GPs in the Territory is half the national average….Certainly I would like to have more doctors trained in the Territory' (ABC News on-line, 24 July 2012) in response to questions about expanding the capacity to take more interns in the NT.

5.1 Further issues to consider

There are further issues to consider in taking forward the NT integrated accreditation of vocational and prevocational general practice training facilities such as:

• How to incorporate interstate interns into the integrated accreditation model– currently the majority of PGPPP doctors are from feeder hospitals other than the NT. This is due to the low numbers of the interns in the NT and the high allocation of PGPPPs places. If the PGPPP offered intern placements from interstate feeder hospitals, the NT integrated accreditation would need to be endorsed or something similar by the interstate feeder hospital. Will this be an issue for other States / Territories?

• As recruiting GP supervisors has been problematic for the current PGPPP program, how will an expanded placement program requiring an additional level of supervision deal with this?
• Piloting placements for interns in remote settings – how can this be done safely? Are new models of supervision, additional resources or flexible arrangements needed for these particular circumstances?

• How will the national level issues impact on NT integrated accreditation? Eg. national intern standards finalised, GP term compulsory / recommended or optional? PMAF finalised and endorsed. How will these decisions effect NT integrated accreditation?

6. Recommendations

• NTPMC to continue its proactive role in promoting the placement of interns into general practice in the NT – in partnership with the relevant hospitals and NTGPE.

• NTPMC to seek formal endorsement from the NT Board of the Medical Board of Australia to develop and deliver integrated accreditation of general practice facilities for PGY1 placements, which may require some adjustment of the current accreditation process.

• More formal and regular links between NTPMC and NTGPE particularly at the Board level and to encourage NTGPE to include NTPMC Executive officer on the accreditation committee.

• For further work on the integrated accreditation tool – it is planned in its current form to be tested with accreditation visits including NTPMC. May need to be revised to be satisfactory for all parties and needs to be formally endorsed by both accreditation committees.

• CPMEC / NTPMC to initiate discussions with other state PMCs from States that regularly release PGPPP doctors for placements in the NT – to discuss whether cross-state intern placements are likely to happen and if so, how to accredit etc.

• Northern Territory is different (high turnover, few local doctors, low GP numbers, remote and Aboriginal health, small numbers of interns, only 2 hospitals that train interns) and any national system that will develop for placing interns in GP rotation needs to include flexibility and commitment to take these differences into account.
7. Conclusion

The GPTAP NT pilot project focused on integrating the accreditation of both vocational and prevocational training in NT general practice facilities as an enabling process to progress the placement of interns in general practice in the NT. It was also planned for this project to trial intern placements in general practice. These project aims were not realised by the end of the project timeframe. On a strategic level, the pilot was undertaken by NTPMC to stimulate the processes to place interns in GP rotations in the NT. The pilot project did help to start the formal discussion and processes but there is still much work to be completed before intern placements in general practice in the NT will be a regular occurrence.

It is important to keep in mind the experiences of South Australia who have long implemented a regime of regularly placing interns into general practice terms. Mugford et al (2001) highlight that when the concept of placing interns in general practice and rural terms was first promoted, many in administrative and clinical medicine had the attitude that it was impossible to achieve. This has also been encountered in the NT but with persistence and stronger partnerships it will be achieved.
8. References


Medical Board of Australia (2011) *Second round consultation on a proposed registration standard for granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training.*


NT Department of Health (2008) *NT Review of Medical Education and Training*.


APPENDICES

A. Project Plan
B. Mapping Standards
C. NT draft Model
D. Accreditation Integration Documents
   Draft Single Survey Visit Form
   Draft NTPMC guidelines for integrated accreditation
Draft Project Plan

General Practice Training Accreditation Pilots:
Northern Territory Pilot

Managed by Northern Territory Post Graduate Medical Council in partnership with Northern Territory General Practice Education

December 2011
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1. Project Overview

The NT pilot project is to develop, implement and evaluate a pilot model that integrates current prevocational and vocational accreditation processes for Northern Territory General Practice facilities providing training. The Northern Territory Postgraduate Medical Council (NTPMC) is coordinating the project.

The NTPMC pilot project is one component of a national project. The national project is being coordinated and managed by the Confederation of Postgraduate Medical Education Council (CPMEC). The national project includes two other jurisdictional postgraduate medical councils (PMCs); Western Australia and Victoria who are running concurrent state-based pilot projects. A signed agreement is in place between CPMEC and General Practice Education and Training Limited (GPET), which outlines the overarching objectives, deliverables and project term along with the pilot project funding allocation.

The NT project is specifically looking to accredit Northern Territory General Practices for the placement of prevocational doctors through the Prevocational General Practice Placement Program. By using a streamlined and integrated accreditation process that also covers vocational level standards, it is expected that the model tested during the pilot will be used in the future for all training practices.

1.1 Project Background and Context

As highlighted in "Streamlining Training Accreditation in General Practice Discussion Paper" (Australian General Practice Training, 2010) separate accreditation processes are currently applied to General Practice facilities depending on the learner level (medical student, junior doctor or registrar), State/Territory jurisdiction, and/or College affiliation of the practice and learners. The separate accreditation processes place demands on the General Practice that are burdensome and not necessary.

There are currently a number of significant drivers that have created a need for addressing the issue of General Practice training accreditation:

- Increasing numbers of graduate doctors expected to seek GP training in the near future;
- Policy decisions to increase vocational positions for GP training – such as those outlined in the Minister for Health and Aging’s ‘Statement of Expectations 2011’;
- Substantial increase in PGPPP opportunities for prevocational doctors nationally; and
- The need for both Primary and Acute care settings for provisionally registered doctors training.
As the need for training placements is set to increase in General Practice settings, it is timely to streamline accreditation processes.

The NT has particular challenges that will shape the model of streamlined accreditation developed and the outcomes of this pilot (see Table 1).

Table 1. Specific Northern Territory Characteristics Relevant to the Project

<table>
<thead>
<tr>
<th>Demographic</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Urban, Regional and Remote practices</td>
</tr>
<tr>
<td>• Large proportion of Aboriginal health services</td>
</tr>
<tr>
<td>• A small population base dispersed over 1.3 million square kilometres</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Small medical program providing two year bonded graduates into our workforce</td>
</tr>
<tr>
<td>• Only 2 jurisdictional training hospitals</td>
</tr>
<tr>
<td>• Need to attract, develop and retain a supervisory workforce</td>
</tr>
<tr>
<td>• A small resourced PMC to undertake accreditation</td>
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</table>

<table>
<thead>
<tr>
<th>Health of Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>• “closing the gap” in health outcomes and life expectancy between Aboriginal and non-Aboriginal NT population</td>
</tr>
</tbody>
</table>

In addition to the drivers for the project, there is also broader context of dynamic change in accreditation processes and standards. In July 2010, the Northern Territory changed to a national registration process for all medical practitioners through the Australian Health Practitioners Registration Authority (AHPRA). During the transition to national registration, States and Territories have retained responsibility for prevocational (PGY1) medical education and training accreditation standards and processes. However, a new registration standard for the internship year (PGY1) will be developed and set by the national Medical Board of Australia (MBA) some time in 2012. The Postgraduate Medical Councils are also working to develop and comply with a CPMEC national framework of prevocational medical accreditation policies, principles and standards.

2. Project Outcomes, Objectives and Outputs

Outcomes:

• A streamlined and integrated accreditation process for General Practice facilities offering prevocational and vocational training in the Northern Territory.
**Project Objectives:**

- To provide a documented and evaluated assessment of a streamlined and integrated process of prevocational and vocational accreditation of general practice training facilities

- To provide an assessment of the applicability and reliability of a single survey and information collection process to support the prevocational and vocational accreditation of training practices by the relevant accreditation bodies in NT for general practice training facilities

- To advise on the accreditation implications for an expansion of capacity for future General Practice training placements in the Northern Territory.

- To further the partnering of primary and acute healthcare training in the Northern Territory.

**Project Outputs:**

- Project plan – endorsed by both NT project Steering Committee and National Steering Committee.

- Project Evaluation Plan – endorsed by both NT project Steering Committee and National Steering Committee

- NT model and rationale for a streamlined, single survey multi-accreditation process

- Evaluation of the NT pilot model

- Final project report including project evaluation and recommendations for a future streamlined accreditation process.

### 3. Project Processes

#### 3.1 Stakeholder Involvement and the Project Steering Committees

National level stakeholders will be engaged primarily through the national project steering committee (the General Practice Training Accreditation Pilot Steering Committee). The national steering committee will be comprised of representatives from GPET, CPMEC, the two General Practice vocational training colleges Australian College of Rural and Remote Medicine (ACRRM) and Royal Australian College of General Practice (RACGP) and a representative for Regional Training Providers. National stakeholders will be consulted and informed of project progress and a national steering committee will approve the project plan and project evaluation.

Local stakeholders will be involved in the project through two key mechanisms. An NT Steering Committee will be convened to guide and endorse the planning,
implementation and evaluation of the project (see Table 2). There will also be specific partnership agreements developed with direct project participants.

Local stakeholders include NT Board of Medical Board of Australia – Accrediting authority, NT PMC – facilitator of accreditation, NTGPE – Regional Training Provider - PGPPP, Royal Darwin Hospital and Alice Springs Hospital – PGPPP Feeder Hospitals, Junior Doctors – Program participants, participating General Practices.

A 'Partnership Memorandum of Understanding' (MOU) will be signed by all direct NT project partners; NT PMC, Royal Darwin Hospital (RDH), Alice Springs Hospital (ASH), NTGPE and the participating General Practices. A key partnership mechanism will be having all partners represented on the General Clinical Training Committee (RDH) and Medical Training Committee (ASH) to inform, advise and coordinate the project implementation.

Table 2. Northern Territory Pilot Project Steering Committee

<table>
<thead>
<tr>
<th>Stakeholder Organisation</th>
<th>Proposed nominations</th>
</tr>
</thead>
<tbody>
<tr>
<td>NT Postgraduate Medical Council</td>
<td>Dr Elizabeth Chalmers, Chair&lt;br&gt;Shirley Bergin, Executive Officer</td>
</tr>
<tr>
<td>NT General Practice Education</td>
<td>Nicole Lamb&lt;br&gt;Dr Tamsin Cockayne</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>Dr Kishan Pandithage (also a Medical Educator)</td>
</tr>
<tr>
<td>Junior Medical Officers</td>
<td>Postgraduate year 3 doctors who have already completed the PGPPP in NT</td>
</tr>
<tr>
<td>Royal Darwin Hospital</td>
<td>Dr Barbara Bauert, Director of Clinical Training</td>
</tr>
<tr>
<td>Alice Springs Hospital</td>
<td>Amanda Cawthorne-Crosby, Medical Education Officer</td>
</tr>
</tbody>
</table>

Coordination with the two other PMC's who are delivering pilot projects will be assisted by CPMEC and direct contact between NT PMC and the other two State organisations.

3.2 Project team

The NT project team is primarily made up of staff of the NT Postgraduate Medical Council (NT PMC) with the support of a project officer contracted through CPMEC. The NT project team will be meeting regularly during the course of the project, with weekly meetings during the intensive periods of the project.

Table 3. Project team
<table>
<thead>
<tr>
<th>Project team member</th>
<th>Project Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shirley Bergin</td>
<td>Project leader, Standards and Accreditation mapping and streamlining, pilot implementation, project coordination</td>
</tr>
<tr>
<td>Dr Elizabeth Chalmers</td>
<td>Project adviser</td>
</tr>
<tr>
<td>Karen Brandt</td>
<td>Steering Committee Secretariat, project administration assistance</td>
</tr>
<tr>
<td>Julia Chalmers</td>
<td>Project planning, project coordination and project evaluation</td>
</tr>
</tbody>
</table>

3.3 Project evaluation

The pilot will undergo an evaluation to inform and highlight the areas of success and need for improvement of the proposed streamlined accreditation standards and process.

An evaluation framework is being applied to all pilot projects being undertaken to enable collation and comparison of the pilots. This framework is being developed by CPMEC.

In addition to the CPMEC evaluation process, the NT pilot will also undertake an evaluation process adapted from the Accreditation Evaluation Process (outlined in the NTPMC Facilities Handbook). This will include indicators and evaluation areas of interest specifically relevant to the NT situation.

The evaluation process will involve online surveys and one-on-one interviews for key stakeholders and pilot participants. The evaluation findings will be written in a draft report for consultation with the NT Steering Committee and then provided to CPMEC.

4. Project Management

The project will be managed by NTPMC, utilising a dedicated part-time project officer. The project has been planned with a work-breakdown structure showing the different elements of the project (see Figure 1), a set of project milestones (see Table 4) and consideration of key risks to the project's success (see Table 5).
Figure 1. Draft Work Breakdown Structure

Northern Territory Pilot

**Project Planning and Reporting**
- 1.1 rough project plan
- 1.2 project team meetings
- 1.3 draft plan for steering committee approval
- 1.4 approval from NT SC and National SC
- 1.5 finalised project plan
- 1.6 draft final report
- 1.7 project team meeting
- 1.8 steering committee meeting and approval
- 1.9 final report submitted to CPMEC

**Streamlining Standards and Accreditation**
- 2.1 collecting and reviewing relevant documents
- 2.2 mapping standards and accreditation processes
- 2.3 development of pilot accreditation model
- 2.4 development of pilot instruments
- 2.5 consultation with Steering Committees
- 2.6 revision / finalised
- 2.7 approval to implement
- 2.8 undertake accreditation processes with hospitals and participating practices
- 2.9 accreditation review

**Pilot Implementation**
- 3.1 Memoranda of Understanding developed between NT project partners
- 3.2 MOUs agreed and signed
- 3.3 information fact sheet for participants – practices, hospitals and JMO's
- 3.4 GP practices recruited (2-4 practices)
- 3.5 recruit JMO's
- 3.6 begin placements
- 3.7 mid-placement review
- 3.8 placement end and evaluation

**Project Evaluation**
- 4.1 National Pilot evaluation framework
- 4.2 NT evaluation plan drafted
- 4.3 NT Steering Committee approval of eval. plan
- 4.4 pre-pilot expectations
- 4.5 post-pilot evaluation surveys and interviews
- 4.6 draft evaluation report
- 4.7 NT Steering Committee approval of eval report
- 4.8 final evaluation report
Table 4. Project milestones

<table>
<thead>
<tr>
<th>Month</th>
<th>Project Milestones</th>
<th>Project Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>December</td>
<td>Draft Project Plan</td>
<td>Project Team meetings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Document Review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mapping Standards and Accreditation Processes begins</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stakeholder briefing and initial engagement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Draft Memorandum of Understanding developed between key stakeholders</td>
</tr>
<tr>
<td>January</td>
<td>Steering Committee Meeting 1</td>
<td>First National Steering Committee Meeting</td>
</tr>
<tr>
<td></td>
<td>Approved Project Plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Evaluation Plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MOUs signed</td>
<td></td>
</tr>
<tr>
<td>February</td>
<td>Steering Committee Meeting 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pilot Accreditation model approved</td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>Pilot Accreditation Implementation Option 1</td>
<td>28 March Term 2 begins</td>
</tr>
<tr>
<td>April</td>
<td>Pilot Accreditation Implementation Option 2</td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>Evaluation data collection</td>
<td>6 June Term 2 ends</td>
</tr>
<tr>
<td>June</td>
<td>Final Steering Committee Meeting</td>
<td></td>
</tr>
<tr>
<td>July</td>
<td>Final Steering Committee Meeting</td>
<td></td>
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<tr>
<td></td>
<td>Draft Evaluation Report</td>
<td></td>
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<tr>
<td></td>
<td>Final Project Report</td>
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<td></td>
<td>Final Project Report</td>
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Table 5. Project Risk Management

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</thead>
<tbody>
<tr>
<td>Feeder hospitals unable to provide intern doctors for pilot term</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>Contacting both hospitals in advance to advise of upcoming project – working with the Director of Clinical Training and Medical Education Officers of both feeder hospitals.</td>
</tr>
<tr>
<td>Unable to complete project within timeframe</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>Good project planning and a dedicated project officer provides the best chance of keeping the project timing on track.</td>
</tr>
<tr>
<td>Northern Territory or National Steering Committee to seek significant changes to the project.</td>
<td>M</td>
<td>H</td>
<td>M</td>
<td>The Steering Committees involved in the project are a valuable source of advice for the project and have an important endorsement role. Regular contact will be made to keep both Steering Committees appropriately updated on project developments.</td>
</tr>
<tr>
<td>Delay in the partnership agreement</td>
<td>M</td>
<td>H</td>
<td>H</td>
<td>All parties have been contacted early on in the project and the discussions about the content and expectations of the partnership MOU have been clear and transparent.</td>
</tr>
<tr>
<td>Unable to get parties to agree to proposed accreditation and term arrangements in time for accreditation for term 2 placements.</td>
<td>M</td>
<td>M</td>
<td>M</td>
<td>Every effort will be made to get accreditation underway for Term 2 placements, but if it is not possible – the accreditation can still take place before the end of the project – even if the placement itself does not finish within the project timeframe.</td>
</tr>
</tbody>
</table>
5. References

Agreement between General Practice Education and Training Limited and Confederation of Postgraduate Medical Education Councils Limited: General Practice Training Accreditation Pilots.


ACCRM General Practice training post and supervisor standards

RACGP General Practice training post and supervisor standards


GPET Limited (2010). Streamlining Training Accreditation in General Practice Discussion Paper


## NT Accreditation Standards

### Function 1 GOVERNANCE

The Delegated Officer will ensure that the Junior doctor Education and Training Program offered is *sufficient* to enable Junior doctors who undertake the program to gain the skills and knowledge in clinical medical practice necessary to competently and safely practise the profession.

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<tr>
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<th>ACRRM</th>
<th>RACGP</th>
<th>NTGPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>These standards are for prevocational doctors</td>
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</table>

### 1. Facility Structure

The Facility Manager is accountable for the provision and quality of the Junior doctor Education and Training Program (IETP) by ensuring that there are appropriate organisation and governance structures in place.

1. Undertake **strategic planning** and provide a **budget** to support the ongoing and future needs of the IETP.
2. Ensure that there is an **organisational structure** with appropriately qualified staff to manage the IETP.
3. Ensure that there are **policies, processes and procedures** in place, which facilitate the delivery and coordination of the IETP including supervision and orientation.
4. Provide adequate **physical and educational infrastructure** to ensure the objectives of the Junior doctor training years are met.
5. Ensure systematic **communication between network partners** to optimise learning outcomes for the Junior doctor.

<table>
<thead>
<tr>
<th>NTGPE Comments</th>
<th>Coverage in NTPMC PMOU</th>
</tr>
</thead>
<tbody>
<tr>
<td>• PGP coordinator re how their current program will meet the NTPMC standards and • NTPMC partnership memorandum of understanding written for project (NTPMC PMOU)</td>
<td>Std T32&lt;br&gt;Std T33</td>
</tr>
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<tr>
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<th>RACGP</th>
<th>NTGPE</th>
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<tbody>
<tr>
<td>Std C2.2;2.3;2.4</td>
<td>Std T32&lt;br&gt;Std T33</td>
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NT Accreditation Standards

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2. Personnel overseeing the Junior doctor Education and Training Program

The Facility Manager is accountable for the provision and quality of the training experience of Junior doctors by ensuring that there are suitable personnel with clinical and educational expertise employed to support and undertake educational planning and the delivery of the Junior doctor Education and Training Program (IETP).

1. Ensure that there are educational support personnel appointed with appropriate skills, knowledge, competencies, time and authority specifically employed to support the IETP.
2. Ensure that there are clinical and educational supervisors appointed with appropriate skills, knowledge, competencies, time, authority and resources employed to support the IETP.
3. Ensure the participation in professional development opportunities by those overseeing the IETP.
4. Ensure that advocacy for Junior doctors, by those overseeing the IETP, is supported by relevant documentation.
5. Ensure that the performance appraisal of all Medical Education Unit personnel involved in the Junior doctors’ training experience is monitored including evaluation of teaching performance where appropriate.

| 1. Ensure that there are educational support personnel appointed with appropriate skills, knowledge, competencies, time and authority specifically employed to support the IETP. | Std 1 C 1.1;1.2;1.3 | Std T34 Quality T37 |
| 2. Ensure that there are clinical and educational supervisors appointed with appropriate skills, knowledge, competencies, time, authority and resources employed to support the IETP. | Std T1 Std T2 Std T3 Std T4 |
| 3. Ensure the participation in professional development opportunities by those overseeing the IETP. | Std 5 |
| 4. Ensure that advocacy for Junior doctors, by those overseeing the IETP, is supported by relevant documentation. | |
| 5. Ensure that the performance appraisal of all Medical Education Unit personnel involved in the Junior doctors’ training experience is monitored including evaluation of teaching performance where appropriate. | Coverage in NTPMC PMOU |
## Function 1 GOVERNANCE

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### 3. Junior doctor Education and Training program

The Facility Manager will ensure that the Junior doctor Education and Training Program (IETP) is composed of an organised Facility Education Program (FEP), Term Education Program and other educational experiences, designed to provide each Junior doctor with the opportunity to fulfil the educational objectives outlined for each term and achieve competence.

1. Ensure that the **IETP is considered in the context of the Facility's service provision**, in accordance with the Clinical Services Capability Framework (where applicable) enabling innovative terms to be developed and accredited to allow for capacity building.
2. Ensure that a flexible **FEP** is delivered in paid time and is accessible and relevant to Junior doctors.
3. Ensure that Junior doctors have equitable access to appropriate **clinical and non-clinical education** opportunities in order to meet his or her educational needs.
4. Ensure that where **secondment terms** are used, the nature of the experience used for the IETP is clearly defined.
5. Ensure that the State based **assessment processes** are followed for all Junior doctors.
6. Where **ward call/remote call** is allocated as part of a compulsory term, ensure that:
   a. There is adequate supervision provided at all times
   b. Junior doctors are only rostered to cover in Units that are currently accredited for Junior doctor training
   c. The Clinical Supervisor for ward call is included in the full assessment process

| Std 2 C 2.5 | | | | | |
### NT Accreditation Standards

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<tbody>
<tr>
<td><strong>d.</strong> The Junior doctor is aware of the change in assessment procedures.</td>
<td></td>
</tr>
<tr>
<td><strong>e.</strong> The clinical Supervisor for the compulsory term liaises with other Clinical Supervisors.</td>
<td></td>
</tr>
<tr>
<td><strong>7.</strong> Ensure that there is regular systematic collection, interpretation and use of <strong>evaluation data</strong> from each Junior doctor for feedback into the program and its continuous improvement.</td>
<td>Feedback T42</td>
</tr>
</tbody>
</table>
## Function 1 GOVERNANCE

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</table>

4. **Junior doctor Term Evaluation Process**

   The Term Education Program will be formally evaluated using a quality framework.

1. Ensure that Junior doctors are given the opportunity to evaluate the Term Education Program using an **evaluation tool** which gathers information on:
   - Supervision
   - Orientation
   - Formal and informal learning opportunities
   - Feedback.
2. Ensure that the term **evaluation results** are reviewed by the committee overseeing the IETP and are used to **quality improve** the terms.
3. Ensure that there is a process in place to maintain the **confidentiality** of Junior doctor term evaluations so as to protect the Junior doctor and encourage frank and honest feedback on the term.

| Std2 C2.8 | Feedback T42 | Coverage in NTPMC PMOU |
Function 1 GOVERNANCE

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<td>Comments from</td>
<td></td>
</tr>
<tr>
<td>5. Junior doctor Education and Training Committee</td>
<td>Ensure that the Committee establishes the general and specific <em>policies of Junior doctor Education</em> in order to protect and preserve the best interests of the patient, the Supervisor, the Junior doctor and the Facility. 1. The <em>Terms of Reference</em> should/will ensure that: a. Appropriate reporting lines are in place and that the communication loop within all levels of the Facility is fully utilised b. Appropriate membership on the Committee including Junior doctor representation c. Independent Chair who does not currently hold a position within the MEU d. The Committee promotes quality assurance and complies with NTPMC Standards, and encourages educational excellence. 2. Ensure that the Committee evaluates the effectiveness and content of all aspects of the IETP.</td>
<td>A term supervisor/GP Medical educator/PGPPP coordinator should be a member on the medical training committees of the training hospitals or primary allocation centres Coverage in NTPMC PMOU</td>
<td>• PGPPP coordinator re how their current program will meet the NTPMC standards and • NTPMC partnership memorandum of understanding written for project (NTPMC PMOU)</td>
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Function 2 JUNIOR DOCTOR EDUCATION AND TRAINING PROGRAM

The structure and content of the program including assessment and supervision, training infrastructure and resources and clinical experiences is sufficient to enable Junior doctors to progress to full registration

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| These standards are for PGY1 junior doctor training to gain full registration |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | These standards are written for participants in any of ACRRM's Vocational Training Pathways                                                                                                                                                                               | The standards are addressed to the general practitioners who are taking responsibility for the training or the registrar within a primary care setting                                                                                                                                 | Comments from  
PGPPP coordinator re how their current program will meet the NTPM standards  
NTPMC partnership memorandum of understanding written for project (NTPMC PMOU)                                                                 | Coverage in NTPMC PMOU                                                                                                                                                                                                                     |

1. Structure of the Junior doctor Education and Training Program  
The structure and quality of the Junior doctor Education and Training Program meets the requirements of the junior doctor Guidelines (NTBMB) and any additional requirements as determined by the NT Board of the Medical Board of Australia who have the legislative responsibility for implementing the Act.

1. Ensure that the allocation to each term is appropriate for the requirements of Junior doctor training such that Junior doctors each must have the compulsory terms of medicine, surgery and emergency for a minimum of 10 weeks each and the remaining 22 weeks in non-compulsory terms.

2. For Secondment Facilities, ensure that the allocation of junior doctors is in accordance with that agreed by the Primary Allocation Facility.
## NT Accreditation Standards

**Function 2 JUNIOR DOCTOR EDUCATION AND TRAINING PROGRAM**

The structure and content of the program *including* assessment and supervision, training infrastructure and resources and clinical experiences is sufficient to enable Junior doctors to progress to full registration.

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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Junior Doctor ETP Orientation</td>
<td>All Junior doctors will be orientated to the Facility and Junior doctor Education and Training Program (ETP) prior to its commencement.</td>
<td></td>
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</tr>
</tbody>
</table>

1. Ensure that all junior doctors receive a comprehensive **orientation program** for the junior doctor Education and Training Program and the Facility including:
   a. Identification of personnel responsible for implementing the junior doctor ETP
   b. Identification of relevant junior doctor ETP policies and procedures including assessment and evaluation processes
   c. Identification of junior doctor support processes
   d. Identification of relevant Facility clinical policies and procedures
   e. Explanation of educational processes used at the Facility including the educational program.
2. Ensure that the **delivery of the Junior Doctor ETP** orientation is consistent with best educational principles including experiential opportunities.
3. Ensure that the Junior Doctor ETP orientation program is **evaluated** by the junior doctors and necessary changes made in line with quality improvement. Data from the evaluations is to be reviewed by the Committee responsible for the oversighting of Junior doctor Education at the Facility.

Coverage in NTPMC PMOU

Comments from:
- PGPPP coordinator re how their current program will meet the NTPMC standards
- NTPMC partnership memorandum of understanding written for project (NTPMC PMOU)
## Function 2 JUNIOR DOCTOR EDUCATION AND TRAINING PROGRAM

The structure and content of the program including assessment and supervision, training infrastructure and resources and clinical experiences is sufficient to enable Junior doctors to progress to full registration.

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<td></td>
</tr>
<tr>
<td>3. Facility Education Program content</td>
<td>1. Ensure that the FEP has <strong>content</strong> relevant to Junior doctors and is mapped to the National Curriculum Framework for Junior Doctors as is applicable to the Facility, and that it is continually updated in response to feedback.</td>
<td>Std 2 C2.6;2.8</td>
<td>Coverage in NTPMC PMOU</td>
<td></td>
</tr>
<tr>
<td>The content of the Facility Education Program (FEP) should be consistent with National Standards of best practice i.e. <em>The National Curriculum Framework for Junior Doctors.</em></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Facility education program delivery</td>
<td>1. Ensure that Junior doctors can <strong>attend</strong> the FEP and demonstrate innovation to meet individual Junior doctor learning needs. 2. Ensure that the <strong>delivery of the FEP</strong> is consistent with best educational principles including experiential opportunities.</td>
<td>Std2 C2.6</td>
<td>Coverage in NTPMC PMOU</td>
<td></td>
</tr>
<tr>
<td>The Facility Education Program (FEP) should be delivered in a manner to maximise attendance and participation in an effective educational (setting) environment.</td>
<td></td>
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</tr>
<tr>
<td>5. Evaluation of the facility education Program</td>
<td>1. Ensure that there is an <strong>evaluation</strong> tool developed to evaluate the FEP, that there is a <strong>process</strong> that encourages all Junior doctors to evaluate the FEP and that utilises evaluation results to quality improve the program in subsequent years.</td>
<td>Std2 C2.8</td>
<td>Coverage in NTPMC PMOU</td>
<td></td>
</tr>
<tr>
<td>The Facility Education Program (FEP) will be formally reviewed and evaluated in a quality framework.</td>
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### NT Accreditation Standards

#### Function 2 JUNIOR DOCTOR EDUCATION AND TRAINING PROGRAM

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</table>

#### 6. Term Content

Terms will provide clinical and educational experiences, which will contribute to the achievement of safe competent clinical practise.

1. Ensure that the term provides appropriate quality and quantity of *clinical experience* such that it enables the junior doctor to achieve competence in clinical activities appropriate to that term.
2. Ensure that the Scope of Practice for the specific term is documented and provided to the junior doctor at the commencement of the term, including specific clinical skills, which require direct observation.
3. Ensure that a flexible, accessible and relevant Term Education Program will provide a variety of formal and informal, clinical and non-clinical teaching and learning opportunities for junior doctors delivered in paid time including opportunities to present at meetings.
4. Ensure that the junior doctors are rostered so as to permit them to attend the formal FEP sessions, which supplement the term experiences.

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<tr>
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<tbody>
<tr>
<td>1.</td>
<td>College results will contribute to evidence for prevocational current PGPPP clinical experiences will also contribute to evidence</td>
<td>Std 2 C2.6</td>
<td>Std T31</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td>Currently this is not done, but we are more than happy to provide this in a more formal manner than currently provided to the PGY2 and above program participants.</td>
<td>Std 2 C2.5;2.6</td>
<td>Std T16</td>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
<td>As above in the outline of the program we provide weekly teaching session via teleconference, the Darwin based placements come into the office. All clinics provide regular teaching in the form of on the job, formal and semiformal teaching. We will also expect them to attend the regular teaching session at RDH as a mandatory component of their placement.</td>
<td></td>
<td></td>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
<td>This is put into the contract with the clinic and is mandatory for all JMO to attend any formal teaching organised by NTGPE</td>
<td></td>
<td></td>
<td>4.</td>
</tr>
</tbody>
</table>
## NT Accreditation Standards

### Function 2 JUNIOR DOCTOR EDUCATION AND TRAINING PROGRAM

The structure and content of the program *including* assessment and supervision, training infrastructure and resources and clinical experiences is sufficient to enable Junior doctors to progress to full registration.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Criteria</th>
<th>ACRRM</th>
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<tbody>
<tr>
<td>These standards are for PGY1 junior doctor training to gain full registration</td>
<td>These standards are written for participants in any of ACRRM’s Vocational Training Pathways</td>
<td>The standards are addressed to the general practitioners who are taking responsibility for the training or the registrar within a primary care setting</td>
<td>Comments from</td>
<td></td>
</tr>
<tr>
<td>1. Ensure that the junior doctor receives a comprehensive orientation to the term prior to commencement of clinical duties including:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Reporting lines</td>
<td>Std T19</td>
<td>• PGPPP coordinator re how their current program will meet the NTPMC standards and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Daily roster</td>
<td></td>
<td>• NTPMC partnership memorandum of understanding written for project (NTPMC PMOU)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Relevant Unit policies and procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Documented clear Learning Objectives for an Junior doctor undertaking this term.</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>2. Discuss with the junior doctor his/her individual learning objectives for the term and develop a learning plan.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Ensure that the junior doctor has a handover with the previous Junior doctor or delegated medical officer of current patients he/she will be managing clinically.</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

7. Term Orientation and Handover

Junior doctors will receive a comprehensive term orientation and handover prior to commencement of clinical duties.

1. 3 day orientation is provided to all PGPPP participants regardless of year level or placement location. We would welcome someone from the PMC to attend the orientation and we will also provide a detailed summary of topics and sessions provided.

2. Will be written up and provided

3. **NO** clinical handovers required in any placements
# NT Accreditation Standards

## Function 2 JUNIOR DOCTOR EDUCATION AND TRAINING PROGRAM

The structure and content of the program *including* assessment and supervision, training infrastructure and resources and clinical experiences is sufficient to enable Junior doctors to progress to full registration

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  - PGPPP coordinator re how their current program will meet the NTPMC standards  
  - NTPMC partnership memorandum of understanding written for project (NTPMC PMOU) |

8. **Term Supervision**

The Junior doctor will be supervised at all times by a medical practitioner with the necessary knowledge, skills and experience to provide safe patient care and effective Junior doctor training.

1. Ensure that there is sufficient **clinical and educational supervision** by Supervisors appointed with appropriate skills, knowledge, competencies, induction, time, authority and resources employed to supervise the junior doctor and that there are opportunities for them to participate in professional development relevant to their role as Supervisors.

2. Ensure that the Facility’s policies on **adequate supervision are implemented** at all times (including when a Junior doctor is rostered to ward call).

<table>
<thead>
<tr>
<th></th>
<th>St 1 C1.1;1.2;1.3 (1.4 is specific to registrars however could be used for Junior doctors/PGY2)</th>
<th>Std T1</th>
<th>Std T2</th>
<th>Std T3</th>
<th>Std T4</th>
<th>Std T5</th>
<th>Std T10</th>
<th>Std T21</th>
<th>Std T22</th>
<th>Quality T25</th>
<th>Std T15</th>
</tr>
</thead>
</table>

1. All placements are fully supervised by accredited trainers. College accreditation evidence can be supplied

2. As above. Junior doctors will **NOT** be on call at anytime during their GP placement.
## NT Accreditation Standards

### Function 2 JUNIOR DOCTOR EDUCATION AND TRAINING PROGRAM

The structure and content of the program including assessment and supervision, training infrastructure and resources and clinical experiences is sufficient to enable Junior doctors to progress to full registration.

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<td>Comments from: • PGPPP coordinator re how their current program will meet the NTPMC standards and • NTPMC partnership memorandum of understanding written for project (NTPMC PMOU)</td>
</tr>
<tr>
<td>9. Junior doctor (Performance) Assessment</td>
<td></td>
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</tr>
<tr>
<td>There will be assessment and appraisal to provide ongoing constructive feedback to Junior doctors, to ensure that both the Junior doctor training objectives are met and that the requirements of registration are complied with.</td>
<td>1. At start of term, detail the specific <strong>process for assessment</strong> within the Unit, particularly outlining the personnel responsible for providing the feedback.</td>
<td>Std T14</td>
<td>Feedback T43</td>
<td>1. Can provide copies of our learning needs appraisals, log books, skills assessments etc. Anything more formal that needs to meet the hospitals requirements must be provided by the hospital to NTGPE in a timely manner and this required information will be forwarded to the supervisor for completion.</td>
</tr>
<tr>
<td></td>
<td>2. There is a <strong>midterm feedback</strong> session by the Term Supervisor for all terms, which exceed five weeks.</td>
<td></td>
<td></td>
<td>2. Happy to comply with this but feel that the hospital needs to be involved in this process</td>
</tr>
<tr>
<td></td>
<td>3. <strong>Feedback sessions</strong> will include input provided by all Supervisors and others observing the doctor’s performance.</td>
<td></td>
<td></td>
<td>3. As above</td>
</tr>
<tr>
<td></td>
<td>4. Ensure that junior doctors are informed when serious concerns exist. There will be a documented <strong>process for managing substandard performance</strong>, which will ensure the welfare of the junior doctor and patients.</td>
<td></td>
<td></td>
<td>4. NTGPE has a policy on program participants at risk and are monitored closely with input from the JD; Supervisor; coordinator and Medical and cultural educators</td>
</tr>
<tr>
<td></td>
<td>5. <strong>Objective summative assessment</strong> occurs as prescribed at the end of each term. The Junior doctor must view the assessment form at the assessment interview, be provided an opportunity to write comments on it, be given a copy of the assessment form prior to it going to the IETP Director and being stored in the Junior doctor’s personnel record.</td>
<td></td>
<td></td>
<td>5. Currently there is not assessment other than the LNA process, happy to work on this to meet the requirements of the JDs learning. Must be in conjunction with RDH and clinics.</td>
</tr>
<tr>
<td></td>
<td>6. <strong>Clinical skills must be assessed</strong> by direct observation and must be documented.</td>
<td></td>
<td></td>
<td>6. This can be done if required but just not sure on how and by whom. Adds work to the already busy supervisor. Logbooks may give evidence to this criterion.</td>
</tr>
</tbody>
</table>
NT Accreditation Standards
Draft Partnership MOU

General Practice Training Accreditation Pilots:
Northern Territory Pilot
Partnership Memorandum of Understanding

February 2012

Project Pilot managed by Northern Territory Post Graduate Medical Council for General Practice Education and Training Limited and Confederation of Postgraduate Medical Education Councils.
Partnership memorandum of understanding

between

Northern Territory General Practice Education (NTGPE - PGPPP),
Royal Darwin Hospital (RDH) or Alice Springs Hospital (ASH)
and
(NT General Practice or Aboriginal Health Service)

Rationale and scope

The purpose of this Agreement is to outline the scope of responsibilities and accountabilities between the parties involved in placing NT Postgraduate Year 1 (PGY1) junior doctors into an elective primary care term (Hospital Term 2) using the national Prevocational General Practice Placement Program (PGPPP). This agreement is for the period of the GPET/CPMEC pilot project being undertaken by NTPMC during 2012.

The NT Postgraduate Medical Council regulates facility and term accreditation for PGY1 prevocational medical training in Northern Territory. This role is delegated by the Medical Board of Australia and endorsed by the NT Department of Health.

Under the NT pilot project, PGY1 placements through PGPPP is a collaboration between a general practice (term), hospital (feeder training hospital) and regional training provider. Therefore, accreditation process requires the commitment and support of all partners for the pilot project to yield useful results for all stakeholders.

Objectives

1. To create accredited sustainable training opportunities for postgraduate year 1 (PGY1) junior doctors in the NT to experience and explore primary health care across the territory.

2. Place and evaluate accredited PGY1 non-compulsory secondment terms in NT primary care settings.

3. To provide an assessment of the appropriateness and reliability of a single survey and information collection process (streamlined and integrated) to support the prevocational and vocational accreditation of training practices by the relevant accreditation bodies in NT for private general practice training and Aboriginal Health Service facilities.

4. Promote a continuous improvement quality approach to PGY1 prevocational medical training placements

This Partnership memorandum of understanding objectives will contribute to the PGPPP objective, which is to “provide professional, well supervised and educational general practice placements for prevocational doctors as part of their prevocational training.”

Partner organisations

The Memorandum of Understanding is between:

♦ Royal Darwin Hospital – Feeder Training Hospital (future Top End Hospital Network)
or
- Alice Springs Hospital – Feeder Training Hospital (future Central Hospital Network):

and

- NT General Practice Education Ltd – Accredited Regional Training Provider – PGPPP provider:

and

- NT General Practices – Urban, Rural and Remote locations (private General Practices and Aboriginal Health Services)

Roles and Responsibilities

Under this partnership, the relevant feeder Training Hospital (RDH or ASH) will:

- Maintain their accreditation Primary allocation status during the period of this partnership Memorandum of understanding and notify the partners if there is any change to this status that may affect their secondment allocation status
- Ensure those functions and standards that apply specifically to governance of the junior doctor education and training programs are continuously improved to meet the needs of prevocational junior doctors
- Ensure systematic communication between “network partners’ to optimize learning outcomes for the junior doctor
- Ensure secondment allocation centre and regional training provider membership on the junior doctor education and training committee (GCTC/MTC) or equivalent
- Provide all policies, guidelines and other documents relating to junior doctor medical education and training to the secondment allocation centre with explanation of their use
- Ensure that advocacy for junior doctors by those overseeing the Intern education training program in the secondment allocation centre is supported by relevant documentation
- Ensure that where secondment terms are used, the nature of the experience used for the Intern education and training program is clearly defined.
- The Facility Education Program should be accessible to all interns regardless of their term allocation. Innovative options to meet individual Intern learning needs and situations are strongly encouraged and may include online learning or independent study options. Off site options will be particularly useful for PGPPP participants.
- Ensure that the term evaluation results are reviewed by the RDH/ASH General Clinical Training Committee (GCTC/MTC) or equivalent overseeing the junior doctor education training program and are used to continuously improve term content and experiences
- Ensure that there is a process in place to maintain the confidentiality of junior doctor term evaluation so as to encourage frank and honest feedback on the term
- Ensure the structure and content of the program including assessment, supervision, training infrastructure and resources and clinical experiences is sufficient to enable Interns to progress to full registration

Under this partnership, NTGPE will through the PGPPP:

- Ensure systematic communication between “network partners’ to optimize learning outcomes for the junior doctor
- If the General Practices accreditation with RACGP and/or ACRRM changes during the period of this partnership Memorandum of understanding the RTP MUST notify the other partners if it may affect their prevocational secondment allocation status
- All policies written and managed by the RDH/ASH General Clinical Training Committee (GCTC/MTC) or equivalent must be understood and complied with; any concerns in being able to comply should be raised with the Chair of this committee.
- Ensure that agreement is made regarding assessment tools to be used by the term supervisors and after completion have them sent onto the primary allocation centre (RDH/ASH) MEU for recording purposes
Support the General Practice/Aboriginal Health Service to meet and maintain the NTPMC prevocational medical education and training standards for secondment allocation centre status (Function 2 Standards 6-9).

Ensure the structure and content of the PGPPP term includes – assessment, supervision, training infrastructure and resources and clinical experiences sufficient to contribute and enable Interns to progress to full registration, which will contribute to the achievement of safe competent clinical practice appropriate to that term.

Ensure that there is a process in place to maintain the confidentiality of junior doctor term evaluation to protect the junior doctor and encourage frank and honest feedback on the term experience.

Ensure representation of the regional training provider/PGPPP as a member of the Royal Darwin Hospital or Alice Springs Hospital junior doctor education and training committee (GCTC/MTC) or equivalent that oversees RDH/ASH junior doctor education and training.

Provide a comprehensive overarching general practice term orientation, where a discussion with the junior doctor about his/her individual learning objectives for the term are discussed and in collaboration with the junior doctor develop a learning plan for the term.

Ensure that there is sufficient clinical and educational supervision by supervisors appointed with appropriate skills, knowledge, competencies, induction, time, authority and resources employed to supervise the junior doctor and that there are opportunities for them to participate in professional development relevant to their role as supervisors.

Ensure that the primary allocations policies on adequate supervision are implemented and followed at all times.

Ensure that there will be assessment and appraisal to provide ongoing constructive feedback to junior doctors to ensure that both the junior doctor training objectives are met and that the contribution to the requirements of registration are complied with.

Ensure that the junior doctor is informed when serious concerns regarding their performance exist. Ensure that the primary allocation centers poor performance policy is followed and is advised verbally as soon as possible after the poor performance is identified and then followed up in writing.

The term education program will be formally evaluated using a quality framework.

Under this partnership, General Practices/Aboriginal Health Services will:

Maintain their accreditation with RACGP and ACRRM during the period of this partnership Memorandum of understanding and notify the partners if there is any change to this status that may affect their prevocational secondment allocation status.

Ensure systematic communication between “network partners’ to optimize learning outcomes for the junior doctor.

All policies written and managed by the RDH/ASH General Clinical Training Committee (GCTC/MTC) or equivalent must be understood and complied with; any concerns in being able to comply should be raised with the regional training provider/PGPPP coordinator.

Ensure that there is a process in place to maintain the confidentiality of junior doctor term evaluation to protect the junior doctor and encourage frank and honest feedback on the term experience.

Ensure representation of the general practice/aboriginal health service as a member of the Royal Darwin Hospital or Alice Springs Hospital junior doctor education and training committee (GCTC/MTC) or equivalent that oversees RDH/ASH junior doctor education and training.

Provide a comprehensive local term orientation, where a discussion with the junior doctor about his/her individual learning objectives for the term are discussed along with his/her learning plan for the term.

Ensure a medical practitioner with the necessary knowledge, skills and experience to provide safe patient care and effective junior doctor training will supervise the junior doctor at all times and the primary responsibility of the patient care remains with the supervisor.

Ensure that the junior doctor is informed when serious concerns regarding their performance exist. Ensure that the primary allocation centers policy is followed and that
the regional training provider/PGPPP coordinator is advised verbally as soon as possible after the poor performance is identified and then followed up in writing.
- Have and use the assessment tools for the term supervisors provided by the regional training provider/PGPPP coordinator, after completion have them sent onto the PGPPP coordinator for the primary allocation centre records

**Governance structure and reporting**

The agreement will be the responsibility of all parties to implement and monitor. The NTPMC will be monitoring the implementation of responsibilities for the purposes of progressing the pilot project and will request information for project reporting purposes from time to time during the project period.

**Meetings**

NTPMC Pilot Project Steering Committee  
General Clinical Training Committee or Medical Training Committee

**Communication, information sharing and consultation processes**

Through NTPMC Pilot Project Steering Committee, Medical training committees of both training facilities (GCTC and MTC), Medical Education Units (MEU) of both training facilities, NTGPE staff and educators including the PGPPP coordinator

**Conflict resolution**

Initial mediation will be through the NT Project Steering Committee if it is unable to be resolved at this level then it will pass to the NT Postgraduate Medical Council and if the issue cannot be resolved at the local jurisdictional level the CPMEC Steering Committee will be asked to mediate.

**Review and evaluation**

End of pilot/project

Evaluation may include, but not be limited to:
- Feedback from junior doctors (PGY1 + PGY2)
- Feedback from surveyors (NTPMC + NTGPE)
- Feedback from clinical supervisors
- Feedback from both MEU’s (RDH + ASH) and GP Educators
- Outcomes from the quality assurance process
- Other issues identified by any party in this partnership MOU.

Where agreed by the partners, changes and amendments will be made to the working arrangements and the partnership MOU in accordance with the findings of the evaluation.

**Resources and facilities**

Local within each budget
Authorisation

NTPMC pilot project steering committee

Program Timeframe:

- This Partnership MOU is for the period of the GPET/CPMEC Pilot Project 2012
- The Partnership MOU is to be reviewed by NTPMC Steering Committee as part of the GPET/CPMEC pilot project 2012. Any additions or alterations identified from the review shall be incorporated into a new Partnership MOU for future placements in the NT.
- Additions or alterations may also be negotiated at any time during the GPET/CPMEC Pilot Project 2012 and if agreed to by the collaborating partners then they should be implemented and become an addendum to this Partnership MOU

NTPMC Standards Accountabilities

Schedule 1 details the respective responsibilities as they apply to meeting NTPMC Standards for Prevocational places in terms/units for PGPPP requirements for all parties.

Duty of Care

When placing junior doctors into a PGPPP placement, NTGPE must ensure that junior doctors are:

- adequately supervised
- orientated into the location of the placement;
- given contact numbers for support and welfare
- provided with opportunities for term medical education and training (clinical and non-clinical)
- not placed in an unsafe work environment where harm may be caused to a patient or junior doctor

Partnership Memorandum of Understanding Signatures

| Signed: ___________________________ | Signed: ___________________________ | Signed: ___________________________
| Name: ___________________________ | Name: ___________________________ | Name: ___________________________
| Date: ......................... | Date: ......................... | Date: ......................... |
| Partner Name: Royal Darwin Hospital or Alice Springs Hospital (please circle applicable facility) | Partner name: NT General Practice Education/PGPPP | Partner name: General Practice/Aboriginal Health Service |

CONTACT PERSON FOR NOTICES, LIAISON AND REPORTING

NTPMC

Pilot Project Officer: Julia Chalmers
Postal Address: GPO Box 40596, Casuarina, NT 0811
Telephone No.: 08 89992836
Facsimile No.: 08 89992588
## SCHEDULE 1 – IDENTIFIED ACCOUNTABILITIES

<table>
<thead>
<tr>
<th>ACCOUNTABILITIES</th>
<th>ORGANISATION</th>
<th>TIMEFRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Providing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1 x PGY1 in hospital term 2 or 3</td>
<td>RDH</td>
<td>Prior to term 2</td>
</tr>
<tr>
<td>• 1 x PGY2 in hospital term 2 or 3</td>
<td>ASH</td>
<td></td>
</tr>
<tr>
<td><strong>Providing placement in General Practice/Aboriginal Health Service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Placement opportunity for PGY1 at an urban General Practice/Aboriginal health service in Darwin and Alice Springs area</td>
<td>NTGPE/PGPPP</td>
<td>Prior to term 2</td>
</tr>
<tr>
<td>• Placement opportunity for PGY2 at any General Practice/Aboriginal health service (preferably rural or remote) in Darwin and Alice Springs regions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Providing Facility Education Program (FEP)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Timetable of listed relevant hospital sessions during term 2 and 3</td>
<td>RDH/ASH and NTGPE/PGPPP</td>
<td>At commencement of hospital year ongoing</td>
</tr>
<tr>
<td>• Where applicable timetable of listed relevant general practice sessions during term 2</td>
<td></td>
<td></td>
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<tr>
<td><strong>Providing Term Education Program (TEP)</strong></td>
<td></td>
<td></td>
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<tr>
<td>• Timetable of listed GP relevant term sessions during term 2 and 3</td>
<td>NTGPE/PGPPP</td>
<td>At commencement of year</td>
</tr>
<tr>
<td><strong>Delivery and Assessment</strong></td>
<td></td>
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<tr>
<td>• Provide and have accessible quality training facilities relevant to the program</td>
<td>NTGPE/PGPPP</td>
<td>ongoing</td>
</tr>
<tr>
<td>• Provide documentation where relevant supplied by RDH/ASH</td>
<td>RDH/ASH</td>
<td></td>
</tr>
<tr>
<td>• Inform students of the context and purpose of their assessments</td>
<td></td>
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<tr>
<td>• Version control for managing documents (including policies, procedural documents and learning/assessment materials)</td>
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<tr>
<td>• Provide learning and assessment materials</td>
<td></td>
<td></td>
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<tr>
<td>• Develop and implement training and assessment strategies</td>
<td></td>
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<tr>
<td><strong>Review and Evaluation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Work collaboratively to resolve issues promptly to ensure program’s success</td>
<td>RDH/ASH and NTGPE/PGPPP</td>
<td>ongoing</td>
</tr>
<tr>
<td>• Conduct ongoing evaluation by key stakeholders:</td>
<td>NTPMC Project Officer</td>
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</tr>
<tr>
<td>• Feedback from junior doctors (PGY1 + PGY2)</td>
<td>NTPMC</td>
<td></td>
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<tr>
<td>• Feedback from surveyors (NTPMC + NTGPE)</td>
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<td>• Feedback from both MEU’s (RDH + ASH)</td>
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<td>• Feedback from GP Educators</td>
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<td>• Outcomes from the quality assurance process</td>
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<tr>
<td>• Other issues identified by any party in this PMOU</td>
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<td></td>
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<tr>
<td><strong>Financial Arrangements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Limited funding for pilot project</td>
<td>GPET/CPMEC</td>
<td>commencement</td>
</tr>
<tr>
<td>• Placements</td>
<td>PGPPP/RDH/ASH/Gen prac</td>
<td></td>
</tr>
</tbody>
</table>
Secondment Allocation Facility Accreditation Model

Primary Allocation Facility
RDH/ASH (Training Feeder Hospital)
- Prevac focus

Second Allocation Facility
General Practice/Aboriginal Health Service/Community Medical Centre
- Prevac focus

PCY2 - 4 terms total various depending on stream/pathway

Interns
Mandatory Terms: Surgery, Medicine, Emergency Medical Care
Elective Terms: Various
Total = min 47 wks of full time or equivalent service

TEP
(Includes ACFJD)

FEP
(Including ACFJD)

MEU

DMS

DCT

MER

MEO

MEA

FEP sessions need to be coordinated and communication in topics etc. if unable to attend sessions due to location training missed could be picked up at a later time

GP Specific

RTP
(RTGPE)

DMCE
POFPE Coord
Med Educator
MEA

GCTC/MTC

LEGEND
RDH = Royal Darwin Hospital
ASH = Alice Springs Hospital
FEP = Facility Education Program
TEP = Term Education Program
ACFJD = Australian Curriculum Framework for Junior Doctors
MEU = Medical Education Unit
RTP = Regional Training Provider
GCTC/MTC = General Clinical Training Committee or Medical Training Committee
NTGPE/NTPMC GP Training Practice Accreditation Survey Visit Form

Name of Practice:

Date of Survey:

Current Accred Details:

Surveyors:

NTGPE:

NTPMC:

Preamble
This survey is to be undertaken by those already trained by NTGPE to undertake accreditation of practices for GP terms. The design of the survey uses the following methods:
- Themes
- Articulation of the relevant standards being examined under each theme

Each set of relevant standards has a series of guiding prompts/questions under it to aid the surveyor. The overall intent, however, is that the survey will be done by way of a dynamic conversation finding out about the strengths and weaknesses of the particular learning environment, whilst updating the practices regarding the required standards. The conversation therefore is unlikely to proceed question by question, but rather as a broad discussion with areas being probed as appropriate.

Tools surveyor should take:
National Minimum terms and Conditions
PGPPP and GPR supervision Guidelines – NTGPE
Supervisor Training Brochure
Theme 1: Overview of Clinic
RACGP: T12, T28, T35
ACRRM: 8.4.2, 8.4.3, 8.4.4, 8.4.5, 8.2.1, 8.2.3, 8.2.4, 8.2.5, 8.1.1, 8.7.1, 8.7.5

- Suitable range of clinical services consistent with Australian general practice are provided (Quality T.12)
- Facility should be accredited under RACGP minimum practice standards by a recognized accreditation body (Quality T.35) with GPs as part of clinical management (T.28)
- For ACRRM Training Post situated in a rural or remote location, appropriate employment of Registrar, policies/protocols (Criteria 8.4.2, 8.4.3, 8.4.4, 8.4.5, 8.2.1, 8.2.3, 8.2.4, 8.2.5, 8.1.1, 8.7.1, 8.7.5)

Sample Questions:

*Can you please give us an overview of your clinic – the set-up, staffing, the number and type of learners and your current supervisors?*

*What areas of specialty or added services does your clinic offer?*

Notes:

Theme 2: Teacher competency
RACGP: T1, T2, T3, T4
ACRRM: 7.1.1, 7.1.2, 7.1.4
NTPMC: F2S8C1

- Vocational Registration (T.4)
- Current unrestricted registration with National Medical Board (T.1, Criterion 7.1.1)
- Fellow and active Member of RACGP/ACRRM or equivalent organisation with ME recommendation (T.3, T.2, T.7, T.8, Criterion 7.1.2).
- Appropriate role model – high standards of clinical competence, communication skills, professional values in relation to patient care (Criterion 7.1.4) – letter confirming Clinical Privileges
- Junior doctor supervisors appointed with appropriate skills, knowledge, competencies, induction, time, authority and resources employed to supervise the junior doctor. (NTPMCF2S8C1)

Sample Questions:

*What is your background and what are the skills you bring to training others in General Practice?*

*Check that all required paperwork has been submitted for RACGP +/- ACRRM*

Notes:
Recommendations

Theme 3: Professional development in teaching and supervision
RACGP: T5, T10, T13, T26
ACRRM : 7.1.5, 7.2.1, 7.2.2, 7.2.8, 7.2.9, 7.2.10, 7.3.1, 7.3.2, 7.3.4, 7.4.1, 7.4.2, 7.4.3, 7.4.4
NTPMC: F2S8C1

☐ Demonstrates a commitment to teaching (Criteria 7.2.1, 7.2.2, 7.2.8, 7.2.9) and to supporting Registrars and learners (Criteria 7.4.1, 7.4.2, 7.4.3, 7.4.4)
☐ Preparation for/ability as a trainer (experiences, references, understanding academic principles of general practice, adult learning, attendance at course, or higher degree) (T.10) including possibly a introductory course (Q T13) eg GP Supervisor orientation
☐ Familiar with a range of teaching methods and resources and appropriate selection to assist learning (Criterion 7.3.1, 7.3.4),
☐ skilled in assessing/providing feedback on performance, establishing and reviewing learning plans (Criterion 7.3.2).
☐ Commitment to ongoing Professional Development (Criterion 7.1.5) and other education activities (Criterion 7.2.10, T.5, Quality T.26) (NTPMCF2S8C1)

Sample Questions:

How long have you been teaching and supervising learners in General Practice?
What educational resources do you use for supervising and teaching?
How do you keep your skills in supervision and teaching current?
Could you please describe how you approach learning planning and tracking for learners?

Notes:

Recommendations:
Theme 4: Supervision workloads
RACGP: T6, 9, 18, 21, 22, 23, 24, 25
ACRRM : 7.2.11, 7.2.3, 7.2.4, 7.2.5, 7.3.3, 8.7.3
NTPMC:F2S8C1, F2S8C2

☐ There is sufficient clinical and educational supervision by supervisors appointed with appropriate skills, knowledge, competencies, induction, time, authority and resources employed to supervise the junior doctor. (NTPMCF2S8C1)

☐ Policies on adequate supervision are available and implemented (NTPMCF2S8C2)

☐ 1 FTE Trainer should take responsibility for no more than 2 Registrars (Quality T.18, Criteria 7.2.11)

☐ Availability and access to Trainers/Supervisors in practice when needed (T.21, T.22, T.23, T.25, Criteria 7.2.4, 7.2.5))

☐ Supervision within guidelines (T22 , Criterion 7.2.5) including onsite
  - 100% in the first month of general practice training (Quality T.25)
  - 80% for remainder GPT1, 50% for GPT2, 25% for GPT3/4 (T.22);
  - offsite Supervisors must be available by phone or make arrangements for another recognised GP teacher to be available, including after hours (T.24, Criterion 8.7.3)
  - offsite for GPT3/4 only in exceptional circumstances and if workforce issues and Registrar competence warrant this (T.23) (Criterion 7.2.5)

☐ Hours of teaching (T.6, T.9) – 3hrs GPT1, 2hrs GPT; (Criterion 7.2.3)

☐ Supervisor and Registrar collaboratively plan exposure to activities required in learning plan/ACRRM. Including ACRRM procedural skills log book (Criterion 7.3.3)

Sample Questions:

How many Supervisors do you have and how do you allocate supervision within the clinic?

Are you aware of the particular requirements of supervision at various stages of GP training?
(have NTGPE guides for PGPPP and GPR present)

Are your supervisors ever providing remote supervision?

Once allocated a supervisor how is the teaching and learning plan developed for a learner?

How is teaching (formal and informal) done in the practice?

Notes:
Recommendations:

**Theme 5: Clinical service requirements of learners and workload**

RACGP: 27, 30, 38, 39, 40, 41
ACRRM: 8.5.1, 8.5.2, 8.5.3, 8.5.4, 8.5.5
NTPMC: F2S6C1, F2S6C2

- Provision of a quality and quantity of learning experiences appropriate to the range of General Practice (Criteria 8.5.1, 8.5.2, 8.5.4, 8.5.5) (NTPMC F2S6C1+2)
- Provide adequate but not excessive workload (Criterion 8.5.3) including
  - not more than 4 patients per hour in GPT1 and GPT2 (T.39)
  - average of at least 8 patients per session in usual general practice situations (T.38)
- Registrar clinical activity (T.27, T.41) and structure of duty hours consider needs of patients, continuity of care and educational needs of trainee (T.30), Criterion 8.5.3) including flexibility for trainee (T.30)
- Provision of a quality and quantity of learning experiences appropriate to the range of General Practice (Criteria 8.5.1, 8.5.2, 8.5.4, 8.5.5) (NTPMC F2S6C1+2)
- Workload of trainee to be monitored and managed (T.40) by supervisors

Sample Questions:

How does the practice organize and monitor the workload for your registrars (+/- PGPPP)?
How are patients allocated when the learner is first in the practice?
How do you ensure they see a full range of clinical presentations – are there any deficits in certain domains?
Is your practice able to offer flexible working hours at all or after hours training?

Notes:
Recommendations:

Theme 6: Learning in Practice
RACGP: 14, 15, 16, 17, 19,
ACRRM: 8.3.1, 7.2.6, 7.2.7, 7.3.2, 7.3.3, 7.3.4, 7.3.5, 8.6.2, 8.6.1, 8.8.1, 8.8.2
NTPMC: F2S9C6, F2S7C2, F2S9C2, F2S9C3, F2S6C3, F2S9C4, F2S9C5, F2S7C3

☐ Supervisors must provide orientation to the practice (T.19) and (Criterion 8.3.1)
☐ Supervisor must conduct a risk assessment of learner’s ability to practice within context of the training post, level of supervision and current stage of training in specific areas that have an increased risk of adverse outcomes and litigations (T.17) (Criteria 7.3.2, 7.3.3, 7.3.4)
☐ Provide time for educational release activities (Criterion 8.6.1)
☐ Support access for ME to undertake direct observation sessions (ECTV) (T.15) (NTPMCF2S9C6)
☐ Assist with learning plan (T.14, Criterion 7.2.6, NTPMCF2S7C2) by week 4 of each semester
☐ Supervisor to provide a planned and relevant education session each week in the 1 hour face to face sessions (T.16, Criterion 8.6.2)
☐ Conduct formative assessment of Registrar (Criterion 7.2.7), assist with documentation of training records (Criteria 7.3.5, 7.3.3, NTPMCF2S9C2+3)
☐ Education program has a variety of formal and informal, clinical and non-clinical teaching and learning opportunities including opportunities to present at meetings. (NTPMCF2S6C3)
☐ Ensure learners are informed when serious concerns exist. Have a documented process for managing substandard performance, which will ensure the welfare of the junior doctor and patients (NTPMCF2S9C4)
☐ Objective summative assessment occurs end of the term with results reported to learner (NTPMCF2S9C5, Criterion 8.8.1)
☐ Learner has a patient handover with the supervisor of current patients he/she will be managing clinically (NTPMCF2S7C3)
☐ Consent to Registrar providing feedback to RTP and ACRRM on TP and Supervisors (Criterion 8.8.2)

Sample Questions:

How does the practice orient the GPR/PGPPP when they begin?
How is the teaching time set and how are these sessions organized and run?
How does the practice/supervision team go about determining the skills and the level of the learner when they arrive in the practice?
What feedback is provided to learners and in what format?
How does your practice manage a ‘difficult learner’?

Notes:
Recommendations:

Theme 7: Practice Requirements and set up
RACGP: 29, 31, 32, 34, 36, 37
ACRRM: 8.4.1, 8.4.2, 8.4.3, 8.4.4, 8.4.5, 8.2.1, 8.2.2, 8.2.3, 8.2.4, 8.2.5, 8.1.1, 8.6.1, 8.7.1, 8.7.2, 8.7.4, 8.7.5, 8.8.1, 8.8.2
NTPMC: F2S9C6, F2S7C2, F2S9C2, F2S9C3, F2S6C3, F2S9C4, F2S9C5, F2S7C3

- Registrar provided with adequate consulting space (T.29 Criterion 8.4.1), Reference materials and patient information materials available (T.31, Criterion 8.2.2);
- Private space provided for teaching purposes and systems in place to protect teaching time from interruptions (T.32)
- Registrar, Supervisor and TP covered by appropriate insurance and medical registration (Criterion 8.7.2)
- Practice staff informed of function and needs of learner, provide feedback to GP on how trainee interacts with them and encourage trainee to take an interest in practice administration (T.34, Criterion 8.7.4)
- Practice should be able to function adequately without the trainee present when they attend educational activities (Quality T.36)
- There should be adequate administration staff to support all the clinical staff in the facility (Quality T.37)

Sample Questions:

- How do you allocate rooms for learners to use?
- What resources are available for the GPR/PGPP – books, online, electronic records?
- How are appointment diaries kept and can the GPR book appointments themselves?
- Do you have copies of the GPRs indemnity?
- How do you staff the clinic if the GPR is away – does this have a large impact on the clinic?
- Do you feel your clinic is aware of the role of training in General Practice? How do the admin staff support this training?

Notes:
Recommendations:

OVERALL SUMMARY

<table>
<thead>
<tr>
<th>THEME</th>
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<td>2 Teacher competency</td>
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<td>3 Professional development in teaching and supervision</td>
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<td>5 Clinical service requirements of learners and workload</td>
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<td>6 Learning in Practice</td>
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<td>7 Practice requirements and set up</td>
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FOR PGPPP Placements ONLY
NTPMC Rating Scale Matrix

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<tr>
<th>Function and Standard</th>
<th>C1</th>
<th>C2</th>
<th>C3</th>
<th>C4</th>
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<tr>
<td>Function 1 – Governance</td>
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<td>Standard 5: Education Training Committee (Hospital – representation on)</td>
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<td>Function 2 – Intern Education and Training Program: General Practice</td>
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<td>Standard 6: Term Content</td>
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<td>Standard 7: Term Orientation &amp; Handover</td>
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<td>Standard 8: Term Supervision</td>
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<td>Standard 9: Intern (Performance) Assessment</td>
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Rating Scale Explanation

7
A 5 point Rating Scale is to be used based on that used by the ACHS (definitions adapted from ACHS EQUIP, 2002).
1. Low Achievement (LA) – awareness and knowledge of the Standards but only fundamental systems in place.
2. Some Achievement (SA) – implemented systems but little or no monitoring of outcomes against Standards.
3. Moderate Achievement (MA) – collection of outcome data from systems designed to implement Standards and evidence of improvements to systems.
4. Extensive Achievement (EA) – evidence of innovation and implementation of best practice including sharing of practice at a State or National level.
5. Outstanding Achievement (OA) – considered leaders in the field relevant to the Criterion being assessed. There is evidence of benchmarking and comparing systems internally and/or externally.

Applying the Rating Scale
Each Criterion is to be awarded a rating from LA to OA. Please note that demonstration of all the components recommended in the Accreditation Guidelines would result in an achievement of a MA rating. A rating of EA would require evidence of innovation and implementation of best practice whilst a rating of OA would require demonstrated benchmarking and leadership in the area.

SITE SURVEY VISIT OVERVIEW PROFORMA

Practice Name : 
Date Site Survey Conducted : 
Surveyors Conducting Site Survey : 
Type of Visit : 
Date Report to Committee : 

Conclusions:

Significant Findings and Recommendations:

Follow up:-
**Surveyor Recommendation for Accreditation Committee:**

<table>
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<tr>
<th>College</th>
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<tr>
<td>Level</td>
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<tr>
<td>Accreditation Period</td>
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<td>Supervisors Accredited</td>
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<td>Interim Reviews</td>
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Signed:  

Dated:  

Please return this and all other paperwork to Susie Lehmann NTGPE
CHAPTER 7 – GUIDELINES

GUIDELINES FOR REGIONAL TRAINING PROVIDERS ASSISTING GENERAL PRACTICES ACHIEVE PREVOCATIONAL ACCREDITATION

BACKGROUND

The Northern Territory Postgraduate Medical Council (NTPMC) has delegated authority from the Medical Board of Australia for accrediting junior doctor Education and Training positions. A comprehensive accreditation process has been developed through a robust consultation with stakeholders and a set of Standards established which are used to assess both the governance of the junior doctor Education and Training Program (ETP) and the experience within a specific term. These Standards are applied to all Intern positions within Northern Territory Department of Health Facilities along with junior doctor positions outside Northern Territory Department of Health including private hospitals and general practice settings. Regional Training Providers deliver education and training to Junior Doctors within a specific geographical region through the Prevocational General Practice Placement Program (PGPPP).

Feedback from stakeholders has identified the need for specific guidelines for General Practices to assist with their understanding of the NTPMC Accreditation Standards. The following Guidelines have been developed to assist General Practices to identify the appropriate evidence required for accreditation against each Standard. They provide guidance as to the minimum requirements and the degree of evidence necessary to achieve a Moderate Achievement Accreditation rating. They are intended to assist General Practices in implementing best practice in junior doctor Education and Training.

General Practices will only be applying for Secondment Facility status (see definition) and this will mean that in partnership with a Primary Allocation Facility (Training Feeder Hospital) all standards would be covered. However in this guideline we have included all of the standards so that a Regional Training Provider assisting the General Practice can see how they may contribute to the overall aim of Prevocational Medical Education and Training Accreditation.

The Standards that a General Practice must meet to gain Prevocational Secondment Facility status are:

- Function 2 Standard 6 Term content
- Function 2 Standard 7 Term Orientation and Handover
- Function 2 Standard 8 Term Supervision
- Function 2 Standard 9 Junior Doctor (Performance) Assessment

The other standards will require an indication of compliance at the time of visit and/or evidence of holding current RACGP or ACRRM accreditation status.

For a full description of all terminology used throughout this document, please refer to the NTPMC Accreditation Glossary. Please find a smaller glossary list over the page.
GLOSSARY

A Glossary of common NTPMC accreditation terminology is provided below to assist. Please refer as needed when using these guidelines:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Term</td>
<td>A period of practical experience and training that may occur in a number of areas. A term usually occurs in one or more units with components of orientation, supervision, education, assessment and clinical experience. A term is generally 10 – 12 weeks and should be a minimum of five weeks.</td>
</tr>
<tr>
<td>Primary Allocation Status</td>
<td>This is the Accreditation status awarded to a facility capable of providing all the compulsory terms required for Intern registration and junior doctor education and training.</td>
</tr>
<tr>
<td>Secondment Allocation Status</td>
<td>This is the Accreditation status awarded to a facility with accredited terms, but which is unable to provide one or more of the compulsory terms required for Intern registration. It is an elective term for junior doctor (PGY2) education and training.</td>
</tr>
<tr>
<td>FEP</td>
<td>Facility Education Program which refers to the formal education program comprised of a series of educational sessions provided for Junior Doctors at your practice.</td>
</tr>
<tr>
<td>ETP</td>
<td>The Education and Training Program is the overall program offered to Junior Doctors including terms, education sessions, orientations, supervision, assessment and evaluation.</td>
</tr>
<tr>
<td>GCTC/MTC</td>
<td>Junior doctor Education and Training Committee (General Clinical Training Committee/Medical Training Committee).</td>
</tr>
<tr>
<td>IPAP</td>
<td>Improving Performance Action Plan.</td>
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</table>

FUNCTIONS, STANDARDS AND CRITERION

FUNCTION 1 - STANDARD 1: FACILITY STRUCTURE

The aim of this Standard is to ensure that a suitable General Practice structure is in place to ensure a high quality Junior Doctor Education and Training Program (ETP) can be implemented. Complementary to the structure are the policies and procedures in place to support the implementation of the ETP.

NTPMC understands that the structure of General Practices can vary markedly. For this reason, some criterion may not be applicable to your practice. As a general practice who is requesting secondment allocation status only some of these standards will require documented evidence if they hold RACGP and/or ACRRM accreditation status, however it may be useful to understand how these standards apply in a general practice setting.

CRITERION 1 – STRATEGIC PLANNING AND BUDGET

General Practices involved in Junior Doctor Education and Training should be able to provide an explanation of:

- Why they are involved in Junior Doctor Education and Training
- How this activity fits with other education and training undertaken at the practice e.g. vocational registrar training
- How the practice sees education and training changing at the practice in the next 5 years e.g. expansion of training planned
- Potential changes to the Practice in the coming 4 years e.g. expansion of staffing.

In addition the General Practice must demonstrate that they have sufficient funds to conduct general practice training which may include: ability to fund supervisor professional development opportunities, resource and administration facilities e.g. office for supervisor of Junior Doctor training.

**CRITERION 2 – ORGANISATIONAL STRUCTURE**

General Practices will vary in their size from a single practitioner to one which employs multiple General Practitioners. This Standard requires explanation of the various roles within the practice as they relate to the ETP. For example, who provides the orientation to the practice (is this the Junior Doctor Supervisor or is it the Practice Manager), who does the Junior Doctor go to if there are issues experienced in regards to clinical care vs. issues relating to patient bookings etc? What is the role of the Medical Education Officer (MEO) and Director of Clinical Training (DCT) from the primary allocation facility to the Practice?

**CRITERION 3 – POLICIES AND PROCESSES**

If the Practice is accredited by the Australian General Practice Accreditation Limited (AGPAL), there will already be established operational policies and procedures. The NTPMC standard would require that the Junior Doctor is orientated to these Practice policies and procedures at commencement of the Term. In addition, the General Practice should be aware of the Primary Allocation Policies and Procedures in regards to:

- Attendance at Facility Education Programs and release from duties
- Supervision Policy
- Assessment Policy
- Junior Doctor Well Being Policy
- Term evaluation

The General Practice needs to consider how they will implement these policies relevant to their Practice whilst the Junior Doctor is on secondment with them. This is particularly so in regards to the Supervision Policy which must be adhered to at all times.

The General Practice should collate the relevant policies and processes and indicate where they are stored for the Junior Doctor to access.
CRITERION 4 – PHYSICAL AND EDUCATIONAL INFRASTRUCTURE

The physical infrastructure required to ensure a high quality Junior Doctor Education and Training Program should be carefully considered by the General Practice. It should include:

- A consulting room available for the Junior Doctor to use to assess and manage patients. This room may be dedicated to the Junior Doctor or alternatively a different room is made available to the Junior Doctor depending on the Practice requirements.
- Adequate access to resource materials e.g. online reference materials. Junior Doctors should have access to the internet when working at the Practice. A dedicated work area should be provided to allow time and space to undertake patient related research activities.
- Junior Doctors should always have easy access to a printer
- A secure space available for the Junior Doctor to house personal belongings e.g. bag
- A space available within the practice to conduct training sessions or clinical skills training e.g. a procedural room

CRITERION 5 – COMMUNICATION WITH PARTNER FACILITIES

Regular, quality communication between the Primary Allocation Facility and the General Practice is crucial to ensure continuity and congruency of the ETP and appropriate support services for the Junior Doctors. At a minimum there should be a clearly established procedure for communication between the facilities. In addition, there should be regular meetings of the personnel involved in administering the ETP e.g. the DCT and appropriate General Practice representative should meet/communicate at least once per term. The Delegated Officer responsible for the Junior Doctor Education Program at the General Practice should be a member of the Committee overseeing the ETP at the Primary Allocation Facility and there should be a regular agenda item regarding the secondment terms. Minutes of meetings are appropriate evidence of the communication strategy being implemented.

STANDARD 2: PERSONNEL OVERSEEING THE JUNIOR DOCTOR EDUCATION AND TRAINING PROGRAM

The aim of this Standard is to ensure that there are suitably trained and supported personnel to oversee the implementation of a high quality Junior Doctor Education and Training Program (ETP). These personnel should include not only those with administrative responsibilities for the ETP, but also those involved in supervision of the Junior Doctors within the clinical environment.

NTPMC understands that the personnel structure of General Practices can vary markedly. For example, some practices work through a consortia or training group. Other practices may have a strong relationship with the Primary Allocation Centre. Some practices may have their own educational support personnel. Consequently, some criterion may not be applicable to your practice.

CRITERION 1 – EDUCATIONAL SUPPORT PERSONNEL

The General Practice will be able to provide the names and qualifications of each of its personnel employed in roles to assist the administration of the ETP. This may be a General Practitioner in regards to implementing education and assessment processes, the Practice Manager in regards to orientation or communication with the Primary Allocation Facility. Obviously within a General Practice there will not be an MEO or DCT. Where the MEO/DCT from the Primary Allocation Facility provides a role in the implementation of the ETP at the General Practice, this should clearly be documented.
The General Practice should be able to provide clear evidence of each of the various roles within the Practice, including descriptions which outline the expectations of the General Practice in terms of the ETP for each personnel involved and the time that they have allocated to this role.

**CRITERION 2 – CLINICAL AND EDUCATIONAL SUPERVISORS**

Within the General Practice each Junior Doctor should be allocated an Educational or Term Supervisor. The General Practice should be able to provide a list of General Practitioners involved in supervising the Junior Doctor where there is more than one. In addition, there should be a role description for the Term Supervisor which outlines their responsibilities and the allocated time for this role.

**CRITERION 3 – PROFESSIONAL DEVELOPMENT**

Professional development is considered crucial for those involved in overseeing the ETP. The General Practice should provide a list of professional development opportunities available for those personnel involved in overseeing the ETP. These may include courses offered by the Primary Allocation Facility, their General Practice Division, GPET or RACGP.

**CRITERION 4 – ADVOCACY FOR JUNIOR DOCTORS**

Where Junior Doctor Advocacy is provided through a Primary Allocation Centre that has been accredited by NTPMC, this criterion will not be applicable to the General Practice.

This Criterion has been deemed not applicable for the General Practice setting and as such will be rated as Not Applicable. It does not mean that GP Supervisors do not advocate for Junior Doctors.

**CRITERION 5 – PERFORMANCE APPRAISAL OF ETP PERSONNEL**

Where appraisal of IETEP personnel is carried out by a Primary Allocation Centre that has been accredited by NTPMC, this criterion will not be applicable to the General Practice.

This Criterion has been deemed not applicable for the General Practice setting and as such will be rated as Not Applicable.

**STANDARD 3: JUNIOR DOCTOR EDUCATION AND TRAINING PROGRAM**

The aim of this Standard is to ensure that the Junior Doctor Education and Training Program (ETP) is comprised of relevant education and training to ensure that the Junior Doctors can gain the necessary clinical and professional knowledge, skills and attitudes to achieve registration.

**CRITERION 1 – ETP CONSIDERED IN THE FACILITIES OVERALL SERVICE PROVISION**

This Criterion has been deemed not applicable for the General Practice setting and as such will be rated as Not Applicable.
CRITERION 2 – FEP POLICY

The General Practice needs to provide the Junior Doctors with a Facility Education Program (FEP) which may be conducted within the General Practice, be accessed via videoconferencing from the Primary Allocation Facility or provided as part of a consortia of General Practices. This Program should be offered in a flexible format to allow access to all Junior Doctors and in paid time. As such the General Practice should be able to provide evidence of a policy to allow Junior Doctors access to this program, in paid time and the process by which they monitor adherence to this policy e.g. attendance records.

CRITERION 3 – EQUITABLE ACCESS TO CLINICAL AND NON-CLINICAL EDUCATION OPPORTUNITIES

The General Practice should be able to provide Junior Doctors with access to clinical and non clinical additional education opportunities (outside the FEP) and a process for accessing these opportunities. The General Practice should also liaise with the Primary Allocation Centre to determine what opportunities may be available to Junior Doctors. Junior Doctors should be made aware of the professional development opportunities open to them and the process for accessing them, through the Primary Allocation Facility such as:

- Advanced Life Support (ALS) programs
- Clinical skills or Simulation Programs offered
- Learning on the Run Programs
- NTPMC Accreditation Surveyor training
- JMO Forum attendance

CRITERION 4 – SECONDMENT TERMS

This Criterion has been deemed not applicable for the General Practice setting and as such will be rated as Not Applicable.

CRITERION 5 – ASSESSMENT OF JUNIOR DOCTORS

The Territory Based Assessment Forms should be used for the assessment of all Junior Doctors at the General Practice.

CRITERION 6 – WARD CALL

This Criterion has been deemed not applicable for the General Practice setting and as such will be rated as Not Applicable.

CRITERION 7 – ETP EVALUATION DATA

Junior Doctor feedback is required on the ETP to ensure that quality improvements are made each year. The General Practice should have a process for collecting and collating Junior Doctor evaluation on the ETP and reviewing annually to ensure that the quality cycle is completed. This should include information collected by the Primary Allocation Facility, Junior Doctoral General Practice evaluation mechanisms, and evaluation of the FEP. A process should be clearly enunciated regarding the reporting of this information to the committee responsible for overseeing the ETP. The General Practice should be able to provide the Accreditation Survey Team with examples of actions resulting from the outcomes of this evaluation.
STANDARD 4: JUNIOR DOCTOR TERM EVALUATION PROCESS

The aim of this Standard is to ensure that Junior Doctors receive an opportunity to formally evaluate a term and that this information is reviewed by the committee responsible for overseeing the ETP. In addition, it is expected that de-identified data is provided to the Term Supervisor for quality improvement activities.

NTPMC understands that some General Practices will evaluate their terms through the Primary Allocation Centre. In such cases, this Standard shall not be applicable.

CRITERION 1 – EVALUATION TOOL

It is expected that a tool will be developed which affords the Junior Doctors an opportunity to give feedback on:

- Clinical experience gained
- Achievement of learning objectives
- Adequacy of supervision
- Adequacy of feedback and appraisal
- Opportunities for learning
- Positive and negative aspects of the term
- Suggested changes to the term

CRITERION 2 – QUALITY IMPROVEMENT PROCESS

A copy of the process for providing the evaluation data to the Term Supervisor should be provided. This process should indicate how data is presented to the Term Supervisors. It is expected that this process would occur annually.

A copy of minutes of the committee overseeing the ETP should be provided indicating review of term evaluations and recommendations made.

CRITERION 3 – MAINTAINING TERM EVALUATION CONFIDENTIALITY

It is expected that for the integrity of the term evaluation process that data will be de-identified so as to maintain confidentiality for the Junior Doctors involved. A copy of the process for managing term evaluations should be provided, clearly indicating how confidentiality will be maintained.

STANDARD 5: JUNIOR DOCTOR EDUCATION AND TRAINING COMMITTEE

The aim of this Standard is to ensure that there is a group established to oversee the Junior Doctor Education and Training Program (ETP). Within a General Practice there is often a practice meeting. This meeting may have additional roles of oversight such as specialty training, practice management etc, however the Junior Doctor Education and Training Program is a standard agenda item and is discussed regularly at this meeting.

CRITERION 1 – TERMS OF REFERENCE OF ETP COMMITTEE

The General Practice Management Meeting should clearly indicate that Junior Doctor Education and Training is discussed and that the Junior Doctor Term Supervisor is able to bring up issues regarding the Junior Doctor
Education and Training for discussion by the entire practice. There may also be a structure where a consortium of General Practices meets to discuss Junior Doctor Education and Training and that this is where issues relevant to the ETP are discussed. If this is the structure utilised there should be formal Terms of Reference for the group clearly outlining the ETP issues for discussion.

**CRITERION 2 – COMMITTEE’S ROLE IN EVALUATING ETP**

The General Practice should provide evidence of examples of:

- issues discussed which were relevant to the ETP, and
- actions resulting from these discussions.
FUNCTION 2

STANDARD 1: STRUCTURE OF JUNIOR DOCTOR EDUCATION AND TRAINING PROGRAM

The aim of this Standard is to ensure that a suitable Junior Doctor Education and Training Program (ETP) is structured to enable compliance with the Registration Act.

CRITERION 1 AND 2 – ALLOCATION OF TERMS (PRIMARY AND SECONDMENT FACILITIES)

A General Practice Term is a Secondment Term. Therefore Criterion 2 of this Standard is applicable. A roster from the Primary Allocation Facility should clearly indicate the length of each General Practice term and any holidays undertaken during the term.

STANDARD 2: ETP ORIENTATION

The aim of this Standard is to ensure that there is a suitable orientation program provided at the beginning of the Junior Doctor year prior to commencement of duties, which outlines the details of the Junior Doctor Education and Training Program (ETP). In the case of a General Practice this refers to the orientation to the Practice itself as distinct from the orientation to the term content which is assessed later in the Accreditation Standards.

CRITERION 1 – ORIENTATION PROGRAM

The Facility should provide a copy of their ETP orientation program. The orientation program should include:

- Practice policies and procedures
- Practice facilities e.g. patient examination rooms, waiting rooms, procedural rooms
- Patient booking system
- Patient result system
- Relevant IT systems
- ETP policies and processes e.g. assessment, liaison with Primary Allocation Facility, Facility Education Program
- Process for pay, sick leave
- Practice staff and who to liaise with
- Any mandatory training to be undertaken whilst at the General Practice

CRITERION 2 – DELIVERY OF ORIENTATION PROGRAM

This criterion is deemed not applicable for General Practice where the program is usually delivered one to one in an interactive manner.

CRITERION 3 – EVALUATION OF ORIENTATION PROGRAM

As part of the quality improvement cycle, General Practices need to ensure that the ETP orientation program is evaluated. General Practices should also ensure that the Junior Doctors are given an opportunity to evaluation their orientation to the practice. A copy of the tool used to evaluate the program should be provided which includes and opportunity for the Junior Doctor to provide suggestions for changes to the
program for the following term. The results of these evaluations should be discussed at the Practice Management meeting or its equivalent.

STANDARD 3: FACILITY EDUCATION PROGRAM AND TRAINING PROGRAM

The aim of this Standard is to ensure that a Facility Education Program (FEP) is provided with content which is consistent with national standards for best practice. Where the General Practice provides its own FEP or a group of General Practises conducts an FEP in collaboration then the following standards will be applied to the FEP.

Where the FEP is provided by the Primary Allocation Facility then it will be deemed to have been previously accredited during the Primary Allocation Centre’s accreditation and therefore will not be addressed the General Practice Accreditation Survey.

CRITERION 1 – FEP CONTENT

The FEP should be developed with consideration to the experiences to be gained throughout the entire ETP. This may involve mapping against national standards such as the Australian Curriculum Framework for Junior Doctors (ACFJD). The Practice should also work with the Primary Allocation Centre, to ensure that FEP provided at both settings is integrated and complementary. This ensures the Junior Doctor receives an appropriate and well rounded educational program throughout their Junior Doctorship. The program should employ a flexible format which incorporates the acquisition of knowledge, skills and attitudes using best educational practice. The program should indicate the relevant components of the ACFJD to enable Junior Doctors to monitor their progress against the curriculum framework.

In the General Practice setting, consideration should be given to appropriate ambulatory care topic areas and to utilisation of in practice expertise. This will further enhance the Junior Doctor’s General Practice experience.

STANDARD 4: FACILITY EDUCATION PROGRAM DELIVERY

The aim of this Standard is to ensure that the Facility Program (FEP) is delivered in a flexible manner to maximise attendance of Junior Doctors and is delivered using best educational principles.

Where the FEP is provided by the Primary Allocation Facility then it will be deemed to have been previously accredited during the Primary Allocation Centre’s accreditation and therefore will not be addressed the General Practice Accreditation Survey.

CRITERION 1 – FEP ATTENDANCE

The FEP should be accessible by every Junior Doctor and attendance records should indicate percent attendance for the term. This attendance record should be reviewed by the Practice Management Committee or its equivalent and poor attendance addressed.

CRITERION 2 – FEP DELIVERY

The FEP should be consistent with best educational principles. A copy of the program’s activity outlines should be provided and reflect:

- A mixture of didactic and experiential opportunities, encouragement of innovative approached such as blended and peer group learning
• Opportunities to practice skills and receive feedback
• Opportunities for Junior Doctors to ask questions
• Self reflection activities

STANDARD 5: EVALUATION OF THE FACILITY EDUCATION PROGRAM DELIVERY

The aim of this Standard is to ensure that the Facility Education and Training Program (FEP) is evaluated and recommendations are made according to this evaluation for future implementation of the program. Where the FEP is provided by the Primary Allocation Facility then it will be deemed to have been previously accredited during the Primary Allocation Centre’s accreditation and therefore will not be addressed in the General Practice Accreditation Survey.

CRITERION 1 – FEP EVALUATION TOOL AND PROCESS

An evaluation tool should be provided which is used for every session of the FEP. This tool should allow the Junior Doctors to provide feedback on:

• Content of individual sessions
• Performance of individual presenters/facilitators including ability to answer questions, respect of learner knowledge, development of a safe learning environment
• Learning achieved from the session via self evaluation
• Provide suggestions for changes to the program for the following year

The convenor of the FEP should provide the evaluation data in report form to the Practice Management Committee or its equivalent and include recommendations for change. Survey Teams should be provided with a copy of this Report and copies of minutes of the Practice Management meeting or its equivalent, indicating agreed changes to the program for future implementation. This should be done twice per annum.

Please Note: The following Standards are the standards that **must** be met by the secondment facility in order to achieve secondment facility accreditation status

*STANDARD 6: TERM CONTENT

The aim of this Standard is to ensure that all terms will provide clinical and educational experiences which contribute to the development of safe practice and achievement of competency.

CRITERION 1 – CLINICAL EXPERIENCES

The General Practice Term should be able to outline the clinical experiences offered to a Junior Doctor undertaking this term. This should include case-mix data demonstrating patient throughput and acuity as well as Junior Doctor involvement in clinical case management.

CRITERION 2 – SCOPE OF PRACTICE

The General Practice Term Supervisor should be able to clearly explain and document the Junior Doctor’s Scope of Practice, including any processes or procedures which must not be done by the Junior Doctor alone. This may include things such as patient discharge arrangements, test result follow-up, specific procedural tasks such as excision of lesions etc.
CRITERION 3 – EDUCATION PROGRAM AND LEARNING OPPORTUNITIES

It is expected that additional education opportunities outside clinical experience may be offered to Junior Doctors throughout a general practice term. A summary of these should be available to Surveyors. Examples of these may be:

- Presentation skills – presenting to other general practitioners within the practice
- Research skills – participation in small research studies
- Audit skills – management of data collection, analysis of data
- Teaching skills – students, patients

CRITERION 4 – TERM ROSTERING

A copy of the weekly timetable indicating roles of the Junior Doctor should be provided. Timetables should indicate where appropriate:

- Patient consultations
- Home Visits
- Nursing home visits
- Meetings
- Education activities

Daily timetables should indicate hours worked and consider industrial as well as training requirements.

*STANDARD 7: TERM ORIENTATION AND HANDOVER

The aim of this Standard is to ensure that Junior Doctors receive adequate orientation and handover of clinical cases prior to commencement of their clinical duties.

CRITERION 1 – TERM ORIENTATION

It is expected that a formal orientation to the General Practice term is provided to each Junior Doctor by the Term Supervisor. This is a specific orientation to their term as distinct from the General Practice orientation that is assessed under Function 2 – Standard 2.

The term should have a formal orientation manual which outlines:

- Weekly Timetable
- Learning Objectives
- Clinical Duties
- Relevant clinical policies and procedures for the specific General Practice
- Supervisor/s and reporting lines
- Assessment procedures

CRITERION 2 – DISCUSSION OF LEARNING OBJECTIVES
The Term Supervisor should discuss the term learning objectives with each Junior Doctor at the orientation. Specific learning objectives should be agreed upon relevant to the individual Junior Doctor and their previous experiences and learning requirements. A copy of Junior Doctor learning plans including these individual variations in learning objectives should be provided to indicate that this Criterion is being implemented. Junior Doctor learning plans include identification of individual learning objectives, opportunities for reflection, an action plan and review cycle.

**CRITERION 3 – HANOVER**

Adequate handover is essential for safe and quality clinical care of patients, so evidence of the process for handover at the start of each term should be provided. Whilst it is understood that the General Practitioners themselves will also be involved in the handover process, it is a valuable learning opportunity both for the outgoing and also the incoming Junior Doctor.

Handover may not be possible face to face and may involve a phone handover with the current Junior Doctor in the week preceding commencement of the new term. A formal process for facilitating this handover should be implemented and monitored for adherence.

**STANDARD 8: TERM SUPERVISION**

The aim of this Standard is to ensure that Junior Doctors receive adequate supervision whilst undertaking their clinical duties. This should take into consideration the appropriate levels of supervision according to duties to be undertaken by the Junior Doctor.

**CRITERION 1 – SUPERVISION**

The delegated Term Supervisor should provide Junior Doctors with details of additional supervisors within that term. A list of supervisors for the term should be available to the Junior Doctor. This list should indicate the supervisor's current appointment e.g. General Practitioner full time or part time (indicating which days they will be available for supervision). There should also be clear understanding of the process for supervision including direct, indirect and remote supervision.

The General Practice Term Supervisor should also provide evidence of their involvement in professional development to assist them in their role as a Junior Doctor Supervisor. These may be formal programs on supervision offered by the Medical Education Unit at the Primary Allocation Facility or, alternatively, state based education programs such as Teaching on the Run, Professional Development for Registrars Program or programs run by the RTP, RACGP,ACRRM or GPET.

**CRITERION 2 – SUPERVISION POLICY IMPLEMENTATION**

It is expected that the General Practice will have developed a policy on adequate supervision. This policy should include:

- Definition of supervision and types of supervision
- Who is able to provide Junior Doctor supervision
- How to access supervision if immediate supervisor is unavailable
- Process for addressing perceived inadequacy of supervision
Supervisors should be aware of this policy and be implementing it at all times.

**STANDARD 9: JUNIOR DOCTOR (PERFORMANCE) ASSESSMENT**

The aim of this Standard is to ensure that Junior Doctors receive assessment and appraisal to ensure that learning objectives and relevant competencies are being monitored and achieved.

**CRITERION 1 – ASSESSMENT PROCESS**

It is expected that at the term orientation Junior Doctors receive an outline of the assessment processes of that term including who is responsible for giving feedback and appraisals, and how this information will be collated e.g. direct observation, reports from supervisors, and information from co-workers such as the Practice Nurse and Practice Manager.

**CRITERION 2 – MID TERM ASSESSMENT**

It is expected that there will be a mid term assessment completed for terms of longer than 5 weeks duration. A copy of the process for this mid term assessment should be provided by the primary Allocation Facility. Junior Doctor evaluations of the term should indicate whether or not they received mid term feedback and information on how useful this feedback was.

**CRITERION 3 – FEEDBACK SESSIONS**

A copy of the assessment process as outlined under Standard 9 – Criterion 1 should be provided. There should be evidence of input from a variety of sources such as co-workers e.g. the Practice Nurse and Practice Manager.

**CRITERION 4 – PROCESS FOR MANAGING SUBSTANDARD PERFORMANCE**

The General Practice Term Supervisor should be aware of the process for managing the underperforming Junior Doctor. A copy of the process (e.g. IPAP – Improving Performance Action Plan) for informing Junior Doctors of serious concerns should be provided. This process should include:

- Specifics of the concern
- Remediation plan
- Allocation of responsibilities for implementation of the remediation plan
- Timeframe for review

The General Practice Term Supervisor should also be aware of the support available to them from the Primary Allocation Facility including the MEO, DCT and Director of Medical Services (DMS) if necessary.

**CRITERION 5 – SUMMATIVE ASSESSMENT**

A copy of the end of term assessment tool should be provided by the Primary Allocation Facility. The General Practice Term Supervisor should be able to describe the process for ensuring that this is completed for each Junior Doctor prior to them leaving the term and the process for sending this to the Primary Allocation Facility for follow up review.
CRITERION 6 – CLINICAL SKILLS OBSERVED AND ASSESSED

A copy of the recorded clinical skills observed should be provided by the Facility. The General Practice Term Supervisor should be able to describe the process for ensuring that this is completed for each Junior Doctor prior to them leaving the term and the process for sending this to the Primary Allocation Facility for follow up and review.
Function and Standard

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**Function 1 – Governance**

Standard 5: ET Committee (Hospital) (membership on)  
Y/N

**Function 2 – Intern Education and Training Program**

**General Practice**

Standard 6: Term Content

Standard 7: Term Orientation & Handover

Standard 8: Term Supervision

Standard 9: Intern (Performance) Assessment

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**ACCREDITATION RATING SCALE**

**Rating Scale**

A 5 point Rating Scale is to be used based on that used by the ACHS (definitions adapted from ACHS EQUIP, 2002).

1. Low Achievement (LA) – awareness and knowledge of the Standards but only fundamental systems in place.
2. Some Achievement (SA) – implemented systems but little or no monitoring of outcomes against Standards.
3. Moderate Achievement (MA) – collection of outcome data from systems designed to implement Standards and evidence of improvements to systems.
4. Extensive Achievement (EA) – evidence of innovation and implementation of best practice including sharing of practice at a State or National level.
5. Outstanding Achievement (OA) – considered leaders in the field relevant to the Criterion being assessed. There is evidence of benchmarking and comparing systems internally and/or externally.

**Applying the Rating Scale**

Each Criterion is to be awarded a rating from LA to OA. Please note that demonstration of all the components recommended in the Accreditation Guidelines would result in an achievement of a MA rating. A rating of EA would require evidence of innovation and implementation of best
practice whilst a rating of OA would require demonstrated benchmarking and leadership in the area.

The following Criteria are only to be awarded an LA (where not achieved) or an MA (where achieved):

- Function 2/Standard 6/Criteria 4

The following Criteria can only be rated to a maximum of MA:

- Function 2/Standard 9/Criteria 1

New Units can only be rated to a maximum of MA, which is to be based on the intention to implement or the projected outcome. A Survey will occur once Interns are in situ as per the New Unit Survey Process.

In some circumstances a rating of Not Applicable (N/A) is appropriate at the discretion of the Team Coordinator e.g. F2/S7/C3 where there is no need for a handover of patients between terms by the Interns as there are no inpatients to hand over, such as in Emergency and Anaesthesia Terms.