National General Practice Training and Accreditation Pilot Project
Victorian Final Report

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This report was researched and prepared by Judy D’Ombrain, Project Officer, Postgraduate Medical Council of Victoria, with input from the Victorian Working Group for the GPTAP Accreditation Pilot Project (2012)

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GLOSSARY

**Accreditation**  The process by which certification is granted to an organisation which meets the standards and criteria upon which it is reviewed.

**ACFJD**  Australian Curriculum Framework for Junior Doctors

**ACRRM**  Australian College for Rural and Remote Medicine

**AGPAL**  Australian General Practice Accreditation Limited

**AGPT**  Australian General Practice Training

**BME**  Beyond Medical Education

**Bogong**  Bogong Regional Training Network

**CPMEC**  Confederation of Postgraduate Medical Education Councils

**GP**  General Practice or General Practitioner

**GPET**  General Practice Education and Training

**GPRime**  Online learning platform that enables all AGPT education and learning environments to be managed electronically. Has a self-directed learning focus.

**GPTAP**  General Practice Training Accreditation Pilot Project

**Intern**  Doctors in the first postgraduate year of training after graduation from medical school; also called PGY1

**JMO**  Junior Medical Officer

**MBA**  Medical Board of Australia

**Parent Hospital**  The hospital providing a prevocational doctor on rotation to a general practice

**PGPPP**  Prevocational General Practice Placement Program

**PGY**  Post Graduate Year (usually PGY1, PGY2 or PGY3)

**Pilot Study**  A small study conducted in advance of a planned project, specifically to test aspects of the research design and to allow necessary adjustment before commitment to the final design

**PMCV**  Postgraduate Medical Council of Victoria

**Prevocational Doctor**  A medical practitioner in the early years of clinical practice (PGY1/2/3/4+) who has not yet entered a vocational training program

**RACGP**  Royal Australian College of General Practitioners

**Rotation**  A defined period of employment in a unit/department/medical practice

**RTP**  Regional Training Provider

**SGPT**  Southern General Practice Training

**Standards**  The specific objectives, processes or procedures to be achieved and the rationale for the objectives to provide quality education to prevocational or vocational doctors

**Supervisor**  Clinician designated as being sufficiently qualified and experienced to monitor and direct the clinical learning of a medical trainee

**Survey Team**  A group of surveyors chosen for their individual expertise to undertake an accreditation survey visit of a health service or facility

**Surveyor**  An individual trained in all aspects of an accreditation program who acts on behalf of the authorised accrediting body to visit a health service or facility and assess its compliance with the accreditation standards

**VMA**  Victorian Metropolitan Alliance
EXECUTIVE SUMMARY

Background
In November 2011, an agreement was reached between General Practice Education and Training (GPET) and the Confederation of Postgraduate Medical Education Councils (CPMEC) to undertake and evaluate pilots of models of streamlined and integrated prevocational and vocational training practice accreditation in three states/territories. The General Practice Training Accreditation Project (GPTAP) in Victoria was initiated in December 2011 through the Postgraduate Medical Council of Victoria (PMCV) and the final report was submitted to CPMEC in August 2012.

Aim
The aim of the Victorian GPTAP was to provide a documented and evaluated assessment of a streamlined and integrated process of prevocational and vocational accreditation of medical training in general practices with a view to assessing the applicability and sustainability of an integrated process. The project has sought to address the perspectives of stakeholders, including general practice supervisors, Regional Training Providers, Colleges and PMCV in relation to the accreditation process and other issues such as quality, cost, scalability of the process, and organisational, practice and program impacts.

Methodology
A Project Officer, Ms Judy D’Ombrain, was appointed by the PMCV to coordinate the GPTAP in Victoria. A Victorian Working Group of relevant stakeholders, was convened and met at regular intervals for the duration of the project. A Project Plan and an Evaluation Methodology were developed and submitted to the GPTAP National Steering Committee for approval.

Pilot survey visits were undertaken at three general practices, two of which came under the jurisdiction of Southern General Practice Training (SGPT), and one that was administered by the Victorian Metropolitan Alliance (VMA). Regular communication took place between PMCV, SGPT and VMA, prior to the visits to identify opportunities for streamlining and to develop appropriate tools and processes. The resulting collaborative pilot tools and processes were submitted for approval to the Steering Committee prior to being implemented at the pilot survey visits which occurred in May 2012.

At the conclusion of each pilot visit, a brief paper-based survey was distributed to all general practice staff who had been involved in the pilot survey in order to assess their response to the pilot process.

At the conclusion of the three survey visits, a 24-question online evaluation survey was distributed to all twenty-three participants in the pilot project. This survey aimed to obtain detailed feedback on every aspect of the pilot project in Victoria. Some questions used rating scales and closed questioning techniques, while others allowed scope for broad comments across a range of areas.

The data collected from both surveys was then analysed and measured against the stated aims and objectives of the Victorian pilot project; the outcomes form the basis of this report.

Results/Achievements
Victorian stakeholders identified a number of duplications and gaps in the existing general practice accreditation instruments and processes, as well as shortcomings in the overall governance structure for prevocational general practice accreditation. Not all of these could be addressed within the scope of this project, however several significant streamlining modifications were undertaken, including the following:

• Alignment of vocational and prevocational accreditation cycles and visits to general practices;
• Partial streamlining of pre-visit documentation;
• Joint survey visits and integrated interviewing sessions during the accreditation visits; and
• Establishment of ongoing collaborative working relationship between RTPs and PMCV.

As a result of the project there were savings in terms of cost, time and workload identified, some unanticipated benefits, and a number of challenges were also encountered. These are documented in the body of this report.

Recommendations

1. The PMCV and Victorian RTPs should continue to work towards a streamlined process of postgraduate (prevocational and vocational) medical accreditation for general practices, incorporating streamlined pre-visit documentation and survey visits, building on the Victorian pilots.

2. In relation to initial general practice accreditation, both the RTP and PMCV should attend initial meetings with general practices and jointly assess the practice’s suitability for hosting prevocational training posts.

3. Streamlined accreditation should aim in the future to include streamlined reporting to general practices, and streamlined accreditation standards.

4. Streamlined accreditation should be supported by clear governance and reporting structures that ensure continuous improvement.

5. Streamlined accreditation should be appropriately recognised and resourced.

6. A comprehensive costing, funding and reporting model for general practice accreditation agencies should be developed to assist the streamlining process.

7. General practitioner surveyors should be trained in both vocational and prevocational accreditation.

8. Victorian RTP accreditation processes should be aligned in order to support a streamlined statewide vocational accreditation process.

Future Directions for Victoria

This project facilitated the development of broad streamlined accreditation of postgraduate medical training in general practice. The streamlined accreditation process successfully implemented in the pilots in Victoria resulted in an accreditation framework (Appendix 5) which emphasises optimised integration and sharing of pre-visit documentation by PMCV/RTPs; alignment of survey visit dates and cycles both for initial and re-accreditation and credentialing of surveyors for both vocational and prevocational accreditation.

The accreditation framework was limited in the sense that full integration of the standards utilised by PMCV and the RTPs (RACGP/ACRRM) was not achieved as it was outside the scope of this particular project, however all parties agreed that alignment of the standards should be pursued and were willing to participate in such a project.

For the future, it is the intention of the parties to this project to continue to pursue alignment of accreditation survey dates, to implement a program for co-credentialing of surveyors and to further integrate and align pre-visit documentation.
1. INTRODUCTION

1.1 Background

Prevocational doctors have had the opportunity to undertake rotations in general practices through the Prevocational General Practice Placements Program (PGPPP) since 2008 in Victoria both at PGY1 (intern) and PGY2 levels. The PGPPP is overseen nationally by General Practice Education and Training (GPET) with devolution of funding and management of training practice positions locally through the Regional Training Providers (RTPs) in each State/Territory. The RTPs are mandated by the Royal Australian College of General Practitioners (RACGP) and/or the Australian College for Rural and Remote Medicine (ACRRM) to develop, accredit and monitor general practice training positions at the vocational level. Whilst the Colleges, through the RTPs, have developed extensive curricula and processes for quality assurance and improvement of vocational general practice training, it is the Postgraduate Medical Council of Victoria (PMCV) which is responsible for accreditation and ongoing monitoring of medical training positions at the prevocational level, including general practice rotations funded by the PGPPP.

Accreditation of medical training positions is a quality assurance process that establishes and monitors standards to ensure a high standard of clinical training and supervision for junior doctors. In Victoria, prevocational medical accreditation involves self-assessment by the training facility (health service / general practice) followed by a visit from a trained survey team to undertake a formal evaluation of the medical training program provided.

The Postgraduate Medical Council of Victoria (PMCV) currently has delegated responsibility from the Medical Board of Australia (MBA) (for PGY1) and the Victorian Department of Health (for PGY2+) to ensure all prevocational medical training positions in Victoria meet minimum standards of supervision, education and welfare and are accredited. A survey report is prepared following a visit which is considered by the PMCV Accreditation Subcommittee before being forwarded to the practice for a response to the recommendations therein. The expansion in prevocational training capacity in general practice has resulted in an average 10 general practice visits per annum.

The Regional Training Providers (RTPs) are delegated by GPET to undertake accreditation of vocational general practice training according the RACGP / ACRRM standards. A report following the visit is prepared which is considered by an Accreditation Committee of the College.

1.2 Participants and stakeholders

In Victoria, there are four RTPs and around 40 PGPPP positions distributed across the State (refer Appendix 1).

At the commencement of the project, initial discussions occurred with all four RTPs in Victoria - Bogong RTP (Bogong), Beyond Medical Education (BME), Southern General Practice Training (SGPT) and Victorian Metropolitan Alliance (VMA). In February 2012, agreement was reached that SGPT and VMA would provide suitable pilot general practice sites within the timeframe of the project and therefore they agreed to participate in the project. The remaining two RTPs (BME and Bogong) were kept informed periodically on the progress of the project and given an opportunity to express ideas and opinions in relation to the proposed changes to the existing accreditation processes for general practice training. During March 2012, a Victorian Working Group was convened to monitor progress, discuss strategies and initiate implementation of the pilot accreditation visits in Victoria. A list of members of the Victorian Working Group for the pilot project is included at Appendix 2.

A complete list of stakeholders in the Victorian pilot project is included in the Victorian Evaluation Plan (Table 1), in Appendix 4 of this report.

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1 In this pilot project, all RTPs involved utilise the RACGP standards and report to the RACGP, thus in this report reference has not been made to ACRRM requirements.
1.3 Scope of Victorian project

The project brief was to identify between two and four general practice sites where both vocational and prevocational general practice training posts are currently in place. The challenge was to identify general practice pilot sites that were (a) scheduled for accreditation or re-accreditation by both the RTP and PMCV within the timeframe of the study, and (b) willing to participate in the pilot accreditation process.

The pilot sites identified were:
- Clocktower Medical Centre, Sale (SGPT) (RA-2)
- Kardinia Health, Belmont, Geelong (SGPT) (RA-1)
- Preston Family Medical Centre, Preston (VMA) (RA-1 Metropolitan)

Clocktower was the only pilot site with an intern post where a previous prevocational accreditation survey had been undertaken by PMCV. The other two sites have PGY2 posts, but neither had previously been accredited by PMCV. The Preston site is classified as metropolitan, and the other two sites as regional. One of the requirements of the project was to incorporate an RA-5 (remote) classification site as one of the pilots, however there are no RA-5 classified general practices in Victoria.

1.4 Objectives

The General Practice Training Accreditation Pilot Project (GPTAP) was undertaken as part of an agreement entered into by CPMEC and GPET in November 2011. The stated aims of the project at the national level were to address the following evaluation goals:
- The extent to which the streamlined and integrated prevocational and vocational training practice accreditation process has delivered robust and consistent accreditation outcomes across the pilot medical practices; and
- The perspective(s) of stakeholders, including supervisors, RTPs, Colleges and PMECs involved in accreditation in relation to process and outcome quality, cost, scalability of the process, and other organisational, practice and program impact.

The implementation of the Victorian GPTAP was to achieve the following objectives:
- Meet the objective stated in the Minister’s Statement of Expectations 2011 to streamline accreditation for general practice training;
- Reduce the practice accreditation burden for supervisors by eliminating multiple site visits and information collection;
- Reduce College, PMC and RTP accreditation costs;
- Maintain the quality of placements for medical learners including prevocational and vocational training; and
- Support the training standards and requirements of the PMCV and Colleges.

The degree to which each has been met in the Victorian pilots will be addressed in the following sections of the report.
1.5 Biases and limitations

A number of potential biases and limitations were identified in the Victorian GPTAP as follows:

- The small sample size of three general practices, although larger than the minimum specified in the project brief, is nevertheless not necessarily representative of Victorian general practice training as a whole. For instance, only one metropolitan practice was included, and there are currently no remote (RA5) sites in Victoria. Similarly, only one practice with a PGY1 level post was included in the project, whereas across the State there are a total of 24 PGY1 and 20 PGY2/2+ positions in general practices, managed by all four RTPs.

- Two of the four Victorian RTPs were not represented in the project, although they were kept informed of developments.

- There may be potentially important data that has been missed due to stakeholder groups not being included in the pilot accreditation process: the three groups that could have been included and were not are: parent health services, junior doctors and patients of the practices. Self-selection by prevocational doctors for general practice rotations may mean that their enthusiasm colours their actual experience and thus their interview responses during accreditation may not accurately reflect the quality of the post (This could be equally true of vocational trainees).

- In a project with such limited timelines, it is common for participants to focus on negative aspects (i.e. what didn’t work so well) rather than on the possible positive processes and outcomes, thus potentially losing the balanced viewpoint that would normally emerge from a longer term study.

2. PROJECT METHODOLOGY

2.1 Timelines, administration & communication

The project was scheduled to begin in December 2011 and be completed by 31 August 2012. The Victorian GPTAP commenced in February 2012 after the Xmas/New Year break and staff returning from annual leave. The strategic timelines for each stage of the project are set out in the Victorian Project Plan attached as Appendix 3.

The project was coordinated at the Victorian level by a Project Officer, Ms Judy D’Ombrain who was appointed by PMCV and supported by the Victorian GPTAP Working Group.

Regular email and phone contact was maintained with GP, RTP and PMCV stakeholders throughout the duration of the project. PMCV held internal progress meetings monthly to plan and monitor development of strategic documents and processes, and regular meetings were held between VMA and PMCV representatives and between SGPT and PMCV representatives. Victorian Working Group meetings were convened in April, May and July to reach agreement on streamlining of documents and process, develop the Evaluation Plan, provide and review feedback on pilot survey visits, recommend on the format for accreditation survey reporting, and review the draft report for the project. Victorian progress reports were presented at the National Steering Committee meetings in March and June 2012.
2.2 Key features of the Victorian GPTAP

In 2012 in Victoria, there are currently 24 PGY1 and 20 PGY2+ PGPPP funded places. Approximately 25% of these posts are metropolitan (RA-1), with the remainder being regional and having RA-2 to RA-4 ASGC classification. There are no RA-5 classified general practices in Victoria. The map contained in the PGPPP 2012 brochure (Appendix 1) illustrates the distribution of PGPPP positions across Victoria.

Discussions held between PMCV and the four Victorian RTPs in connection with the accreditation pilot project constituted the first comparison of their respective accreditation accountabilities, responsibilities, requirements, tools and processes. During the initial stages of the project when key documents were being assessed and compared for their similarities and differences, it became apparent that there was a large degree of overlap and duplication between the processes and documents of Colleges, the PMCV and participating RTPs. In particular, the RACGP/ACRRM vocational training standards and the PMCV prevocational training standards clearly exhibit many parallels across the range of areas that are accredited in the general practice setting, although it was also evident that there are aspects of prevocational medical training assessed by PMCV that are not covered by the RACGP/ACRRM standards.

However, the agreement between CPMEC and GPET specifically excluded any revision of the prevocational and vocational training standards and, hence, the Victorian GPTAP did not consider streamlining the standards and did not attempt to align them. Consequently, during the pilots, the practices were required to undertake a self-assessment against the PMCV prevocational standards and the RACGP vocational standards separately.

2.3 Streamlining opportunities: duplications & gaps

Duplication in collection of data from practices, both in the pre-visit stage as well as at the visit itself, was clearly identified. Similarly, gaps in a number of aspects of the accreditation process were identified during the pilot project, and opportunities for streamlining both documentation and processes were acknowledged by participating parties. A summary of these opportunities is set out below.

- Vocational and prevocational GP accreditation surveys are carried out separately and in different cycles, resulting in multiple accreditation visits to practices which impact on resources (time, cost, staff workload) for both practices and accrediting agencies.
- PMCV and RTP pre-visit overview documents duplicate questions about the practice and the supervisors and also about the practice facilities and amenities.
- RTP overview documents do not request information about the parent health service which manages the allocation of prevocational medical trainees.
- There is considerable overlap in the supporting evidence to be provided by the practice in relation to various aspects of accreditation including supervision, education, feedback, assessment and evaluation.
- Accreditation surveyors are currently trained separately as either vocational-level or prevocational-level surveyors, and both must be present at joint survey visits, resulting in a larger survey teams on visits. At the accreditation visit, PMCV interviews all GP trainees if possible, whereas the RTP does not routinely interview trainees (because they regard their frequent educational visits as fulfilling that requirement).

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2 Prevocational General Practice Placements Program, 2012 Victorian Placements at the AGPT/PGPPP website: http://www.agpt.com.au/PrevocationalTraining/PGPPPHome/, or see Appendix 1, pp.33-36. Of these, 15 places are administered by SGPT and 10 by VMA, with BME and Bogong making up the remainder. Of the total 40 places, 10 are located within the Melbourne metropolitan area, and the remaining 30 are regional posts. All VMA posts are metropolitan.

3 Refer Australian Government website: www.doctorconnect.gov.au
• During the project it was identified that there is variation in processes and documentation between the four Victorian RTPs.

• Currently, accreditation reporting following a survey visit is undertaken separately by PMCV and the RTPs. Both organisations prepare survey reports which are considered by their respective accreditation committees but only PMCV provides their report to the practice for response.

2.4 Identified gaps in governance procedures

In discussing and comparing governance procedures with regard to vocational and prevocational GP posts, it emerged that a number of gaps exist that require thoughtful attention and resolution. Whilst not all of the identified gaps could be addressed during this project, nonetheless it seemed appropriate to note them as opportunities for further attention and streamlining in the future. The major gaps in overall governance of GP training positions are summarised below:

• There is a lack of clear recognition in the current funding and reporting structure for PGPPP in regard to the role and responsibility of PMCV in accrediting prevocational medical training positions in general practices. While PMCV has responsibility for prevocational medical training accreditation, it does not receive funding or report directly to GPET in relation to PGPPP placements. This is a national issue.

• Regular 4-way communication between practices, RTPs, PMCV and parent health services seldom occurs, particularly when new placements are being assessed.

• As a result of communication gaps, junior doctors experiencing personal or professional difficulties may not always be brought to the attention of the parent health service for ongoing follow-up.5

• There is no requirement, currently, for PMCV to be included in the process of assessing the suitability of practices for prevocational placements prior to the allocation of PGPPP funding for junior doctor posts. PMCV is generally advised after the PGPPP funding is approved when the practice seeks accreditation of the post.

• It is currently not clear what body (if any) is responsible for monitoring the supervision workload of GP supervisors in terms of learners per supervisor. As junior doctor numbers continue to increase, this could become an important issue for some practices.

2.5 Key features of pilot accreditation model developed during the project

The pilot streamlined accreditation process developed in Victoria has the following features:

• Vocational and prevocational general practice accreditation was carried out in a single joint survey visit.

• Vocational general practice training accreditation was regarded as the responsibility of the RTPs, and was assessed against the existing RACGP standards.

• Prevocational general practice term accreditation was regarded as the responsibility of the PMCV, and was assessed against the existing PMCV prevocational medical training accreditation standards for general practices.

• The stakeholders mutually agreed that the streamlining and integration process that was the objective of this pilot would occur largely at the level of alignment in terms of the timing and frequency of survey visits and sharing of pre-visit information.

• The pre-visit documents forwarded to practices for completion and return prior to the survey visit consisted of some shared information and some documents (e.g. standards self-

5 Equally, this discrepancy can occur in reverse: it was reported at the Kardinia visit that the RTP is not notified by either the practice or the parent hospital of a junior doctor who may be experiencing difficulties before or during a general practice rotation.
assessment to be completed by practices which had previously been accredited) that were specific to either PMCV or the relevant RTP.

- There may be opportunity for joint accreditation reporting and/or awarding of accreditation certificates in the future, although this was not achievable within the pilot project.

A flowchart for an aligned accreditation framework which was used for the pilots is attached in Appendix 5 of this report. The major principles underpinning this framework are:

1. PMCV is responsible for accreditation of prevocational (intern & PGY2) positions (funded by PGPPP) and RTPs are responsible for accreditation of vocational positions.
2. Practices are accredited for vocational training either prior to or at the same time as applying for prevocational training.
3. In the pre-visit stage, PMCV and the relevant RTP share general practice overview information excluding standards. Full pre-visit document integration is the goal.
4. This accreditation framework allows for co-credentialing of surveyors (by PMCV and RTP) so they can accredit for both prevocational and vocational medical training.
5. Re-accreditation for prevocational and vocational medical training to occur at the same time and in the same cycles (currently 3 years) with the practice accredited as a ‘postgraduate medical training practice’.
6. Process supported by ongoing communication between RTPs and PMCV on prevocational medical training issues.

The following sections provide more detail on the streamlined accreditation process undertaken at the pilot general practices.

(i) Accreditation standards
As previously mentioned, any streamlining of the prevocational and vocational training standards was outside the scope of the current project. There is some debate as to whether streamlining of standards would necessarily be of benefit at either the vocational or prevocational level of general practice training, since there are, and will always be, certain areas of need that are unique to vocational and prevocational trainees respectively.6

(ii) Alignment of accreditation cycles and visits
The most obvious opportunity for streamlining was perceived to be in the area of alignment of general practice accreditation cycles and visits. Currently there is no awareness of timing of surveys between RTP vocational surveys and PMCV prevocational surveys, and once discussion had taken place as to the frequency of these surveys, it became obvious that, with relatively little degree of compromise, re-accreditation visits could be scheduled to occur at both levels on the one day. Similarly, where RTPs currently carry out paper-based or electronic surveys at intervals between accreditation visits, PMCV could envisage aligning its current practice with that model so that the accreditation burden would be significantly reduced for individual general practices.

(iii) Cover letter to practices
The participating RTPs undertook to liaise in the first instance with each pilot general practice, to establish suitable dates, times and survey visit timetable, and to distribute all pre-visit documentation on behalf of both themselves and PMCV. A cover letter to be sent to each pilot practice was developed to explain the nature and purpose of the current pilot survey process to each general practice, and to outline the respective roles in relation to accreditation of PMCV and the relevant RTP (the cover letter is included in this report in Appendix 7).

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6 This disparity in views was made apparent in the evaluation data collected in Victoria for this pilot project.
(iv) Accreditation documentation

Both RTPs and PMCV shared their current documents, excluding the accreditation standards, and compared them for similarities and differences (see Appendix 6 for list of documents). There was found to be considerable overlap in the pre-visit material asked for by all. In recognition of the tight project timelines, PMCV agreed to replace the PMCV Part 1 document usually completed by facilities to be surveyed and received basic information about each general practice through a sharing of the SGPT and VMA pre-visit overview documents, and also sought to gain specific preliminary information relevant to prevocational posts, such as parent hospital details, and specific PGY1 and PGY2 requirements at the practice, by means of a brief additional document (included in this report in Appendix 6). During the visits, this information proved to be adequate.

(v) Visit structure

In relation to the visit structure, the RTPs in each of the three pilots provided a surveyor and an administrator to assess the vocational dimension, and PMCV provided a surveyor and an administrator to carry out the prevocational assessment. The GPTAP project officer attended all pilot visits as an observer.

Both PMCV and RTPs interview the supervisors who are involved with the registrars and junior doctors at the practice. In contrast, while PMCV interviews all trainees at the practice (including vocational trainees if possible) during a survey visit in order to gain as comprehensive as possible a picture of the compliance of the practice with assessment standards, the RTPs have not, in the past, included such interviews in their visit as they consider interaction with the trainees during education sessions is sufficient. For the purposes of the pilot visits, the RTP representatives also participated in the learner interviews.

A timetable template for each pilot visit (Appendix 7) was provided by PMCV to both the RTP and the practice staff, in an effort to streamline the visits as far as possible, and to ensure that all participants knew in advance of the visit what the intended structure would be and to have the names of all interviewees in advance of the visit.

(vi) Accreditation reporting process

The accreditation reporting process was also discussed at Victorian Working Group meetings.

Under present arrangements, RTPs draft a report for vocational accreditation of a practice, including any recommendations and then submit their report to the RACGP for approval. Once approved, the RACGP sends a certificate of accreditation to the practice on behalf of the RTP.

In the case of prevocational accreditation, the PMCV survey team drafts a report which is considered by the PMCV Accreditation Subcommittee. Once approved, PMCV sends the report to the practice, together with a letter of accreditation.

Although feedback received from stakeholders was divided regarding the preferred method of reporting accreditation outcomes to practices, it was generally agreed that some degree of integration in the reporting process should be aimed for in the future, in order to preserve the overall spirit of collaboration and alignment, and also to ensure that there are no inconsistencies in the reports and recommendations made to practices between the prevocational and vocational streams.

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7 As mentioned earlier in the report, the ACRRM accreditation process was not reviewed in the pilot, but that body closely mirrors the RACGP in terms of its reporting process to general practices.

8 Refer evaluation data, Qu.23, Appendix 9.
3. PILOT EVALUATION

3.1 Evaluation plan

During April 2012, a Victorian Evaluation Plan was submitted to the National Steering Committee setting out the proposed strategies for evaluating the effectiveness of the Victorian pilot general practice accreditation model. That plan is included in Appendix 4.

3.2 Evaluation tools & methods

Due to the high number of stakeholders involved in the Victorian GPTAP and the tight timeframe for the entire project, it was decided by the Victorian Working Group that two evaluation surveys would be developed and circulated following completion of the pilot visits in order to assess the level of satisfaction with the combined accreditation process as implemented.

The two evaluation surveys developed and implemented as part of the pilot accreditation project in Victoria were designed to assess:

a. The effectiveness of the study design in meeting the stated aims of the project;
b. The effectiveness of the newly-developed accreditation data collection tools and instruments;
c. The strengths and limitations of the approach adopted;
d. The benefits and challenges identified; and
e. Scope for future improvement in streamlining of general practice accreditation.

The first of these was the ‘General Practice Staff Post-Accreditation Initial Response’ survey, a short paper-based questionnaire distributed in hard copy to all general practice staff who had been involved in the pilot accreditation survey. This anonymous survey was distributed immediately following the conclusion of each visit, consisted of six questions and was designed to be completed in 5-10 minutes. Where possible completed surveys were collected ‘on the spot’ by the Project Officer. Where this was not possible, practice staff were given reply-paid envelopes to return their completed survey questionnaires to PMCV. There were 12 completed questionnaires received, signifying a 100% response rate. Key findings are discussed in Section 4 of this report and the data collected is summarised in Appendix 7.

The second evaluation tool was the ‘Online Pilot Evaluation Survey’ which was distributed using surveymonkey to all participants in the Victorian GPTAP. The survey was designed to be anonymous and to give all participants the opportunity to express their views on the full range of accreditation components addressed in the pilots. It comprised 24 questions and was estimated to take 30-40 minutes to complete. It was emailed to a total of 23 stakeholders and a total of 12 responses were received, although only 10 were completed sufficiently to allow meaningful analysis, representing a 43.5% response rate. Reminder emails were sent to encourage further participation in the survey, however a number of factors can be cited that affected, or may have affected, the response rate. These include:

- Left employment (1 known incidence).
- On leave during evaluation period (4 reported incidences).
- Difficulty with electronic survey ‘timing-out’ prior to being completed (1 reported incidence).
- Non-availability of email addresses (2 reported incidences).
- Necessarily short window for evaluation period (12 days) due to project deadlines.

A wide range of responses and comments were received, and the key features are set out in Section 4. The evaluation survey questionnaires are included as Appendix 8 and a summary of data and comments received is included as Appendix 9.
4. SURVEY FINDINGS

This report has so far outlined the opportunities for accreditation streamlining that were identified, what the barriers to streamlining were and to what extent streamlining occurred. Overall the participants were satisfied with the management of the project as the chart below illustrates.

![Chart showing participant satisfaction with the Victorian GPTAP overall management.](image)

The evaluation surveys provided some interesting data (Appendix 9) for analysis in relation to the outcomes of the pilot streamlined accreditation survey visits. The main topics evaluated included:

- Stakeholder expectations
- Tools and instruments developed
- Communication and management during project
- Survey visits
- Accreditation recommendations and reporting
- Costs, time and workload.

4.1 Stakeholder expectations

Some participants reported that they had no expectations, while others sought achievement of “total streamlining of accreditation of all levels of GP training nationally”. The majority of stakeholders, however, cited their expectations at the commencement of the GPTAP project as echoing the aims and objectives set out in the Introduction to this report. They include:

- achieve a single combined GP accreditation survey;
- meet the needs of all stakeholders;
- reduce duplication, accreditation burden, time and cost;
- improve efficiency and simplify the accreditation process;
- maintain quality of placements for learners; and
- foster collaboration between stakeholder organisations.

90% of respondents reported that their expectations had been met by the Victorian project, but there were five broad areas of concern raised. These included:

- Receipt and completion of pre-visit documentation by practices;
- Incomplete collection of required information;
- Accreditation documentation not fully streamlined (including reporting documentation) with some duplication remaining;
- Co-ordination of survey visit structure; and
- An excessive number of assessors at the visit.
In addition, one respondent commented on having no pre-conceived expectations but being awakened to the potential of joint accreditation being of great benefit to general practices; and another respondent regarded the pilot project as having exceeded expectations in terms of highlighting the amount of commonality that exists between vocational and prevocational general practice accreditation for medical training.

4.2 Tools and instruments developed

With regard to pilot accreditation documentation, in response to the statement “I was satisfied with the survey documentation that was jointly developed for the pilot,” 60% of respondents agreed that they were satisfied, 20% were neutral, and 20% disagreed, as indicated in the chart below. Four respondents commented that they would like one fully integrated set of documents and two commented that they thought that a single set of accreditation standards should be developed for vocational and prevocational general practice training posts in Victoria, with one person saying that accreditation should be administered by a single body only. Conversely, one respondent regarded the possible future streamlining of accreditation standards as being undesirable and counter-productive to the general practice accreditation process in Victoria.

The cover letter and the pre-visit overview documents were cited as the principal joint accreditation documents, and were reported as being “comprehensive, useful and easy to use”.

The chart below sets out the level of satisfaction among participants regarding the pilot accreditation documentation developed and implemented in Victoria.

![Chart showing participant satisfaction with pilot survey documentation.](image)

In recognition of the complexity of the situation in Victoria, one respondent commented on the fact that there are currently five separate sets of accreditation documentation, making streamlining far more challenging than in some other jurisdictions.

In terms of stakeholder accreditation requirements having been met during the pilot process, 100% of respondents reported being satisfied at that level. Qualifying comments included remarks about time-efficiency, good vocational/prevocational balance, and valuable insight having been gained into other areas of general practice training.
4.3 Communication and management during project

The dimensions of communication and management in the Victorian pilot project were examined in the evaluation survey from a number of perspectives and are summarised in the chart below.

![Survey Visit Communication](chart.png)

*Chart showing participant satisfaction with survey visit communication.*

Pre-visit instructions to the pilot general practices regarding completion and return of documentation were set out in detail in the cover letter (Appendix 7), as mentioned above, and were forwarded by the relevant RTP to the practice. In the evaluation survey, 80% of respondents agreed that instructions were provided adequately in the cover letter and accompanying forms. The remaining 20% however cited communication issues as having led to problems with the completion and return of documentation.

Communication about the pilot visit timetables was similarly regarded by 80% of respondents as having been satisfactory, with comments such as “good paperwork and email communication from PMCV to stakeholders (RTPs and GPs)”, and “good mutual negotiation to achieve satisfactory timetabling of visits” reinforcing that level of satisfaction. Two respondents, however, regarded the timetable template as irrelevant and/or not used to structure the survey visit. The reason given for this was that interviewing requirements for RTPs are less complex than those for PMCV.

Communication about the structure of interviewing sessions at survey visits was an additional aspect of the pilot project that was evaluated. 70% of respondents were satisfied with the way survey visits were planned, 20% were dissatisfied, and 10% replied that this aspect was not applicable to them. The majority of comments received referred to “spontaneity” as being the hallmark of pilot visit structure, rather than any pre-planned nature and 40% agreed that a degree of spontaneity was an inevitable feature of a pilot survey. However, 20% would have preferred more structure and balance in the visits. Both RTP and PMCV surveyors had prepared focussed interview questions in advance, which facilitated efficiency in obtaining required information from general practice staff on the day. Only one comment was received citing “inappropriate issues outside the accreditation brief” being raised for discussion during the visit. This is perhaps an instance of where spontaneity can spill over into digression, or it may simply have been an extension of a conversation into a related area due to the exploratory nature of the pilot project and a desire by participants to identify as many opportunities as possible for streamlining of current processes.

One interesting observation regarding visit structure though, was that “not all aspects of the pilot visit were relevant from an RTP perspective owing to their (i.e. the RTPs’) considerable pre-existing knowledge of the practice”. This raises the question as to whether, in combining vocational and prevocational visits, the pilots may have actually inadvertently succeeded in creating an incidence of duplication owing to variation in levels of prior knowledge of the respective accrediting organisations.
The following options were put to stakeholders in the final online evaluation survey:

- To maintain separate reports;
- To formulate one report with separate sections for vocational and prevocational material; or
- To formulate one fully integrated report combining both vocational and prevocational dimensions and possibly issuing one joint certificate of accreditation.

Interestingly, responses received to this question were almost equally divided in terms of preferences for the three models however 70% did prefer one PMCV/RTP report while 30% preferred separate reports.

Chart showing participant survey reporting preferences.

### 4.4 Survey visits

From the data received in the survey of general practice staff only, approximately half thought that the pilot visit was equal in length to previous single accreditations, while 25% thought the pilot visit was longer and the remainder were unable to comment. Of those who thought the visits were longer, the majority qualified this by remarking that this was to be expected in a pilot situation or that a combined visit would necessarily take longer than a single visit. It could therefore be concluded that the duration of pilot visits was not regarded as a negative aspect of the pilot accreditation overall.

100% of GP respondents thought that vocational & prevocational issues were given appropriate weight during the visit, with positive comments about the comprehensiveness of the questioning as well as helpful information being provided to the practices.

Not all visits adhered to the pre-prepared timetable, either because vocational and prevocational accreditation teams were at variance as to how the visit should proceed, or because general practice staff members were not available for interview at the scheduled time. Where possible, all supervisors and all trainees were interviewed. Although it had not been the intention for both survey teams to attend all interviews (e.g. the RTP surveyors do not usually interview the junior doctors at a visit) what actually occurred was that the RTP surveyors attended all the meetings. Interestingly, the comments received in the online evaluation survey indicate that this aspect proved to be one of the unforeseen benefits of the pilot since it provided insight into general practice training as a whole, as well as opportunities to gain knowledge that would otherwise have been missed.
4.5 Cost, Time and Workload

4.5.1 Pilot Survey Feedback and Perceptions

In preparing to undertake this project the stakeholders identified three stages of streamlining that could be undertaken:

1. Joint survey visits and streamlining of the accreditation cycle
2. Combined pre-survey visit documentation and reporting
3. Integrated accreditation standards for both vocational and prevocational medical training.

Following the pilot visits, it became clear that further cost savings could be achieved in the streamlined accreditation process by credentialing GPs to undertake both vocational and prevocational survey visits.

This project focused on the implementation of joint survey visits as this stage was identified as the most resource intensive for practices. Some work was done in regard to combining pre-visit data collection although this was limited due to time constraints of the project, the fact that the participating RTPs have different requirements and was not extended to the accreditation standards as these were outside scope. In relation to reporting, no streamlining was achieved due to different requirements for the RTPs and PMCV. For the purposes of the project the respective standards were completed separately by the practices and the survey teams which may account for the additional workload noted below. Note that, following the pilot visits, the prevocational and vocational standards were mapped identifying the similarities and gaps in the criteria. This can be found in Appendix 10.

Clearly, a combined vocational and prevocational accreditation visit eliminates the need for two separate visits to the practice and there is less disruption to the running of the practice resulting in reduced time and costs. There was a risk identified that a combined accreditation visit may take longer than two individual separate visits, however, as noted below, this did not occur.

In the surveys administered at the conclusion of each pilot visit and online following the completion of the three pilots, feedback was sought as to the impact of the combined survey visit on practices in terms of cost, time and workload. It should be noted, though, that of the three practices which participated in the pilot visits, only one had previously been accredited by both the RTP and PMCV. The following feedback was received:

- In the post-pilot survey, almost unanimously, the practice staff found that there had been no perceptible change in costs associated with joint accreditation. In terms of workload and time in the pre-visit phase, the majority thought that there had been some increase, because there was additional paperwork to be completed. However in all cases, it was felt that in future combined surveys this extra burden would be reduced or removed because the documentation and processes would be familiar a second time around. There was overall agreement that the visit time was the same as for previous non-combined visits, signifying a demonstrated time-saving for the practices.

- In the online evaluation survey undertaken by all accreditation participants, respondents were asked to rate (on a scale of 1-5) their perception as to whether the streamlined model implemented in the pilot had reduced the accreditation burden. Here the responses were far more diverse, with 20% saying that they Strongly Agree, 20% saying that they Agree, 40% saying that they held a Neutral position, and 20% saying that they Disagree with the assertion that the pilot model had resulted in a reduction in the accreditation burden. In breaking down the accompanying comments into patterns or trends, it emerged that four general practice staff thought that the joint process did, save time (and therefore money), while three reported that it created more work and took more time for their organisation.
Two respondents in the online survey remarked that one survey visit instead of two would be easier for general practices. However, needing more space within the practice to accommodate a larger accreditation team was seen as a negative outcome of having a single combined visit.

From the RTP and PMCV perspective, information-sharing was cited as being a positive time-saving dimension, although a comment was made that if each RTP in Victoria was to retain separate documentation and accreditation instruments, there would be less likelihood of achieving a high level of streamlining and an accompanying reduction in time and workload.

The possibility of joint vocational / prevocational surveyor training in the future was cited as a worthwhile strategy to produce both time and cost savings at the RTP/PMCV level, and would also potentially reduce the overall accreditation workload as well as the size of accreditation teams at visits.

The question was asked of survey participants whether they would require additional resources in order to be able to implement a streamlined general practice accreditation model. In response, 30% said Yes, 20% said No, 40% were unsure, and 10% said this question was Not Applicable to them. Comments received indicate that the majority of stakeholders believe that any further streamlining of general practice accreditation would require additional funding resources for all accrediting organisations, although one respondent pointed out that in the longer term, reducing the size of accreditation teams and more fully streamlining documentation would potentially reduce the overall costs of accreditation for RTPs, PMCV and GPs.

In summary, while a variety of cost, time, space and workload savings could be identified to varying degrees amongst project participants, the one clear gain in the pilot model appears to have been in reducing the number of accreditation visits for general practices from two to one.

4.5.2 Summary of Accreditation Costs and Cost Analysis Projection

As reported by Greenfield & Braithwaite, (2008)\textsuperscript{10} “the financial costs of accreditation for organisations are an under-researched area. There are contrasting assessments made in the few studies that have been conducted.”\textsuperscript{11} Key findings of their 2008 Australian study include the following, which may prove to be of interest when examining the cost dimension of the General Practice accreditation process in relation to vocational and prevocational training positions:

- Sites face similar accreditation costs, regardless of characteristics such as size and location
- Rural and smaller sites incur a greater burden from accreditation
- There is no significant difference in cost for a site regardless of accreditation outcome, nor does previous accreditation affect the cost
- Accreditation preparation costs are the majority of the total expenditure
- Preparation for accreditation is seen by practices as being labour intensive\textsuperscript{12}

Prior to the GPTAP Accreditation Pilot Project, under separate accreditation arrangements for vocational and prevocational general practice posts, the costs to RTPs have included development, distribution and collection of relevant documentation, training and attendance of a clinician surveyor, attendance of an administrative person to document responses to interview questions at

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\textsuperscript{11} ibid., p.176

\textsuperscript{12} ibid., p.177
each visit and to collate the report for submission to RACGP, travel costs to individual accreditation sites, maintenance of accreditation schedules and liaison with the College and individual practices.

Similarly, the costs to PMCV have included all of the above, except that their accountability is to the PMCV Accreditation Subcommittee and they are required to liaise with parent hospitals in addition to the general practices. In relation to the general practices themselves, as demonstrated by Bohigas, Smith et. al (1996), accreditation costs are incurred mainly in respect of salaries (in relation to pre-visit preparation as well as the actual accreditation visit to the practice (2-3 hours) and overhead costs (e.g. completion of pre-visit documentation, provision of evidence documents, phone calls, etc.) This, of course, impacts on the earning capacity of the practice as a whole due to reduced consultation time, both before and during the visit(s).

As far as can be ascertained, GPET makes no specific funding allocation to cover PGPPP accreditation-related costs, and more work needs to be done towards establishing an accurate costing framework at the prevocational accreditation level in general practices. Similarly, the RACGP nor ACRRM do not specify funding breakdown for vocational-level GP training accreditation costs incurred by RTPs, and further work is needed to establish an accurate costing framework at this level.

In preparing this report and considering the outcomes of the pilot survey visits it is useful, in retrospect, to think of the pilot model as ‘Stage 1’ of a progressive process towards streamlining General Practice accreditation. The hallmarks of this stage have been to introduce streamlining of the accreditation cycle between the PMCV and RTPs, and the introduction of a single combined accreditation survey visit. The logical progression to ‘Stage 2’ would involve the introduction of joint RTP/PMCV accreditation surveyor training, and the consequent reduction in the size of survey teams attending GP accreditation visits. This stage is planned to come into effect in early 2013. Beyond this, a possible ‘Stage 3’ would see the introduction of fully streamlined documentation and reporting processes, while ‘Stage 4’ would venture into the territory of producing a single combined set of accreditation standards. Clearly, a considerable amount of additional work and collaboration, as well as additional funding, would be required before Stages 3 and 4 could be implemented. However, Stages 1 and 2 have already been set in motion in Victoria in connection with the GPTAP Pilot, and consequently a rudimentary cost analysis and projection has been undertaken to attempt to estimate the various cost components for each of the stakeholders. This is set out in the table below, with a comparison between pre-pilot costings and costings using the pilot joint accreditation model. It would be expected that some individual cost items may be further reduced in future accreditation surveys once all parties become fully familiar with new documentation and processes, and further streamlining measures (such as reduction in the size of surveyor teams and sharing of interview data) come into full effect.

The broad item cost categories used in the table are based on a number of assumptions about both direct and indirect cost components incurred by the respective stakeholders (PMCV, RTP and General Practice) which are elaborated upon in the footnotes to each. The costings for the pilot accreditation are taken from the survey undertaken at Clocktower Medical Practice in Sale, largely because this was the only one of the three pilot sites that had previously been accredited for intern training posts and thus had existing precedents for cost comparisons across the full range of components. The RTP data has been provided by Southern General Practice Training since this is the agency responsible for accreditation of the Clocktower clinic.

It should be noted that all accreditation expenditure as presented in the table is totally discretionary in terms of how costs have been allocated by each agency.

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<table>
<thead>
<tr>
<th>Item Cost per visit</th>
<th>PMCV</th>
<th>RTP</th>
<th>GENERAL PRACTICE</th>
<th>PMCV</th>
<th>RTP</th>
<th>GENERAL PRACTICE</th>
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</thead>
<tbody>
<tr>
<td>Surveyor Costs</td>
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<td>$530</td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>$350</td>
</tr>
<tr>
<td>Administration costs</td>
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<td>$405</td>
<td>$300</td>
<td>$1,000</td>
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<td>$200</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>TOTAL:</strong></td>
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<td><strong>$1,196</strong></td>
<td><strong>$1,300</strong></td>
<td><strong>$1,970</strong></td>
<td><strong>$1,196</strong></td>
<td><strong>$1,150</strong></td>
</tr>
</tbody>
</table>

The costs in this table are estimates only as comparison of costs of the pilot visit to separate visits formerly conducted was difficult and could only be done for one of the pilot practices as the other.

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14 The costing model used in this table is based on the one developed by NSW Clinical Education & Training Institute as set out in it’s *A framework for accrediting prevocational medical education, training and supervision in general practice settings, Version 1.2, November 2010*, p.14.

15 These cost estimates include all associated costs, including training, fee, if any, paid to a surveyor, report preparation, etc. These costs are based on an 8-hour day (visit and travel). Have assumed that PMCV surveyor costs will be halved by credentialing vocational surveyors for prevocational accreditation.

16 These figures include all associated costs, including estimated costs of non-remunerated time for completion of pre-accreditation documentation, attendance at the survey visit, etc. This cost estimate based on 2 supervisors meeting for one hour each per visit.

17 The assumption is made that during an accreditation visit there will be costs associated with trainee doctors being required for interview and therefore not generating income for the practice during that period. This cost estimate is based on 1 intern and 2 registrars meeting with surveyors for one hour. Note that this meeting only occurs for prevocational accreditation as the vocational accreditation is satisfied by regular ECTVs conducted by RTPs.

18 Included within this category are salary costs for the Accreditation Manager (PMCV & RTP) and the Practice Manager (General Practice). Other costs may be incurred for support staff, maintenance of accreditation schedules, processing of pre-accreditation documentation, liaising with practices to set up the visit arrangements, briefing the surveyor team, reporting to relevant authority, preparing final report & accreditation letter/certificate.

19 For PMCV, the maximum claimable per visit is $350 for travel costs and $150 for accommodation and food costs – for this cost estimate assume carpooling and no accommodation. It should be noted that some of these costs will vary depending upon whether the practice being accredited is located within the Melbourne metropolitan area or in a Victorian regional setting and its assumed that no accommodation will be required. For RTPs, travel is paid at the rate of 0.74 cents per km so cost could vary up to $600.

20 This category normally includes an allocation for rent, telephone, computer hardware & software, photocopying, provision of evidence documents, stationery, procurements, minor capital works (e.g. creating teaching &/or additional consulting space), etc.
two had not previously been accredited by both PMCV and the RTP. It was noted in relation to these estimates that, in future, when combined visits are more structured and organised, that further savings for practices may be achieved. This table incorporates expected savings for PMCV from credentialing surveyors for both vocational and prevocational accreditation.

4.6 Other suggestions

As stated above, the evaluation tools employed in the Victorian project reveal that participants agreed that, overall, the objectives of the project were satisfactorily achieved.

However, respondents to the evaluation survey were given the opportunity to offer suggestions that would, in their view, produce a better streamlined general practice accreditation process than the one implemented in Victoria during the pilot (Question 18). A total of eight comments were received, and these could be regarded as highlighting aspects of the project where the stated objectives were only partially met, or where additional mechanisms would be required to be introduced before complete achievement of an integrated general practice accreditation model could be attained. Below is a summary of areas that were raised in the responses to Question 18 of the evaluation survey:

- Further streamlining of accreditation documentation, especially to ensure that both initial and re-accreditation processes are adequately catered for. The reporting process is an example of where further streamlining of documentation could occur in the future. At the practice level, further streamlining of documentation would prevent confusion and almost certainly result in a further reduction in burden on practices.

- Streamlining of surveyor training so that one jointly-credentialled surveyor could carry out both the vocational and prevocational elements of general practice accreditation.

- One contact person should be allocated in advance of the survey visit, to ensure all accreditation documentation is correctly completed and returned to the appropriate agency prior to the survey visit.

- Further streamlining of visit structure such as ensuring no duplication in questions asked and having both accreditation teams meet with all learners at the practice.

- In a non-pilot project situation, a longer lead time for accreditation surveys would be desirable in order to ensure co-ordination of visit dates to the mutual satisfaction of all parties as well as allowing for smooth distribution, completion and return of all pre-visit documentation.

- There needs to be increased emphasis on the role of parent hospitals in maintaining the quality of prevocational general practice terms through active communication with practices, trainees and RTPs.

- The role and responsibilities of State/Territory PMCs in relation to initial accreditation of prevocational general practice training posts needs to be highlighted and recognised prior to allocation of PGPPP funding and for ongoing accreditation.
5. ACHIEVEMENT OF OBJECTIVES

The project objectives and outcomes to be achieved were listed in section 1.4 and are addressed in this section.

Despite the various challenges, the pilot project nevertheless largely achieved its objectives due, in particular, to the high degree of collaboration and cooperation between PMCV and the participating RTPs. The required number of combined general practice accreditation surveys was carried out, a degree of streamlining in respect of alignment of visits and cycles as well as in documentation and process was achieved, and full evaluation and reporting of the Victorian experience took place within the designated time period for the pilot project.

5.1 Objectives

1. *Provide a streamlined and integrated process of prevocational and vocational accreditation of general practices including the preparation of streamlined and integrated survey and information collection instruments.*

The most immediately obvious achievement has been the successful implementation of three pilot surveys that have combined both vocational and prevocational dimensions within a single general practice visit, thus eliminating multiple site visits for the purposes of medical training accreditation. Additionally, the documentation of each accrediting organisation has been streamlined to some extent, and, while not fully integrated at every stage of the accreditation process, the documents developed have assisted in reducing the duplication of information collection from general practices, thus lessening the burden on both practices and accrediting agencies in terms of workload, time and cost. However, during the pilot phase, as has been demonstrated in Section 4.5 above, no savings in respect of the accreditation agencies were achieved although it is anticipated that implementation of an ongoing streamlined accreditation program would result in cost efficiencies.

As a consequence of enhanced communication and collaboration between RTPs, PMCV and general practices, including sharing of information and the gaining of a deeper insight and appreciation of each other’s accreditation requirements, the quality of the general practice trainees’ placements have been at least maintained, and perhaps even strengthened.

The Victorian GPTAP has also succeeded in promoting good working relationships between accrediting bodies, an outcome that will surely pave the way for further streamlining in the future as shown by the fact that 90% of the respondents to the evaluation survey anticipated closer collaboration between PMCV, RTPs and GPs in the future.

2. *Evaluate the extent to which the streamlined and integrated prevocational and vocational training practice accreditation process has delivered robust and consistent accreditation outcomes across the three pilot general practices.*

The same process in terms of documentation and visit interviews was successfully implemented at all three pilots, and all accreditation requirements for both participating RTPs and for PMCV were satisfied. It is anticipated that this model could be implemented across Victoria, and that belief is borne out in the collective responses to Question 19 of the online evaluation survey.  

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21 In response to the question “Would you be willing for this model to be used for future General Practice accreditation visits?” 100% of respondents answered yes.
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3. **Assess the applicability and reliability of a single survey and information collection process.**

As a result of the three pilot visits it was apparent from the feedback received that the information collected following streamlining of the pre-visit documents adequately met the assessment needs of PMCV and the RTPs\(^{22}\). Despite the challenge posed by the fact that there are four RTPs in Victoria, each with its own accreditation processes especially in terms of documentation, the evaluation data reveals that pilot participants were satisfied with the information collection process at each visit. In fact, in terms of having a single joint survey visit, feedback received during the evaluation phase consistently indicated that the overall quality of information collected about each practice was enhanced by this dimension.\(^{23}\) With regard to reporting accreditation outcomes to practices, streamlining did not occur in the pilot project, chiefly because of accreditation agencies having separate accountabilities. Opinion was divided as to the desirability of developing one fully integrated report, or separate vocational and prevocational sections within a joint report, largely because of the perceived difficulty in achieving this satisfactorily without having one integrated set of Standards\(^{24}\). However the reporting dimension is one which could conceivably be further streamlined in the future. This objective is addressed in Recommendation 3 of this report.

4. **Consider the perspective(s) of stakeholders, including supervisors, RTPs, Colleges and PMECs involved in accreditation in relation to process and outcome quality; cost; scalability of the process; and other organisational, practice and program impact.**

The relevant stakeholders were all intimately involved at every stage of the project and their perspectives were taken into account in the ongoing management of the project. Feedback throughout this report highlights that this objective was met. The pilot accreditation project built upon past professional interaction between PMCV and the Victorian RTPs. This was reported in the evaluation survey to have been an extremely positive benefit arising out of the project, and has paved the way for ongoing good relations.

As a direct result of the accreditation pilot project, two joint general practice accreditation survey visits have since been undertaken in Victorian general practices at Portland and Nathalia, using the same model and involving SGPT, Bogong RTP (who did not formally participate in the GPTAP project) and PMCV. This is a clear indication that the integrated approach has been regarded as producing both process and outcome quality, and also that scalability at the statewide level is both practical and achievable.

The cost impacts remain to a large extent unmeasurable, because, as reported in Section 4.5 above, exact expenditure in both time and monetary terms is difficult to calculate for RTPs and PMCV, and any future division of costs between accrediting agencies for specific aspects of the accreditation process would require further governance guidelines.

Organisational and cost impacts for supervisors and practices have been universally positive, with feedback indicating that the single visit process has significantly reduced their cost and time dimensions, although workload remained predominantly unchanged\(^{25}\).

\(^{22}\) See responses to Question 9 in the online Evaluation Survey in Appendix 9.

\(^{23}\) Note, for instance, the following comments received in the online Evaluation Survey: “...conducting the visits together with RTPs is actually beneficial in terms of understanding the practice’s overall learning environment & commitment to learning” (Qu.4); “...the balance was good & being witness to conversations regarding vocational training certainly added a useful dimension to our understanding of the practice” (Qu.11); “Having the RTP representative as part of the Team actually assisted in the accreditation from the PMCV perspective as she was able to provide useful background information which I suspect the GPs would not have seen as relevant or may not have had detail about” (Qu.12); “A positive outcome was the value of the joint visits in discussing both prevocational & vocational aspects of training – both teams meeting with the learners was particularly valuable in my view” (Qu.17).

\(^{24}\) See responses to Question 23 in the online Evaluation Report in Appendix 9.

\(^{25}\) As reported in the General Practice post-visit paper-based ‘initial response’ survey, Questions 1, 4 & 5 (Appendix 8.).
5.2 Outcomes

1. Meet the objective to streamline training practice accreditation in the Minister’s Statement of Expectations 2011.

It can be demonstrated that the Victorian GPTAP has been at least partially successful in streamlining general practice accreditation according to the Minister’s Statement of Expectations. It has consistently sought cooperative and collaborative interaction between RTPs, PMCV and pilot general practices to identify duplications and gaps in the current tools and processes and worked to reduce these and bring about a more streamlined model of accreditation which is illustrated in Appendix 5.

2. Reduce the practice accreditation burden for supervisors by eliminating multiple site visits and information collection.

It is clearly evident from the pilot visits that the accreditation burden is reduced for practices by streamlined postgraduate (prevocational and vocational) medical training accreditation due to reduced number of visits, reduced need for documentation and, it was concluded, that the joint visit are not much longer than each of the two separate visits would be. One issue is that more space is needed for meeting with a larger survey team although it was noted that in future, survey teams could be reduced in size if surveyors are trained for both vocational and prevocational medical training accreditation.

3. Reduce College, PMC and RTP accreditation costs.

Initial feedback was that there was an increase in accreditation burden for PMCV and the RTPs due to the need for coordination of the visit. For the RTPs, while the costs remained unchanged, the parameters of time and workload were reported to have increased during the pilot project and from PMCV’s perspective cost, time and workload were all increased (since PMCV had not previously accredited two of the three practices).

In future there may be some savings achieved by reducing the size of survey teams by cross-credentialing of surveyors and more fully streamlining documentation, however, the workload associated with coordination of a streamlined accreditation process will likely continue to require some additional administrative resources. The effect of the streamlined accreditation process on College accreditation costs was not assessed in the Victorian GPTAP project.

The degree to which there was a reduction in the overall accreditation burden to the organisations that participated in the pilot, is indicated in the chart below. This chart represents the responses of general practice, RTP, PMCV and surveyor participants, although the correlation between response and stakeholder group is inconclusive.

![Chart showing perception of reduced burden to stakeholder bodies during pilot (Qu.13 in Evaluation Survey)](chart.png)

*Chart showing perception of reduced burden to stakeholder bodies during pilot (Qu.13 in Evaluation Survey)*
4. **Maintain the quality of placements for medical learners through strong governance processes, jointly overseen by Supervisors, RTPs, PMCV & Colleges.**

The Victorian GPTAP has demonstrated that a streamlined accreditation process for general practice medical training placements would maintain the quality standards of those posts. In fact, the combined interaction between the vocational and prevocational surveyors, particularly in relation to the learners and supervisors, enhanced the outcomes of the survey visits in terms of allowing access to information that would otherwise not have been shared across prevocational / vocational boundaries.

The combined accreditation survey enabled practice supervisors to see the training process as a continuum, rather than as separate processes for vocational and prevocational learners. Opportunities for joint teaching and learning were brought to the fore, and an increased awareness of the particular needs of learners at varying stages of their careers was instilled in supervisors by virtue of being presented simultaneously with the training accreditation standards of both the RACGP/ACRRM and the PMCV. These two sets of standards constitute the framework through which strong governance processes are maintained in relation to prevocational and vocational medical training posts in general practices in Victoria.

6. **CHALLENGES ENCOUNTERED**

In undertaking the GPTAP project, a number of challenges presented themselves from the Victorian perspective, some involving communication and liaison between local, interstate and national stakeholder groups, and some to do with logistical issues given the geographical disbursement of sites and agencies across the State. A summary of the major challenges encountered is given below:

- As mentioned previously, under the existing GPET/PGPPP guidelines, there is a lack of recognition in regards to responsibility for prevocational accreditation of general practice prevocational training posts and no funding provided to undertake this role. The RTPs are mandated to carry out general practice accreditation at the vocational level, but the prevocational level is outside the scope of the RACGP/ACRRM standards. The RTPs administer funding for each GP placement, but it is unclear if this funding allocation covers the accreditation function. PMCV is delegated by the Medical Board of Australia to accredit all PGY1 placements in Victoria, but receives no funding for accrediting GP posts established under the PGPPP scheme.

- The cost impact of the combined pilot accreditation surveys proved difficult to measure and evaluate from the perspective of general practices, RTPs and PMCV, since there are no benchmark costing or funding allocation breakdowns in respect of general practice accreditation.

- Working initially with the four Victorian RTPs to identify the required 2-4 general practice sites for accreditation pilots in Victoria was logistically challenging. This meant finding sites that were scheduled for both RTP and PMCV accreditation in the near future and approximately around the same date so that, with a degree of compromise, the visits could be aligned to allow joint vocational and prevocational accreditation visits. Inevitably, the two RTPs that could not provide such sites within the timeframe of the project were disappointed and requested to remain involved in the pilot project in whatever ways were possible so that they could have some influence over what new initiatives were developed.

- Geographical distance was a challenge. Stakeholders were dispersed across the state, and finding mutually convenient meeting places was an issue. Teleconferencing was used for some meetings, but some participants found this less than satisfactory. Similarly, finding PMCV accreditation surveyors who were prepared to travel to regional general practice sites in Sale and Geelong within the timelines for visits proved challenging, though not impossible.
Since there had been limited previous interaction between RTPs and PMCV regarding general practice accreditation, initiating discussions about streamlining documentation and processes, where five separate sets of documents and processes already existed, was challenging.

7. BENEFITS IDENTIFIED

The benefits identified, while previously mentioned, are summarised here by stakeholder group.

(i) For General Practices

- **Cost, time and workload:** The brief post-accreditation visit survey of general practice staff (refer to Appendix 8) revealed that it was almost universally agreed that the combined vocational/prevocational accreditation survey had involved very little extra time and cost to the practice than single surveys, and only a slightly increased workload in terms of documentation to be completed and/or provided. This constituted a significant saving to the general practice as it meant only having to fulfil these requirements once instead of twice in a three year period,

- **Maintenance of quality learning posts:** The combined accreditation survey enabled practice supervisors to see the training process as a continuum, rather than as separate processes for vocational and prevocational learners. Opportunities for joint teaching and learning were identified and there was an increased awareness of the particular needs of learners at varying stages of their careers.

(ii) For Regional Training Providers

- **Cost, time & workload:** While the costs remained unchanged, the parameters of time and workload were reported to have increased during the pilot project. However, stakeholders commented that although any additional future streamlining of the general practice accreditation process would require further funding, the streamlined process as it now stands would not require any additional cost.

- **Collaboration:** The collaboration between PMCV and the RTPs was reported in the evaluation survey to have been an extremely positive benefit arising out of the project. Further, collaboration of the vocational and prevocational surveyors during the visits resulted in the exchange of knowledge and information to an extent that had previously not occurred.

- **Maintenance of quality learning posts:** The opportunity for surveyors to meet with all general practice trainees, both vocational and prevocational, and to become familiar with the accreditation requirements for both levels, provided new insight and an awareness of similarities and differences that was previously not achievable.

(iii) For the Postgraduate Medical Council of Victoria

- **Cost, time & workload:** These parameters in the pilot project were all increased particularly as general practices were accredited that had not previously been visited, however comments in the evaluation survey reveal that in future these resource parameters could be reduced in combined surveys where debate and organisation of stakeholder groups would not be required on the same scale. Further, if jointly credentialled RTP surveyors could take on the prevocational dimension at general practice accreditation visits in future, this would further reduce the accreditation cost for PMCV. There is a need for the cost of the accreditation function for prevocational training in general practices as a whole to be recognised.

- **Collaboration:** The interaction between PMCV and the RTPs both at the organisation level and between the surveyors at visits represents an opportunity to develop an ongoing
working relationship to ensure the accreditation burden for general practices is reduced and that all prevocational placements are accredited prior to trainees undertaking those rotations.

- **Maintenance of quality learning posts:** The PMCV surveyors who attended the visits found that the interactions with the vocational surveyors was useful in assessing the practice as a medical training facility across the postgraduate continuum and ensuring maintenance of the quality of the placements.

**(iv) For accreditation surveyors**

- **Cost, Time and Workload:** For the pilot visits, a separate prevocational and vocational clinician surveyor was required to attend to oversee accreditation from the two perspectives. However, if the plan to train RACGP surveyors to become jointly-credentialled for both vocational and prevocational accreditation proceeds as intended, then there will only need to be one surveyor in attendance at each accreditation visit. This would reduce both time and cost, but would increase the surveyor workload. The issue of what organisation would be responsible for paying jointly-credentialled surveyors has not as yet been resolved.

- **Training & credentialing:** Although this was not possible to implement within the pilot project, agreement in principle that PMCV would provide surveyor training to RTP/RACGP accreditors to qualify them to carry out general practice accreditation at both vocational and prevocational levels was seen as potentially a major benefit to all. The initial training would constitute an additional cost for PMCV, but subsequently the overall accreditation cost would be reduced because the size of accreditation teams would be reduced at the visit.

**8. RECOMMENDATIONS**

1. The PMCV and Victorian RTPs should continue to work towards a streamlined process of postgraduate (prevocational and vocational) medical accreditation for general practices, incorporating streamlined pre-visit documentation and survey visits, building on the Victorian pilots.

2. In relation to initial general practice accreditation, both the RTP and PMCV should attend initial meetings with general practices and jointly assess the practice’s suitability for hosting prevocational training posts.

3. Streamlined accreditation should aim in the future to include streamlined reporting to general practices, and streamlined accreditation standards.

4. Streamlined accreditation should be supported by clear governance and reporting structures that ensure continuous improvement.

5. Streamlined accreditation should be appropriately recognised and resourced.

6. A comprehensive costing, funding, governance and reporting model for general practice accreditation agencies should be developed to assist the streamlining process.

7. General practitioner surveyors should be trained in both vocational and prevocational accreditation as a way of potentially reducing the size of accreditation teams in the future.

8. Victorian RTP accreditation processes are encouraged to commence discussions regarding local alignment of documentation and processes in order to support a streamlined state-wide vocational accreditation process.
9. CONCLUSION

Overwhelmingly, stakeholders in the Victorian GPTAP project found their participation to have been worthwhile, 26.

Detailed examination of existing accreditation documentation and processes revealed extensive overlaps in the information gathering, as well as some significant gaps in aspects of general practice accreditation. Although not all identified instances of duplication and omission could be fully addressed in the pilot, significant progress in a number of those areas was made, and the remainder have been documented for future attention, pending agreement by national accreditation agencies.

The partial streamlining of vocational and prevocational accreditation documentation and the successful creation of aligned survey visits has provided a strong platform upon which to build more efficient accreditation processes, reduce the accreditation burden on both practices and accrediting bodies, and ensure the maintenance of all general practice learning posts.

In addition, a number of unforeseen benefits have arisen directly or indirectly out of the project in Victoria. Perhaps the most important of these has been the new working relationship that has developed between the RTPs and PMCV in regards to accreditation, producing a level of collaboration that all involved are keen to maintain into the future.

The project has highlighted the need for greater clarification by government bodies regarding accreditation responsibilities at the prevocational level, and has demonstrated improved communication and stronger links between RTPs, general practices and parent health services should be forged, especially with regard to prevocational evaluation, assessment and feedback processes and, in particular, the provision for ongoing management and support of junior doctors experiencing personal or professional difficulties.

10. FUTURE DIRECTIONS FOR VICTORIA

This project facilitated the development of broad streamlined accreditation of postgraduate medical training in general practice. The streamlined accreditation process successfully implemented in the pilots in Victoria resulted in an accreditation framework (Appendix 5) which emphasises optimised integration and sharing of pre-visit documentation by PMCV/RTPs; alignment of survey visit dates and cycles both for initial and re-accreditation and credentialing of surveyors for both vocational and prevocational accreditation.

The accreditation framework was limited in the sense that full integration of the standards utilised by PMCV and the RTPs (RACGP/ACCRM) was not achieved as it was outside the scope of this particular project, however all parties agreed that alignment of the standards should be pursued and were willing to participate in such a project.

For the future, it is the intention of the parties to this project to continue to pursue alignment of accreditation survey dates, to implement a program for co-credentialing of surveyors and to further integrate and align pre-visit documentation.

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26 Response to online evaluation survey for the project, Qu.22: ‘Do you think your participation in the GPTAP has been worthwhile?’, summarised in Appendix 9.
REFERENCES:

ACRRM Accreditation Standards for Regional Training Provider Recognition, 2007

AGPT / CPMEC General Practice Training Accreditation Pilots Agreement, Terms of Reference and Project Scope, November 2011

Australian Government website: www.doctorconnect.gov.au


CPMEC, Prevocational Medical Accreditation Framework, 2009


NSW Clinical Education & Training Institute, A framework for accrediting prevocational medical education, training and supervision in general practice settings, Version 1.2, November 2010

PGPPP, Practice Guidelines for the supervision and training of doctors in the Prevocational General Practice Placements Program, November 2010

PGPPP, Provider Guidelines for the supervision and training of doctors in the Prevocational General Practice Placements Program, November 2010


PMCV General Practice Accreditation Standards, 2010 and revised version, 2012

PMCV National Accreditation Framework for General Practice and Community Settings Project, Final Report, Revised April 2009

RACGP Standards for General Practice Accreditation, 2010

RACGP Draft Vocational Training Standards, 2011
APPENDIX 1

“...I chose a PGPPP rotation to help me confirm that a career in General Practice was for me, also for a bit of a change from the specialty medical resident term I had been doing in the hospital up to that time.”

“I had heard some good feedback from some colleagues regarding the PGPPP rotation and wanted to decide if these were accurate for myself. The better working hours were also attractive.”

“I received excellent supervision from the many experienced General Practitioners at the practice I did my PGPPP in, they sat in on my early procedural skills and dermatology evaluations allowing me to learn in a well supported, non-threatening fashion.”

“I would certainly recommend undertaking a PGPPP post to junior doctors, to those considering General Practice and those not, for all doctors could do with a good understanding of primary care medicine and the role of the General Practitioner within the larger framework of patient care in the health system.”

Dr Brendan Fitzgerald
PGPPP Rotation, Northern Hospital
### 2012 Victorian PGPPP placements

<table>
<thead>
<tr>
<th>Feeder Hospital</th>
<th>Practice</th>
<th>Year Level</th>
<th>No of Rotations</th>
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### 2012 Victorian PGPPP placements

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## APPENDIX 2

### GPET ACCREDITATION PILOT PROJECT, 2012

#### VICTORIAN WORKING GROUP

#### MEMBERS

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<thead>
<tr>
<th>Member Name</th>
<th>Position</th>
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<tr>
<td>Dr. Peter Stevens, General Practitioner</td>
<td>PMCV Accreditation Surveyor</td>
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<tr>
<td>Dr Jane Greacen, General Practitioner</td>
<td>PMCV Accreditation Surveyor</td>
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<tr>
<td>Dr Susannah Ahern, Medical Director</td>
<td>PMCV</td>
<td></td>
</tr>
<tr>
<td>Ms Carol Jordon, Executive Officer</td>
<td>PMCV</td>
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<tr>
<td>Ms Monique Le Sueur, Accreditation Manager</td>
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<tr>
<td>Ms Judy D’Ombra, Project Officer</td>
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<tr>
<td>Ms Karen Alexander, PGPPP Coordinator</td>
<td>SGPT</td>
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<tr>
<td>Ms Linda Kruger, Development Manager (Eastern Region)</td>
<td>SGPT</td>
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<tr>
<td>Ms Angela Beilby – Registrar Support Officer (Western Region)</td>
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<td>Dr Judith Culliver, PGPPP Coordinator</td>
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<tr>
<td>Dr Angelina Salamone, Accreditation Coordinator</td>
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PROJECT PLAN

GENERAL PRACTICE TRAINING ACCREDITATION PILOTS

Aim
To undertake and evaluate pilots in Victoria of models of streamlined and integrated prevocational and vocational training practice accreditation.

Objective
To provide a documented and evaluated assessment of a streamlined and integrated process of prevocational and vocational accreditation of training facilities. The pilots and their evaluation will 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 Victoria.

Background
Accreditation of prevocational training posts is a quality assurance process that establishes and monitors standards for prevocational training positions to assist in a high standard of clinical training for junior doctors. Accreditation usually involves self-assessment by the training facility followed by a visit from a trained survey team comprising a diverse range of professionals to formally evaluate the health service or practice.

The Postgraduate Medical Council of Victoria (PMCV) currently has delegated responsibility from the Medical Board of Australia (for PGY1) and the Victorian Department of Health (for PGY2+) to ensure all prevocational medical training positions in Victoria meet minimum standards of supervision, education and welfare and are accredited.

Consequently, PMCV is accrediting general practices for the provision of prevocational doctor training (mainly PGPPP funded PGY1 and PGY2 posts) which overlaps with the accreditation processes of the four Regional Training Providers (RTPs) in Victoria.

This project is being undertaken as part of an agreement entered into by CPMEC and GPET in November 2011 and will address the following evaluative goals:

- The extent to which the streamlined and integrated prevocational and vocational training practice accreditation process has delivered robust and consistent accreditation outcomes across the pilot medical practices.
- The perspective(s) of stakeholders, including supervisors, RTPs, Colleges and PMECs involved in accreditation in relation to process and outcome quality; cost; scalability of the process; and other organisational, practice and program impact.
**Timelines**

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<td>Project completion date</td>
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**Methodology**

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<td>- PMCV (admin/surveyors)</td>
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<td>- Participating RTP representatives</td>
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<tr>
<td>(Non-participating RTPs will be kept informed of developments and outcomes, and to comment on the Draft Report prior to submission)</td>
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<td>(General Practice staff not eligible for Working Group membership)</td>
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<td>Provide progress reports and seek feedback from PMCV Accreditation Sub-Committee as required.</td>
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</tr>
<tr>
<td>Liaise with four Victorian RTPs to prepare and agree a project plan detailing the pilot tasks, their dates for completion and their reporting requirements.</td>
<td>15 February 2012</td>
</tr>
<tr>
<td>Identify 2-4 general practices in consultation with the RTPs to undertake pilot streamlined survey process. The practices selected will cover the range of vocational and prevocational training posts available under the AGPT program and the Prevocational General Practice Placements Program (including intern and PGY2+ placements).</td>
<td>15 February 2012</td>
</tr>
<tr>
<td>Submit Project Plan to Project Steering Committee.</td>
<td>20 February 2012</td>
</tr>
<tr>
<td>Liaise with participating RTPs to understand and compare/contrast existing PMCV and RTP general practice accreditation processes including Standards, pre-visit documents, surveyors, survey visits, reporting and recommendations etc. (assume current PMCV, RACGP and ACRRM standards).</td>
<td>31 March 2012</td>
</tr>
<tr>
<td>Identify opportunities for integration and any gaps in the accreditation processes for prevocational medical positions undertaken by PMCV and the participating RTPs.</td>
<td>31 March 2012</td>
</tr>
<tr>
<td>Provide the agreed survey and information collection instruments and methodologies to the Steering Committee for approval</td>
<td>15 April 2012</td>
</tr>
<tr>
<td>Actions</td>
<td>Deadline</td>
</tr>
<tr>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>PILOTS:</strong></td>
<td>30 June 2012</td>
</tr>
<tr>
<td>Undertake at least 2 and up to 4 pilots in Victorian general practices including at least one practice located in an RA2-5 location.</td>
<td></td>
</tr>
<tr>
<td>PRACTICE &amp; DATE to be agreed with RTPs:</td>
<td>10 May 2012 18 May 2012 22 May 2012</td>
</tr>
<tr>
<td>1. Kardinia Health, Belmont, Geelong (PGY2) - SGPT</td>
<td></td>
</tr>
<tr>
<td>2. Clocktower Medical Centre, Sale (PGY1) - SGPT</td>
<td></td>
</tr>
<tr>
<td>3. Preston Family Medical Practice, Preston (PGY2) - VMA</td>
<td></td>
</tr>
<tr>
<td>*When preparing for the pilots, do so in accordance with the approved evaluation methodology.</td>
<td></td>
</tr>
<tr>
<td><strong>EVALUATION:</strong></td>
<td>CPMEC by 15 April 2012 (need to prepare for pilots) June-July 2012 16 July 2012 (in conjunction with Vic RTPs) 31 July 2012</td>
</tr>
<tr>
<td>1. Prepare an evaluation methodology in conjunction with relevant RTPs and provide this to the Steering Committee for approval.</td>
<td></td>
</tr>
<tr>
<td>2. Undertake an evaluation of the pilots in Victoria in accordance with the approved evaluation methodology.</td>
<td></td>
</tr>
<tr>
<td>3. Prepare a draft report on the pilot evaluations for consideration and feedback by the Steering Committee, the Colleges, RTPs, PMCs and participating practices. Within this, report on perspectives of stakeholders in relation to areas of cost, administration, process, scalability, organisational, practice &amp; program impact, and make recommendations as appropriate.</td>
<td></td>
</tr>
<tr>
<td>4. Provide a final report, revised in the light of feedback from the Steering Committee and pilot participants, and including recommendations.</td>
<td></td>
</tr>
</tbody>
</table>
**Outputs and Outcomes**

The successful implementation of this project will:

- Meet the objective to streamline training practice accreditation in the Minister’s Statement of Expectations 2011.
- Reduce the practice accreditation burden for supervisors by eliminating multiple site visits and information collection.
- Reduce College, PMC and RTP accreditation costs.
- Maintain the quality of placements for medical learners through strong governance processes, jointly overseen by Supervisors, RTPs, PMCV & Colleges.

**Budget**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staffing costs:</strong></td>
<td></td>
</tr>
<tr>
<td>Project Officer: $70,000 (pro rata at 3 days week for 8 months) with 20% on costs</td>
<td>$35,000</td>
</tr>
<tr>
<td><strong>Operational costs:</strong></td>
<td></td>
</tr>
<tr>
<td>Telephone, email/advertising, promotional flyer, postage)</td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>Equipment/capital costs:</strong></td>
<td>Nil</td>
</tr>
<tr>
<td><strong>Other costs:</strong></td>
<td></td>
</tr>
<tr>
<td>Administrative support can be provided by PMCV administrative staff to assist with maintenance of the site and updating of links/resources.</td>
<td>$0</td>
</tr>
</tbody>
</table>

**TOTAL FUNDS FOR THE PROJECT** $40,000

**Contact Details**

<table>
<thead>
<tr>
<th>Contact Person</th>
<th>Ms Judy D’Ombrain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position/Title</td>
<td>Project Officer</td>
</tr>
<tr>
<td>Telephone Number</td>
<td>03 94191217</td>
</tr>
<tr>
<td>Email Address</td>
<td><a href="mailto:jdombrain@pmcv.com.au">jdombrain@pmcv.com.au</a></td>
</tr>
</tbody>
</table>
1. Background of Project

**Aim:**
To undertake and evaluate pilots of a model of streamlined and integrated prevocational and vocational General Practice training accreditation in Victoria, as part of a larger study involving three Australian jurisdictions and overseen by CPMEC and GPET.

The pilot and its evaluation will provide an assessment of the applicability of a single survey and information collection process to support the prevocational and vocational accreditation of General Practice training posts by the relevant accreditation bodies in Victoria.

**Scope of Evaluation:**
- Prepare an evaluation methodology for the Victorian pilot project and provide this to the Steering Committee for approval by 15 April 2012
- Undertake an evaluation of the pilot in accordance with the approved evaluation methodology during May / June 2012
- Prepare a draft report on the pilot evaluation for consideration and feedback by the project Steering Committee, Victorian RTPs, the PMCV and the participating General Practices by 15 July 2012
- Prepare a final report, revised in the light of feedback from the above organisations, and submit to the Steering Committee by 31 July 2012 for incorporation into the larger study

2. Overview of the Victorian Program documenting linkages between program activities, impacts and outcomes

*Figure 1. Flowchart outlining the projected Program activities, Impacts and Outcomes*
3. Evaluation Preview: Engage Stakeholders, clarify the purpose of the evaluation, identify key questions and identify evaluation resources

Stakeholders:
The PMCV staff members engaged in the project will involve the following stakeholders at various stages (see Table 1 below).
The Victorian Working Group, comprising representatives from the PMCV and the participating RTPs, will be involved in this evaluation process.

Table 1. Summary of projected stakeholder input to Pilot Accreditation project

<table>
<thead>
<tr>
<th>Stakeholder (organisation or individual)</th>
<th>Role / Input</th>
<th>Stage(s) of Project</th>
<th>Communication channel(s)</th>
<th>Evaluation Method used to obtain feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>RTPs x 4 (Participating &amp; Non-participating)</td>
<td>To source pilot GPs, collaborate on development of streamlined documents &amp; processes, attend pilot accreditation visits. Non-participating RTPs invited to share accreditation documents &amp; comment on interim &amp; final project report</td>
<td>Consultation &amp; input at every stage of the project</td>
<td>Written Face to face</td>
<td>Survey. Also feedback from participants in the pilot process</td>
</tr>
<tr>
<td>PMCV</td>
<td>To coordinate, administer, evaluate &amp; report on the project</td>
<td>Input at every stage of the project</td>
<td>Face to face, written</td>
<td>Review of meeting notes and actions</td>
</tr>
<tr>
<td>General Practice Supervisors</td>
<td>Complete &amp; return pre-visit documents, interview at time of survey visit</td>
<td>Participate in pilot accreditation survey</td>
<td>Online or paper-based</td>
<td>Post-visit interview Survey</td>
</tr>
<tr>
<td>Practice Managers</td>
<td>Assist with preparation of pre-visit documents, interview at time of survey visit</td>
<td>Participate in pilot accreditation survey</td>
<td>Face to face Email</td>
<td>Post visit interview survey</td>
</tr>
<tr>
<td>Victorian Working Group for project</td>
<td>Oversee and coordinate development of pilot model tools &amp; processes, assess challenges &amp; benefits, feedback on draft report</td>
<td>Input at every stage of the project</td>
<td>Face to face Email Teleconference</td>
<td>Review of meeting notes and actions</td>
</tr>
<tr>
<td>Confederation of Postgraduate Medical Education Councils (CPMEC)</td>
<td>To manage the overall project at the national level &amp; report to the National Steering Committee, to liaise with the Colleges, PMCs &amp; RTPs involved in the pilots, &amp; to conduct an evaluation of the outcomes of the pilots in each State</td>
<td>Oversight &amp; input at every stage of the project</td>
<td>Written (submission of project &amp; pilot documents) Email, phone, Face to face (meetings)</td>
<td>Review of submitted documents including Project Plan, Evaluation Plan and Draft Report. Possible verbal &amp;/or written feedback about overall Vic performance</td>
</tr>
<tr>
<td>National Steering Committee</td>
<td>Approve strategic documents, provide guidance</td>
<td>At strategic points in project timeline</td>
<td>Teleconference consultation</td>
<td>Submission of scheduled interim reports</td>
</tr>
</tbody>
</table>
4. Purpose of the evaluation

The evaluation program objectives include:

4.1 To evaluate the impacts and outcomes of the three General Practice pilot accreditation surveys in Victoria (impact evaluation) and provide a combined analysis of key findings. The perceived advantages and disadvantages of the streamlined and integrated model of accreditation, both to the General Practices and to the accrediting bodies, will form an integral part of this section of the evaluation program. Refer to Section 5(ii) of this Plan for details.

4.2 To identify possible risks and key challenges encountered in implementing the program.

4.3 To assess the extent to which the pilot accreditation model has been implemented (process evaluation). Refer to Section 5(i) of this Plan for details.

Key questions

In order to address the objectives of the evaluation, a number of key evaluation questions were formulated (Table 2). Note that this list is not finite and will remain under review until the project reaches the post-accreditation survey stage.

Table 2. Key questions for evaluation of the Pilot Accreditation program in Victoria

<table>
<thead>
<tr>
<th>Question - Focus</th>
<th>QUESTIONS</th>
</tr>
</thead>
</table>
| Process          | ▪ Has the streamlined accreditation process been implemented as intended?  
                  ▪ What factors (both positive & negative) impacted on the implementation?  
                  ▪ Were program participants (i.e. General Practice staff, RTPs, PMCV) satisfied with the process? |
| Impacts and outcomes | ▪ Have the project impacts and outcomes, as outlined in the Project Plan, been achieved?  
                           ▪ What unanticipated positive and negative outcomes have arisen from the pilot program?  
                           ▪ Were all strategies employed appropriate and effective in achieving the impacts and outcomes?  
                           ▪ What have been the critical success factors and barriers to achieving the impacts and outcomes?  
                           ▪ Have benefits been identified in terms of costs and time savings (both to GPs and to accrediting bodies)?  
                           ▪ Have levels of partnership and collaboration increased, or are they expected to increase? |
| Implications for possible future programs and policy | Are there any additional opportunities to streamline the process further for future visits?  
                                                             ▪ What performance monitoring and continuous quality improvement arrangements should be put in place to support the future roll-out of the streamlined and integrated accreditation approach?  
                                                             ▪ What additional resources would be required to further develop the streamlined approach? |
5. Evaluation design, and data collection methods and instruments

Process evaluation and impact/outcome evaluation methods will be used to evaluate the pilot accreditation program in Victoria.

**(i) Process evaluation**

Key indicators for this will be derived from:

- review of key program documents and instruments (e.g. Working Group and RTP / PMCV meeting minutes, GPET/CPMEC contract management records, the Victorian Project Plan, progress reports submitted to the Steering Committee, the CPMEC Evaluation Methodology Template, and the Victorian Evaluation Plan) to assess the extent to which the activities identified in Figure 1 have been implemented, and
- data collection in the form of records of stakeholder interactions, diarised over the duration of the project by the Project Officer. These will be used to establish dimensions such as extent of collaboration and support between stakeholders, and to identify key challenges encountered during the process
- other qualitative methods as appropriate, (e.g. open-ended survey questionnaires (online or paper-based), in-depth interviews, narrative and participant observation) to address aspects of pilot implementation, including the quality and appropriateness of the processes undertaken

Outputs that will be considered in the process evaluation to measure the extent of implementation are presented in Table 3

**Table 3. Key activities and outputs for the project – for process evaluation**

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>OUTPUTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Establish project governance and administrative arrangements</td>
<td>▪ Buy-in and commitment with key project participants established</td>
</tr>
<tr>
<td></td>
<td>▪ Victorian Working Group established</td>
</tr>
<tr>
<td></td>
<td>▪ Contract with national Steering Committee established</td>
</tr>
<tr>
<td>2. Establish performance monitoring and reporting arrangements</td>
<td>▪ Project milestones identified and met</td>
</tr>
<tr>
<td></td>
<td>▪ Key indicators identified for program monitoring and reporting</td>
</tr>
<tr>
<td>3. Develop integrated pilot accreditation action plan</td>
<td>▪ Assess current processes and instruments and identify gaps and opportunities</td>
</tr>
<tr>
<td></td>
<td>▪ Develop pilot processes and instruments</td>
</tr>
<tr>
<td></td>
<td>▪ Finalise action plan</td>
</tr>
<tr>
<td>4. Communication</td>
<td>▪ Liaise with General Practices to arrange pilot accreditation survey visit (suitable time, survey teams, coordination issues)</td>
</tr>
<tr>
<td>5. Identify risks and biases</td>
<td>▪ Assess possible factors that may affect the streamlined process</td>
</tr>
<tr>
<td>6. Seek stakeholder feedback on pilot process</td>
<td>▪ Implement post-accreditation survey questionnaires, focus groups, interviews as relevant</td>
</tr>
<tr>
<td>7. Analyse and interpret data, including feedback from stakeholders and diarised records of all interactions in the pilot project</td>
<td>▪ A mix of both qualitative and quantitative methods will be employed. Both objective and subjective findings will be incorporated into the analysis</td>
</tr>
<tr>
<td>8. Formulate draft report</td>
<td>▪ Circulate to Victorian Working Group for feedback</td>
</tr>
<tr>
<td>9. Formulate final report</td>
<td>▪ Submit to national Steering Committee for evaluation</td>
</tr>
</tbody>
</table>
(ii) Impact / outcome evaluation

As outlined in dot point 6 of Table 3 above, participants will be asked to provide feedback on all aspects of the pilot accreditation process, by means of a variety of data collection tools. In addition, the pilot Practices will be compared to a control group comprised of five Victorian General Practices that were accredited during late 2011 by the PMCV for prevocational posts, using the standard accreditation processes and instruments. This will be achieved by implementing a brief online survey questionnaire to the five 2011 Practices, seeking feedback on aspects of the current General practice accreditation experience, and then comparing responses to both the current and pilot accreditation processes to identify the respective strengths and weaknesses, noting any perceived improvements or retrograde changes to the process.

References

1. Agreement between General Practice Education and Training Limited and Confederation of Postgraduate Medical Education Councils Limited: General Practice Training Accreditation Pilots (2011)
3. RACGP General Practice training post and supervisor standards
6. PMCV Accreditation Standards and Instruments
7. CPMEC, GPET Accreditation Pilots: Project Evaluation Methodology Template (2012)

Evaluation Data Collection Checklist

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Yes ✓ No</th>
<th>Yes ✓ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need to collect information for evaluation has been demonstrated</td>
<td>Yes ✓ No</td>
<td>Yes ✓ No</td>
</tr>
<tr>
<td>All existing sources of Victorian GP accreditation data have been reviewed</td>
<td>Yes ✓ No</td>
<td>Requirements of Project brief and national Steering Committee have been considered</td>
</tr>
<tr>
<td>Duration and timing of data collection has been specified</td>
<td>Yes ✓ No</td>
<td>Scope of data collection activities and reporting is congruent with available funding and timeframe</td>
</tr>
<tr>
<td>Method of reviewing evaluation information has been identified</td>
<td>Yes ✓ No</td>
<td>Appropriate standards of measurement have been adopted</td>
</tr>
<tr>
<td>Method of validating evaluation information has been specified</td>
<td>Yes ✓ No</td>
<td>Guidelines to assist data collection and reporting have been provided</td>
</tr>
</tbody>
</table>

Version 8 – FINAL 11 May 2012
APPENDIX 5

JOINT RTP/PMCV FRAMEWORK FOR ACCREDITATION OF POSTGRADUATE MEDICAL TRAINING POSITIONS (PILOT)

Principles:

1. PMCV is responsible for accreditation of prevocational (intern & PGY2) positions (funded by PGPPP) and RTPs are responsible for accreditation of vocational positions.

2. Practices are accredited for vocational training either prior to or at the same time as applying for prevocational training.

3. In the pre-visit stage, PMCV and the relevant RTP share general practice overview information excluding standards. Full document integration is the goal.

4. This accreditation framework allows for co-credentialing of surveyors (by PMCV and RTP) so they can accredit for both prevocational and vocational medical training.

5. Re-accreditation for prevocational and vocational medical training to occur at the same time and in the same cycles (currently 3 years) with the practice accredited as a ‘postgraduate medical training practice’.

6. Process supported by ongoing communication between RTPs and PMCV on prevocational medical training issues.

<table>
<thead>
<tr>
<th>INITIAL ACCREDITATION (NEW)</th>
<th>RE-ACCRREDITATION (ONGOING)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice applies for accreditation for vocational training and prevocational training. Preliminary meeting involving Postgraduate Medical Council of Victoria (PMCV), relevant Regional Training Provider (RTP), the General Practice (GP) and parent health service (PHS).</td>
<td>Practice advises that postgraduate medical training re-accreditation is due and date set for survey visit by PMCV/RTP/GP.</td>
</tr>
<tr>
<td>Practice completes PMCV Application Form for provisional accreditation of New PGY1/PGY2 Positions and RTP pre-visit and standards documents.</td>
<td>Practice completes PMCV Application Form for provisional accreditation of New PGY1/PGY2 Positions.</td>
</tr>
<tr>
<td>PMCV/RTP undertakes a joint survey visit to the GP which includes representation from PHS, interviews with all supervisors and any learners currently in the practice, review of facilities and discussion of ongoing accreditation conditions (e.g. standards).</td>
<td>PMCV conducts an electronic JMS survey online via surveymonkey where interns/PGY2s are surveyed for their feedback on the rotation experience in relation to the PMCV functions.</td>
</tr>
<tr>
<td>PMCV and RTP survey teams complete an assessment against their respective accreditation standards.</td>
<td>For full survey visit, date of visit to be discussed with practice and RTP/PMCV surveyors. This will be a joint visit by PMCV/RTP which will include interviews with all supervisors and learners and review of facilities (PHS do not attend).</td>
</tr>
<tr>
<td>Practice application for prevocational accreditation considered by PMCV Accreditation Subcommittee. Letter of confirmation of accreditation sent by PMCV.</td>
<td>If paper-based re-accreditation, documents completed by practice to be reviewed by PMCV Accreditation Subcommittee and RTP Accreditation Committee.</td>
</tr>
<tr>
<td>Practice application for vocational accreditation considered by RTP Accreditation Committee. Letter of confirmation of accreditation sent by RTP.</td>
<td>Respective RTP and PMCV Survey Teams assess the GP against the accreditation standards and prepare reports which are submitted to RTP Accreditation Committee and PMCV Accreditation Subcommittee. Survey report sent to practice by PMCV.</td>
</tr>
<tr>
<td>Department of Health and the Medical Board of Australia notified of accreditation recommendations by PMCV. RACGP/ACRRM notified by the RTP to accreditation recommendations.</td>
<td>Department of Health and the Medical Board of Australia notified of accreditation recommendations by PMCV. RACGP/ACRRM notified by the RTP to accreditation recommendations.</td>
</tr>
<tr>
<td>PMCV reviews new prevocational medical training post in year of commencement - Application for Extension of Accreditation form to be completed. A survey of the trainees is undertaken.</td>
<td>PMCV accreditation extended for up to 2 years until re-accreditation (RTP and PMCV accreditation cycles to be coordinated).</td>
</tr>
<tr>
<td>BETWEEN SURVEY VISITS: Any material changes to the program ie: education; supervision are to be notified to PMCV. See PMCV Change of Circumstance Policy.</td>
<td>Department of Health and the Medical Board of Australia notified of accreditation recommendations by PMCV. RACGP/ACRRM notified by the RTP to accreditation recommendations.</td>
</tr>
</tbody>
</table>
APPENDIX 6

DOCUMENTS REQUIRED FOR ACCREDITATION IN VICTORIA

Postgraduate Medical Council of Victoria (PMCV)

- Application for Accreditation of New PGY1 (intern)/PGY2 positions (*initial accreditation*)
- Part 1 – General Practice overview (1) provided by RTP; and (2) additional information on parent health service (See following page: ‘PMCV pre-accreditation Overview document’)
- Part 2 – assessment against PMCV prevocational medical training standards (*for initial accreditation practices to be aware of requirements and survey team assessment occurs and for re-accreditation the practice undertakes a self-assessment against the standards followed by survey team assessment.*)
- Evidence including position description including learning objectives, orientation, handbook, performance assessment, evaluation

Southern General Practice Training

- *Pre-Accreditation Document No.2*  
  o (Section A: Overview – Practice to complete; Section B: RTP to complete at visit)
- * Combined RACGP/ACRRM Re-accreditation Document
- Checklist of Documents to View by Training Practice Accreditors
- Non-FACRRM Supervisor Self-Assessment form
- Registrar Feedback Interview Form for Practice Accreditation

Victorian Metropolitan Alliance

- *Initial Application for Accreditation of a Training Post with the RACGP (2005)*
- *Level 1 Training Practice Initial Accreditation: An Overview*
- Level 1 Teaching Practice Re-accreditation: Self-assessment form
- Evidence including: PGPPP Junior Doctor Handbook, feedback form for HMOs regarding the PGPPP Program, feedback form for the General Practice & Supervisor regarding the PGPPP Program, feedback form for the Parent Hospital regarding the PGPPP Program

*shared with PMCV*
# PMCV pre-accreditation Overview document

## PARENT HOSPITAL DETAILS

<table>
<thead>
<tr>
<th>Parent Health Service</th>
<th>Name:</th>
<th>Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parent Health Service Supervisor of Intern Training (SIT) (if applicable)</strong></td>
<td>Name:</td>
<td>Position Title:</td>
</tr>
<tr>
<td></td>
<td>Time allocated to PGY1 activities (FTE):</td>
<td>Contact Phone:</td>
</tr>
<tr>
<td><strong>Parent Health Service Director of Clinical Training (DCT)</strong></td>
<td>Name:</td>
<td>Position Title:</td>
</tr>
<tr>
<td></td>
<td>Time allocated to PGY1/2 activities (FTE):</td>
<td>Contact Phone:</td>
</tr>
</tbody>
</table>

### Nature of relationship between the Practice & the Parent Hospital

(e.g. level of contact about HMO staffing & management, support provided by parent hospital, shared education programs, existing administrative arrangements (if any), visits by senior staff, etc.)

- Is there a secondment agreement in place?  [ ] Yes  [ ] No

(Evidence Folder (Survey day visit): Provide copies of formal correspondence &/or agreement between parent hospital and the General Practice (if applicable))

<table>
<thead>
<tr>
<th>Distance of General Practice from Parent Hospital</th>
<th>Kms. (approx.)</th>
</tr>
</thead>
</table>

## PGY2 REQUIREMENTS

- Does/will the PGY2 have a dedicated consulting room?  [ ] Yes  [ ] No

- Does the PGY2 have living accommodation provided?  [ ] Yes  [ ] No  [ ] N/A

- Will PGY2 doctors accompany their Supervisor to visit patients off-site in a local hospital or other facility? If so, please specify which facility/facilities.  [ ] Yes  [ ] No

## INTERN REQUIREMENTS

- Does/will the Intern have a dedicated consulting room?  [ ] Yes  [ ] No

- Does the Intern have living accommodation provided?  [ ] Yes  [ ] No  [ ] N/A

- Will the Intern accompany his/her Supervisor to visit patients off-site in a local hospital or other facility? If so, please specify which facility/facilities.  [ ] Yes  [ ] No

---

National General Practice Training Accreditation Project 2012
Cover letter

11 February 2013

Dr XXXX XXXXXX
Principal Supervisor
XXXXXXXXXX Medical Centre
XXX XXXXXXXX Street,
XXXX, Victoria 3XXX

Dear Dr XXXXXX,

General Practice Training Accreditation Project
Pilot Accreditation Visit 2012

The General Practice Training Accreditation Project commenced in December 2011 with the aim of undertaking and evaluating pilots in Victoria of models of streamlined and integrated prevocational and vocational training practice accreditation.

This project is being undertaken as part of an agreement entered into by Confederation of Postgraduate Medical Education Councils (CPMEC) and General Practice Training and Education (GPET) in November 2011 and will address the following evaluative goals:

- The extent to which the streamlined and integrated prevocational and vocational training practice accreditation process has delivered robust and consistent accreditation outcomes across the pilot medical practices.
- The perspective(s) of stakeholders, including supervisors, RTPs, Colleges and PMECs involved in accreditation in relation to process and outcome quality; cost; scalability of the process; and other organisational, practice and program impact.

We thank you for agreeing to participate in the pilot of a General Practice Training Accreditation Survey Visit to be conducted jointly by the Postgraduate Medical Council of Victoria and Southern General Practice Training on XX May 2012.

The assessment process for accreditation of prevocational and vocational training positions has three steps:

1. Self-assessment by the practice against the set standards which is designed to identify outstanding issues and provide a framework for improving medical staff education and training programs. For prevocational training the assessment is undertaken against the PMCV standards and for vocational training the RACGP/ACCRM standards are used.

2. Review of the general practice by a survey team which examines evidence as documented by the practice and uses the clearly defined and established standards set out by PMCV and RACGP/ACCRM. This also involves meetings with the interns [if already in the practice] and other junior medical staff, other clinicians, administrators, and other staff involved in education and training of junior medical staff;

3. Consideration of the survey team report by the PMCV Accreditation Subcommittee and the SGPT Accreditation Committee, and recommendation to the Medical Board of Australia regarding prevocational training accreditation and to the RACGP regarding vocational training accreditation.
Please find enclosed the following documents relating to prevocational accreditation, which need to be completed prior to the pilot survey visit:

- **PMCV Pre-visit Accreditation Overview** document, which should be viewed as a supplement to the SGPT pre-visit overview document that they will forward to you directly for completion and return.

It would be appreciated if these documents could be completed and returned by **X May 2012** to: Ms Judy D’Ombrain, Project Officer, C/o The Postgraduate Medical Council of Victoria, PO Box 2900, St. Vincent's Hospital, 41 Victoria Parade, Fitzroy VIC 3065, or by email at **jdombrain@pmcv.com.au** (Tel: (03) 9419-1217)

Following the completion of the pilot survey visit, all participants will be given the opportunity to provide feedback on the new streamlined accreditation process including the accreditation documents and the survey visit itself.

A project report will be prepared which will be made available to participating stakeholders once the report is accepted by the GPTAP Steering Committee.

Thanks again for your participation in this exciting initiative.

Yours sincerely,

Ms Judy D’Ombrain
Project Officer
PMCV
VISIT TIMETABLE TEMPLATE

Pilot Accreditation Survey Visit – 18th Day of May 2012
Clocktower Medical Centre

PMCV Surveyors: Dr Peter Stevens, Ms Monique Le Sueur (PMCV)
SGPT Surveyors: Ms Linda Kruger, XXXXXXX XXXXXXXXX
GPET Pilot Project Officer: Ms Judy D’Ombrain (observer only)

Interview Sessions:

12.15 pm Interview with Supervisor, Dr XXXXXXX XXXXXXXX
12.30 pm Introductory meeting with:
   Practice Principle & Supervisor Dr XXXXXXXXX
   Practice Manager Mrs XXXXX XXXXXXXX
   LUNCH WILL BE PROVIDED DURING THIS SESSION

1.15 pm Interview with junior doctor

1.45 pm Interview with registrar – Interviewed at Churchill workshop on the previous day

2.15 pm Brief tour of practice facilities conducted by Practice Manager and accommodation if possible

2.30 pm Team debrief

2.45 pm Debrief session with Practice representatives

3.00 pm Survey team departs
APPENDIX 8

GPET PILOT ACCREDITATION PROJECT 2012

QUESTIONS FOR GENERAL PRACTICE STAFF AT POST-ACCREDITATION INTERVIEW: INITIAL IMPRESSIONS

Please state what your role is within the General Practice:
__________________________________________

Pre-Visit Phase:

1. Was the total pre-visit workload (in terms of documentation) greater, lesser or equal to previous accreditation surveys? Please comment if appropriate.
   ______________________________________________________________________________________
   ______________________________________________________________________________________

2. Were all the documents clear and easy to complete? Y/N. Please comment.
   ______________________________________________________________________________________
   ______________________________________________________________________________________

Survey Visit Phase:

3. Were both the vocational and prevocational aspects of the accreditation process given appropriate weight during the visit? Y/N. Please comment.
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

4. Was the overall survey visit longer / shorter / approximately the same length as in previous survey visits? Please choose one and comment where relevant.
   ______________________________________________________________________________________

5. Overall, did the joint vocational and prevocational pilot accreditation model work for your practice? Y/N. Please comment on any aspects that you thought worked particularly well, & those that did not work well.
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

Please return the completed survey questionnaire within 5 days, either by email or in the Reply Paid envelope to Judy D’Ombrain, Project Officer, GPET Accreditation Pilot Project.
Email: jdombrain@pmcv.com.au
Thank you for your participation.

National General Practice Training Accreditation Project 2012
Data analysis Summary for GP post-interview hard-copy survey (May 2012)

This short survey designed to capture the initial responses of all GP staff involved in the pilot accreditation survey was distributed manually at the conclusion of each pilot visit 7 either completed on the spot or posted back within 5 days in a pre-paid envelope. 12 surveys were distributed and 12 were completed and returned (100% response rate).

1) **Pre-visit workload (Qu.1):** 7 (58%) found the workload EQUAL to previous surveys
   2 (17%) “ “ “ “ GREATER than “ “
   3 (25%) had not been involved in previous accreditations.

*Note difference in responses regarding pre-visit workload as opposed to the overall accreditation process: in this question no-one has said that the pre-visit workload was LESS than for previous surveys, whereas in the comments section (Qu.5) 4 respondents (33.3%) indicate that the joint accreditation survey format has avoided duplication & saved time.*

2) **Ease of completion of pre-visit paperwork (Qu.2):** All 12 respondents report that pre-visit paperwork was clear & easy to complete.

3) **Appropriate weight given to vocational & prevocational aspects at visit (Qu.3):** 100% of respondents thought that vocational & prevocational issues were given appropriate weight during the visit, with positive comments about the comprehensiveness of the questioning as well as helpful information provided to the practices.

4) **Length of visit (Qu.4):** 5 respondents (41.7%) found the visit duration EQUAL in length to previous visits. 3 (25%) found the visit LONGER than previous visits. 4 (33.3%) had not participated in an accreditation survey previously and could therefore not comment.

*No-one reported that the visit was shorter, but comments indicate that there was less duplication than having separate visits & therefore overall probably shorter in time than 2 separate visits, but debatable whether this can be inferred.*

5) **Did the model work for your practice? Comment (Qu.5):** All 12 participants made a comment. Multiple responses were received:
   - Comprehensive
   - Helpful
   - Much better – avoids duplication – 3 comments
   - Liked hearing about supervision techniques used in other practices
   - Helpful to be guided by other supervisors
   - Once streamlined, cannot foresee any problems with this model
   - Saves time & everything is covered just as comprehensively
   - Enjoyed being invited to give feedback

6) While one respondent commented positively on the ‘round table discussion’ format & the benefits of being able to share ideas informally, another interpreted this as a negative aspect of the survey visit, preferring a more formal ‘Q&A’ format.
Copy GPET Accreditation Pilot: Post-survey stakeholder feedback

Background & Instructions for Project Stakeholders

In late 2011, GPET and the Confederation of Postgraduate Medical Education Councils (CPMEC - representing all State & Territory postgraduate medical councils) entered into an agreement to undertake and evaluate models of streamlined and integrated prevocational and vocational General Practice training accreditation. The objective was for both prevocational and vocational accreditation to occur at the one visit, with some streamlining of required paperwork for practices. There are three states participating in this project: NT, Vic and WA.

The outcomes sought by GPET included:
Meet the objective to streamline practice accreditation;
Reduce the practice accreditation burden;
Reduce College, PMC & RTP accreditation costs; and
Maintain the quality of placements for medical learners.

PMCV managed the project in Victoria and, in conjunction with SGPT and VMA, undertook three pilot accreditation survey visits in May 2012.

This survey is being undertaken to evaluate the pilot visits and the Victorian arm of the project as a whole. The collected data will be used to inform the Project Report to be submitted to the National Steering Committee in mid-July.

In order to gain maximum benefit from the evaluation phase of the project, we ask that you provide responses that are sufficiently detailed to reflect your true experiences and perceptions. Your responses can be submitted anonymously, although we ask that you identify which stakeholder group you belong to with regard to the pilot accreditation project. Thank you for your participation, and for completing the survey by Monday 28 June 2012.

1. Name and/or Organisation (optional)

2. Please select from the following list the category that best describes your role in the GPTA Pilot Project:

- RTP Representative
- RTP Surveyor
- PMCV Representative
- PMCV Surveyor
- Other (please specify)
Evaluation Questions

3. What were your expectations when you initially agreed to participate in the accreditation pilot project?

4. Did the streamlined accreditation pilot meet your expectations?
   - Yes
   - No
   If not, why not? Please comment.

5. I was satisfied with the pre-visit instructions I received.
   - Yes
   - No
   If 'No', please give reasons

6. I was satisfied with communication about the proposed timetable for the pilot accreditation visit.
   - Yes
   - No
   - N/A
   Please give reasons for your response.
Copy GPET Accreditation Pilot: Post-survey stakeholder feedback

*7. I was satisfied with communication about how the interviewing would be structured during the visit.
   
   - Yes
   - No
   - N/A

Please give reasons.

8. Would you like to comment on any other communication issues that arose during the pilot accreditation process?


*9. I was satisfied with the survey documentation that was jointly developed for the pilot.

   - Strongly agree
   - Agree
   - Neutral
   - Disagree
   - Strongly disagree

Please give reasons for your response.

*10. What were your specific accreditation requirements in this pilot?


*11. The joint accreditation survey visit involving both the PMCV and relevant RTP met my accreditation requirements.

   - Yes
   - No

Please comment further on your response (if 'No', why?)

12. What factors (either positive or negative) do you think affected the implementation of the streamlined accreditation model? Please list with brief comments.

Page 3
**13. The streamlined accreditation model reduced the accreditation burden for my organisation (in terms of time, cost, or any other dimension).**

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>N/A</th>
</tr>
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Comments

**14. I was satisfied with the consultation and overall management of the GPTA Project.**

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>N/A</th>
</tr>
</thead>
</table>

Comments

**15. What benefits or positive outcomes were achieved during this pilot project?**


**16. What challenges or negative outcomes were encountered during this pilot project? Please comment.**


**17. Were there any unanticipated outcomes (either positive or negative) that arose during this pilot project? (If none, write N/A in the box).**


**18. Do you have any suggestions for how a streamlined accreditation process could be better developed and/or implemented?**


Page 4
Copy GPET Accreditation Pilot: Post-survey stakeholder feedback

*19. Would you be willing for this model to be used for future General Practice accreditation visits (+/- any recommendations you made in Question 18). If not, why not?

*20. Do you anticipate closer collaboration (of PMCV/RTPs/GPs &/or parent hospitals) with regard to General Practice training accreditation in the future? Please comment.

- Yes
- No
- Unsure
- Not applicable

Comments

*21. Would your organisation require any additional resources to continue to implement a streamlined accreditation process?

- Yes
- No
- Unsure
- Not applicable

Comments

*22. Do you think your participation in the General Practice Training Accreditation Project has been worthwhile?

- Yes
- No
- Unsure

Comments
**Copy GPET Accreditation Pilot: Post-survey stakeholder feedback**

<table>
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<tr>
<th>23. It is proposed that the results/recommendations arising from the pilot accreditation visit will be reported to each General Practice separately, with the vocational-level report being provided by the respective RTP, and the prevocational report being provided by the PMCV. Although this reporting stage has not yet occurred, could you comment on your preferred reporting method by selecting one of the following options, and then provide reasons for your choice in the comments box below please?</th>
</tr>
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<tbody>
<tr>
<td>○ Separate reports for vocational &amp; prevocational posts (as proposed for the pilot) is my preferred option</td>
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<tr>
<td>○ One report with separate vocational &amp; prevocational sections is my preferred option</td>
</tr>
<tr>
<td>○ One fully integrated RTP/PMCV report covering both vocational &amp; prevocational posts is my preferred option</td>
</tr>
<tr>
<td>○ Other preferred reporting option</td>
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<td>Please comment on the reasons for your choice.</td>
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<tr>
<th>24. Do you wish to make comments about any other aspects of the GPTA Pilot Project not already addressed?</th>
</tr>
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<tr>
<td>Please comment.</td>
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Thank you for taking the time to respond to this survey. Your input is greatly valued.

If you have any queries about the GPTA Project or about this survey, please contact Judy D’Ombrain at PMCV at: jdoombrain@pmcv.com.au
APPENDIX 9

Data Analysis Summary for Online Evaluation Survey (June-July 2012)

Survey link emailed to 23 stakeholders on 13/6/12. As of 25/6/12, 12 responses received (but 2 appear to have only answered Question 2)

(1) Expectations (Qu.3): 10 responses. 10 comments.

- Range of expectations from none, & “to achieve prevocational accreditation at a single GP site”, to the other end of the spectrum where the long-term goal was cited as “to achieve total streamlining of accreditation of all levels of GP training nationally”.
- The majority of responses, however, cited one or more of the following 3 broad aims as being the focus of their expectations:
  - Achieve GP accreditation of vocational & prevocational posts and meet the needs of all stakeholders
  - Reduce duplication of material, visits & process, & in so doing reduce the accreditation burden, improve efficiency, reduce time & cost, simplify the process
  - Foster collaboration & improved working relationships between stakeholder organisations
  - Maintain quality of placements for learners

(1a) Expectations met (Qu.4): 10 responses – c.90%=Yes, 10%=No. 4 Comments.

- 2 regarded their expectations as having been partially met (mainly in terms of aligning of visits)
- 1 had no expectations but had been awakened to the potential of joint accreditation being of great benefit to GPs
- 1 regarded the pilot project as having exceeded expectations in terms of highlighting the amount of commonality that exists between vocational & prevocational accreditation
- Despite c.90% agreeing that their expectations had been met, there were 5 areas of concern raised in the comments:
  - Receipt & completion of pre-visit documentation by GPs
  - Information collection needs only partially satisfied
  - Structure of visits not fully coordinated
  - Number of assessors excessive
  - Documentation not fully streamlined
  - Reporting not streamlined

(2) Satisfaction with pre-visit instructions (Qu.5): 10 responses. C.80%=Yes, 20%=No. 3 comments.

- Agreement that instructions were provided adequately in cover letter & forms
- 2 responses cite communication issues (RTP/PMCV/GPs) as leading to coordination problems regarding completion and return of documents

(3) Communication about visit timetable (Qu.6): 10 responses. C.80%=Yes, 10%=No, 10%=N/A. 6 comments.

- Good paperwork & email communication from PMCV to stakeholders (RTPs & GPs)
- Good mutual negotiation to achieve satisfactory timetabling of visits (2 comments)
Timetable irrelevant &/or not utilised (2 comments) – interviewing requirements less complex for RTPs than for PMCV

(4) Communication about proposed structure of interviewing at visits (Qu.7): 10 responses. C.70%=Yes, 20%=No, 10%=N/A. 7 comments.
- 4 responses cite the spontaneity rather than pre-planning of survey pilot visits which, although not necessarily the preferred strategy, all agreed worked well enough on the day & was considered to be an inevitable feature of a pilot situation
- 1 response felt that adherence to a pre-arranged timetable (as was intended for the pilots) would have lessened the spontaneity & given structure & balance to the visit
- 1 response stated that concise & focussed interview questions were prepared in advance for prevocational interviews
- 1 response stated that not all elements of the pilot visit were relevant from an RTP perspective owing to pre-existing knowledge of the practice (i.e. an incidence of newly-created duplication?)

(5) Other communication issues (Qu.8): 8 responses, all comments:
- 4 respondents found the communication throughout the pilot project to be “effective”, or “more than adequate”, with “no comments required”.
- 5 domains where communication was adversely impacted were identified:
  - Confusion about responsibility for distribution & return of pre-visit documentation (2 comments)
  - Confusion about responsibility for organising the visit timetable (1 comment)
  - Lack of structure & balance in the interview process (2 comments)
  - Inappropriate issues raised during the visit, outside the accreditation brief (1 comment)
  - Tight timeframe of project (& geographical distribution of stakeholders) resulted in administrative communication challenges throughout (1 comment)

(6) Satisfaction with joint survey documentation (Qu.9): 10 responses – on a scale of 1-5, 6=agree, 2=Neutral, 2=Disagree. 7 comments:
- Sharing of completed survey documentation between accrediting bodies had not been pre-arranged (but occurred mutually on request) (1 comment)
- Would like one fully-integrated set of accreditation documents to be developed for vocational & prevocational GP training posts in Victoria (4 comments)
- Would like one combined set of GP accreditation Standards to be developed for vocational & prevocational GP training posts in Vic (2 comments)
- Would like collation of fully-integrated pre-visit documentation to be administered by one accrediting body only (1 comment)
- The Cover Letter sent to pilot GPs was the “main joint document” developed (1 comment)
- The Cover Letter & pre-visit documentation were “comprehensive, useful” & easy to use (1 comment)
- Some areas of duplication remained in the accreditation documentation (1 comment)
- A major challenge is that because there are 4 RTPs + PMCV in Victoria, there are currently 5 separate sets of accreditation documents, & this makes integration/streamlining more challenging than in some other jurisdictions (1 comment)
(7) **Specific accreditation requirements (Qu.10):** 10 responses, all comments.

- To ensure the GP meets both RACGP & PMCV accreditation Standards (1 comment)
- To achieve accreditation at both vocational & prevocational levels (3 comments)
- To achieve vocational re-accreditation & initial prevocational accreditation at one GP (1 comment)
  (The first 3 dot points are technically the same thing from different perspectives)
- To ensure GPs meet PMCV accreditation requirements (3 comments)
- To achieve the transition from provisional to full RTP accreditation at one GP (1 comment)
- To achieve two or more pilot accreditation visits involving PMCV & two or more of the 4 Victorian RTPs, & to integrate/streamline as many aspects as possible (1 comment)

(8) **Joint accreditation visit met my accreditation requirements (Qu.11):** 10 responses, 100%=Yes.

- Verbal affirmation given immediately post-visit that all accreditation requirements had been met (1 comment)
- Visit was time-efficient (1 comment)
- Good balance of RTP/PMCV representation
- The integrated visit provided valuable insight into other dimensions of GP training (1 comment)

(9) **+ve / -ve factors affecting implementation of streamlined accreditation model in pilot (Qu.12):**

8 responses, all comments:

- **Positives:**
  (i) Collaboration & cooperation between parties at PMCV/RTP/GP levels (4 comments)
  (ii) Overlap of accreditation requirements between RTP & PMCV meant that the visit time was no longer than previous single accreditation visits (1 comment)
  (iii) Good pre-visit organisation & communication prior to the visit (2 comments)
  (iv) Flexibility of assessors on the day of visit accommodated unforeseen needs of GP staff (1 comment)
  (v) Desire to reduce accreditation burden was a +ve driver (1 comment)
  (vi) Presence of RTP representative at visit meant that additional useful information was able to be provided to PMCV which the GP may not have been able to provide (1 comment)

- **Negatives:**
  (i) Pre-existing confusion regarding the respective roles & responsibilities of PMCV, RTPs & parent health services impact the potential streamlining process (i.e. inherent in the GPET / PGPPP mandate & funding policy) (1 comment)
  (ii) RTP/PMCV requirements are different, & this may have impacted on the process” (2 comments)
  (iii) The PMCV Standards “do not (in all cases) fit with a PGPPP post”
  (iv) Failure to develop fully-streamlined documentation meant that document collection was complex, and therefore the burden on the GP was not sufficiently reduced (1 comment)
  (v) “Appeared to be some confusion in the content of questions asked” in respect of PMCV & RTP (1 comment) (Does this mean duplication?)
(vi) Tight timelines possibly prevented a greater degree of streamlining from occurring than would otherwise have been the case (1 comment)
(vii) Geographical distance between parties made informal communication difficult, & this may have impacted the project from an administrative perspective (1 comment)

(10) The streamlined model reduced the accreditation burden (Qu.13): 10 responses, 8 comments.
- Strongly agree = 2 (20%)
- Agree = 3 (30%)
- Neutral = 3 (30%)
- Disagree = 2 (20%)

- The majority of comments relate to either time or cost savings, & the disparity in perspectives towards these dimensions reflects the even distribution of responses – i.e. 4 said that the joint process did or would save time (& presumably money) for the GP; 3 reported that it created more work & took more time for their organisation; 1 reported a cost neutral outcome;
- Space to accommodate a larger accreditation team was a negative outcome (1 comment)
- One visit instead of two was assumed to be easier for the GPs (2 comments)
- In the future, a reduced burden for surveyors is possible if training for both vocational & prevocational accreditation is provided & undertaken (1 comment)
- Information-sharing (between PMCV/RTP) was a positive time-saving dimension (1 comment)
- Each RTP having different paperwork and accreditation model made the likelihood of achieving streamlining less likely (1 comment)

Thus, the overall feeling was slightly weighted against the accreditation burden having been reduced in the pilot project. This was certainly the case for PMCV but less so for RTPs & GPs, although still a debatable advance. The only clear gain appears to have been reducing the accreditation visits from 2 to 1.

(11) Satisfaction with consultation & management of project (Qu.14): 10 responses. Strongly Agree= 5 (50%); Agree= 4 (40%); Disagree= 1 (10%). 3 comments:
- Good communication & management at Victorian level (2 comments)
- Number of stakeholders, restricted timeframe & disparate geographical locations meant difficult consultation & management at State level (1 comment)
- The original project brief was ambiguous about exactly what was required of participating States/Territories, with the result that totally different accreditation models were developed (1 comment)
- Newly-developed documents and strategies were only shared via infrequent National Steering Committee meetings, with the result that there was virtually no streamlining or interaction between States (1 comment)

(12) Benefits or positive outcomes achieved (Qu.15): 10 responses, all comments.
- Greater collaboration & communication between GP accrediting bodies across Vic (6 comments)
- Greater awareness & understanding of the different processes & requirements (5 comments)
comments)
- Alignment of vocational & prevocational visits, meaning less disruption to GPs (3 comments)
- Two aligned visits outside the project have been arranged to take place in Vic later this Year (1 comment)
- Recognition of similarities & overlaps in the 2 accreditation processes (3 comments)
- Future possibility of integrated surveyor training in Vic, which could result in reduced PMCV/RTP GP accreditation burden (2 comments)
- Having both PMCV & RTP reps present at visits made information collection more comprehensive than either one alone could achieve (1 comment)

(13) Challenges or negative outcomes (Qu.16): 10 responses, all comments.
- Accreditation documentation at every stage of the accreditation process, both with regard to streamlining as well as to collation & providing feedback (4 comments)
- Working with two separate sets of accreditation Standards (2 comments)
- Limited scope to streamline due to time constraints, geographical factors & number of stakeholders to be considered (1 comment)
- Pre-existing poor definition of roles & responsibilities of accrediting bodies & parent hospitals with respect to PGPPP posts (1 comment)
- Less than full attendance of GP staff, and their lack of awareness of requirements at visit (1 comment)
- Accrediting bodies having different levels of background knowledge about a GP, resulting in duplication at visit (1 comment)
- Implementing change at the surveyor level was a challenge (1 comment)
- No negative outcomes regarding staff availability, length of visit or cooperation (1 comment)

(14) Unanticipated outcomes (+ve or –ve) (Qu.17): 10 responses – 7 thought there were none (N/A), 3 comments
- PMCV & RTPs sharing knowledge & meeting learners together (1 comment)
- New relationships & bonds were established (1 comment)
- Willingness of all parties to participate in pilot project (1 comment)
- Willingness of all parties to make compromises and changes during the process (1 comment)
- Two future joint GP accreditation visits scheduled in Vic following the pilot model (1 comment)

(15) Suggestions for a better streamlined GP accreditation process (Qu.18): 9 responses, 8 comments.
- Clarification from GPET regarding the role & responsibilities of PMCV in relation to accreditation of prevocational GP training posts prior to allocation of funding to PGPPP (1 comment)
- Further streamlining of accreditation documentation (4 comments)
- Further streamlining to ensure both initial & re-accreditation processes are provided for in relation to documentation & process (1 comment)
- Streamlining of surveyor training by providing RACGP-qualified surveyors with PMCV prevocational surveyor training (3 comments)
- Streamlining of survey teams at visits (smaller numbers) but still retaining dual PMCV/RTP representation (3 comments)
Both teams to meet with all learners at the accreditation visit (1 comment)
One contact person for GPs in relation to accreditation survey visit, to ensure all documentation is correctly completed & returned (2 comments)
Further streamlining of the visit structure to ensure efficiency, balance & coverage of all requirements (2 comments)
Longer lead time for accreditation surveys to ensure coordination of visit dates to the mutual satisfaction of all parties (1 comment)
Streamline reporting process. (1 comment)
Develop one set of joint Standards (1 comment)

(16) Willingness to adopt pilot model for future accreditation visits (Qu. 19): 10 responses (9 (90%) = Yes; 1 (10%) = N/A), 1 comment.
- Only with review of pre-visit documentation & structure of the visit (1 comment)

(17) Closer future collaboration re GP training accreditation (Qu.20): 10 responses, 7 comments.
9 = Yes (90%)
1 = Unsure (10%)
- 2 regarded collaboration as essential to the effectiveness of GP training, & therefore to accreditation
- 5 regarded collaboration as desirable, easier &/or likely
- Greater collaboration/communication with the parent health services in relation to GP posts was cited as being necessary to ensure quality & consistency of prevocational training (1 comment)

(18) Additional resources needed for implementing streamlined GP accreditation (Qu.21): 10 responses, 6 comments.
Yes = 3 (30%)
No = 2 (20%)
Unsure = 4 (40%)
N/A = 1 (10%)
- For PMCV to accredit all Victorian GPs that train prevocational doctors, a greatly increased workload would result, requiring additional funding for administration, surveyor training & attendance, and possibly further streamlining of documentation (including Standards) (3 comments)
- Additional RTP surveyor training would require further funding (1 comment)
- Any further streamlining of the GP accreditation process would require further funding resources for all accrediting bodies (2 comments) (No indication of GP perspective)
- Reducing the size of accreditation teams & streamlining paperwork would potentially reduce costs (1 comment)

(19) Participation worthwhile (Qu.22): 10 responses, 2 comments.
Yes = 10 (100%)
- Highlighted the need for consistent accreditation of all GP training posts (1 comment)
- Revealed the duplications & gaps in the current processes/documentation (1 comment)
- Has partially achieved the desired outcomes (1 comment)
- Has promoted good relations between accrediting bodies (1 comment)
- Has been an interesting an informative process (1 comment)
- Joint GP accreditation visits should continue (1 comment)
- Has potentially reduced the accreditation burden for GPs in Victoria in terms of documentation & number of visits (1 comment)

(20) Preferred reporting method (Qu.23): 10 responses, 8 comments.

Separate reports = 3 (30%)
One report with separate sections = 3 (30%)
One fully integrated report = 4 (40%)

(N.B. Almost even distribution of preferences)

From the comments provided, there seems to be a similarly even spread of preferences, even when qualifiers are applied:

- S: Separate reports to be maintained: integrated report would require integrated Standards, & this would not be useful (1 comment)
- J: Joint report to be initiated: for consistency of reporting & faithfulness to the collaborative spirit of the joint accreditation process (1 comment)
- S→I: Separate reports if current model is maintained, but Integrated report to be initiated: if further streamlining occurs to provide surveyors with dual accreditation credentials & if the size of the survey teams is subsequently streamlined (4 comments)
- S→J: Separate reports to fulfil oversight committee requirements, but joint report would be preferred (faithfulness to collaborative spirit) (1 comment)
- S with S: Separate reports with an exchange of report summaries (including recommendations) between PMCV & RTP, prior to sending to GP, to ensure consistency (1 comment)

With 2 exceptions, there was agreement that if the current joint accreditation model is used without further streamlining, then separate reports should be maintained.

(21) Any other comments (Qu.24): 4 responses, all comments.

- There are areas that still require work in the future (1 comment)
- Enjoyed the positive & flexible approach adopted in the project (1 comment)
- The surveyor time commitment would be onerous unless the visit structure is further streamlined (1 comment)
- Significant differences in structures, processes & numbers between States/Territories will surely mean that making meaningful comparisons &/or recommendations for a national streamlined GP accreditation model would be extremely difficult (1 comment)
PMCV General Practice Training and Accreditation Pilot

Funded by GPET through CPMEC
2012

INTEGRATED ACCREDITATION CRITERIA
RACGP/ PMCV/ ACRRM
### Integrated Accreditation Criteria

**8.1** The teaching post must be situated in a rural or remote location.

**T36** The practice should be able to function adequately without the registrar present when they attend educational activities.

**T12Q** A suitable range of clinical services consistent with Australian general practice are provided (e.g. nursing home visits, immunisations, minor surgery, family planning).

**T27** The facility must offer the full range of ongoing primary care to all patients who attend.

**T28** The medical care in the facility must be provided and managed by GPs and the majority of care must be provided by GPs who work at least three sessions (1.5 days / week) to ensure continuity of care.

**T35** The facility should be accredited under RACGP minimum practice standards by a recognised accreditation body (e.g. AGPAL).

**T37** There should be adequate administrative staff to support all the clinical staff in the facility.

**T20** The trainer must ensure that the registrar has adequate insurance coverage and is registered with the AHPRA.

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**ACRRM STANDARDS 2010**

**8.7.1** The teaching post enters into an appropriate employment arrangement with the registrar.

**8.7.2** The teaching post ensures that the registrar, supervisor and training post are covered by appropriate insurance and medical indemnity.

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**RACGP STANDARDS 2005**

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**PMCV STANDARDS (prevocational)**

**FUNCTION 1: General practice structure and culture in relation to Intern/PGY2 support and the delivery of safe patient care**

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**1.1** The practice supports the professional development of the intern/PGY2 through appropriate training and professional development programs.

**1.2** The parent health service has appointed a suitably trained Supervisor of Intern Training and/or Director of Clinical Training who is accessible to the practice and the intern/PGY2 during the rotation.

**1.3** The practice provides rosters and supports work practices that ensure the intern/PGY2 has a balance between education, service and lifestyle.

**1.4** The practice and the parent health service have established processes to enable the intern/PGY2 access to confidential counselling and advice (including career guidance) which is known to the junior doctor and their GP supervisor.

**1.5** The practice and parent health service have in place a process for identifying and managing interns/PGY2s experiencing difficulties who can be assisted promptly and confidentially and that is known to the junior doctors and their GP supervisor.

**1.6** The overall management (orientation, allocation, feedback and appraisal) of the intern/PGY2 year is coordinated between the parent health service and the practice.

**1.1** The teaching post supports the professional development of the intern/PGY2 through appropriate training and professional development programs.

**1.2** The parent health service has appointed a suitably trained Supervisor of Intern Training and/or Director of Clinical Training who is accessible to the practice and the intern/PGY2 during the rotation.

**1.3** The practice provides rosters and supports work practices that ensure the intern/PGY2 has a balance between education, service and lifestyle.

**1.4** The practice and the parent health service have established processes to enable the intern/PGY2 access to confidential counselling and advice (including career guidance) which is known to the junior doctor and their GP supervisor.

**1.5** The practice and parent health service have in place a process for identifying and managing interns/PGY2s experiencing difficulties who can be assisted promptly and confidentially and that is known to the junior doctors and their GP supervisor.

**1.6** The overall management (orientation, allocation, feedback and appraisal) of the intern/PGY2 year is coordinated between the parent health service and the practice.
<table>
<thead>
<tr>
<th>RACGP STANDARDS 2005</th>
<th>PMCV STANDARDS (prevocational)</th>
<th>ACRRM STANDARDS 2010</th>
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</thead>
<tbody>
<tr>
<td>FUNCTION 2: Orientation - Interns/PGY2s participate in formal orientation programs which are designed and evaluated to ensure sound learning occurs</td>
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</tr>
<tr>
<td>T19  The trainer must provide orientation to the practice. 8.3.1 The teaching plan includes an outline of how the post organises orientation to the post, teaching, learning and supervision.</td>
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</tr>
<tr>
<td>2.1  The practice provides orientation at the beginning of each new rotation including a position description and learning objectives (consistent with the Australian Curriculum Framework for Junior Doctors) and use of a Rolling handOVER (ROVER) or equivalent (junior doctor led rotation handover). 8.3.3 The teaching plan includes a description of the post, the patient or practice population and teaching resources.</td>
<td></td>
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</tr>
<tr>
<td>2.2  The intern/PGY2 can access written or electronic material and/or handbooks that include procedures, protocols and policies which supplement the content of the orientation program at the beginning of the rotation. 8.7.5 The teaching post has a policy/protocol available concerning the appointment system, home visits and responding to emergencies and the supervision of registrars in such situations.</td>
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</tr>
<tr>
<td>T34  Practice staff must be informed of the function and needs of the registrar, provided feedback to the GP on how the registrar interacts with them, and encourage the registrar to take an interest in aspects of practice administration. 8.7.4 The teaching post reception and/or clinical staff are informed of the function and needs of the registrar and are encouraged to include the registrar in aspects of Training Post administration and small business management where appropriate.</td>
<td></td>
<td></td>
</tr>
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<tr>
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</tr>
<tr>
<td><strong>FUNCTION 3: Education and Training Program - Interns/PGY2s</strong></td>
<td>are provided with appropriate formal education and training opportunities</td>
<td></td>
</tr>
<tr>
<td>T6</td>
<td>The trainer must be available for 1 hour per week of protected continuous time for face to face teaching and discussion with the registrar for all general practice attachments.</td>
<td>7.2.3 The supervisor complies with the structured educational activity requirements according to the registrar's training pathway and stage of training (Available for 3hrs/wk and 1.5 hrs/wk for teaching PRRT1 &amp; PRRT2 registrars respectively).</td>
</tr>
<tr>
<td>T15</td>
<td>The trainer must support access for a medical educator to undertake direct observation sessions.</td>
<td>7.3.3 The supervisor and registrar collaboratively plan exposure to activities required in the registrar learning plan, the ACRRM Primary Curriculum and the ACRRM Procedural Skills Logbook.</td>
</tr>
<tr>
<td>T9</td>
<td>The trainer must be available for teaching, support and discussion for 3 hours per week for the registrars first six months of general practice training and 2 hours per week for the second six months.</td>
<td>7.3.5 The supervisor assists the registrar with the documentation of training records, including sign off the ACRRM Procedural Skills Logbook.</td>
</tr>
<tr>
<td>T16</td>
<td>The trainer must provide a planned education session each week in the 1 hour face to face sessions (consistent with Registrars learning plan and at an appropriate level).</td>
<td>8.3.2 The teaching plan includes a description of the clinical, educational and social strengths and opportunities to offer registrars.</td>
</tr>
<tr>
<td>T17</td>
<td>The trainer must assess the registrar's competence through consideration of training and experience or, if necessary, by observation in areas that have an increased risk of adverse outcomes and litigation.</td>
<td></td>
</tr>
<tr>
<td>T38</td>
<td>The registrar must average at least eight patients per session in usual general practice situations.</td>
<td>8.5.3 The teaching post provides adequate but not excessive patient workload for the registrar (max 4 patients per hour as per NMT&amp;C but this may vary).</td>
</tr>
<tr>
<td>T39</td>
<td>The registrar must not book more than four patients per hour in the first year in general practice.</td>
<td>8.5.1 The teaching post provides a range of learning experiences for the registrar (list in ACRRM standards).</td>
</tr>
<tr>
<td>T40</td>
<td>The workload of the registrar must be monitored and managed to ensure they do not see a particular group (age or gender) or presentation in an excessive proportion.</td>
<td></td>
</tr>
<tr>
<td>T30</td>
<td>The service demands of the training post must not excessive and the structuring of duty hours and on call schedules consider needs of patients, continuity of care and educational needs of registrar.</td>
<td>3.1 Overall workload and rostered hours ensure appropriate access to learning and that the intern/PGY2 does not see more than 3 patients per hour (2 at the beginning of the rotation).</td>
</tr>
<tr>
<td>T41</td>
<td>Registrars should participate fully in the breadth of general practice including after hours and off site care.</td>
<td>3.4 Education programs are accessible (ie rostered) and attendance is encouraged by all practice staff and monitored.</td>
</tr>
<tr>
<td>T5</td>
<td>The trainer must participate in continuing professional development aimed at improving performance as a general practice educator (see also T26).</td>
<td>6.8.1 The teaching post provides time for educational release activities in accordance with the registrar's stage of training and the requirements of the training provider.</td>
</tr>
<tr>
<td></td>
<td>The practice trains and supports registrars and general practitioners in their role as teachers and supervisors (of interns/ PGY2s)</td>
<td>6.8.2 The teaching post provides time for opportunistic and structured teaching, especially of procedural skills training and emergency courses.</td>
</tr>
<tr>
<td></td>
<td>The trainer must participate in continuing professional development aimed at improving performance as a general practice educator (see also T26).</td>
<td>7.1.5 The supervisor demonstrates commitment to ongoing professional development.</td>
</tr>
<tr>
<td></td>
<td>The supervisor participates in supervisor training and other activities to further develop teaching/mentoring skills.</td>
<td>7.2.10 The supervisor participates in supervisor training and other activities to further develop teaching/mentoring skills.</td>
</tr>
</tbody>
</table>
### RACGP STANDARDS 2005

<table>
<thead>
<tr>
<th>T1</th>
<th>The trainer must have full and unrestricted registration by the Medical Board.</th>
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</thead>
<tbody>
<tr>
<td>T2 &amp; T7</td>
<td>The trainer must be an excellent physician including holding Fellowship with RACGP. Trainers must be active Fellows of the RACGP.</td>
</tr>
<tr>
<td>T8</td>
<td>The trainer must have at least 4 years full time equivalent experience in general practice (can include postgraduate training experience in general practice).</td>
</tr>
<tr>
<td>T4</td>
<td>The trainer must hold vocational recognition as a GP by the Health Insurance Commission.</td>
</tr>
<tr>
<td>T10</td>
<td>The trainer must demonstrate preparation for and ability as a general practice trainer; motivation for hosting doctors in training, previous experience, understanding of adult learning principles and teaching methods.</td>
</tr>
</tbody>
</table>

### PMCV STANDARDS (prevocational)

| T21 | The trainer must be located in the same practice as the registrar unless training is part of a specific program approved by the college that involves distance education. |
| T22 | Trainers or their delegates must be on site during office hours: 80% in months 1-6; 50% in months 7-12 and 25% from month 13 (see also T23). |
| T23 | Trainers may be offsite for the second training year in general practice only in exceptional circumstances and if workforce issues and registrar competence warrant this. |
| T18 | A trainer should take on the responsibility for not more than two registrars (full time equivalents). |
| T24 | When off site the trainer must be available by phone or make arrangement for another recognised general practice teacher to be available including after hours. |
| T3 | The trainer must be a good role model and demonstrate commitment to the development of the profession. |
| T1 | The trainer must have full and unrestricted registration by the Medical Board. |
| T2 & T7 | The trainer must be an excellent physician including holding Fellowship with RACGP. Trainers must be active Fellows of the RACGP. |
| T8 | The trainer must have at least 4 years full time equivalent experience in general practice (can include postgraduate training experience in general practice). |
| T4 | The trainer must hold vocational recognition as a GP by the Health Insurance Commission. |
| T10 | The trainer must demonstrate preparation for and ability as a general practice trainer; motivation for hosting doctors in training, previous experience, understanding of adult learning principles and teaching methods. |

### ACRRM STANDARDS 2010

| T7.1.1 | The supervisor demonstrates current full and unrestricted registration with the Medical Board of Australia. |
| T7.1.2 | The supervisor is a Fellow of ACRRM or has experience and qualifications which are assessed by ACRRM to be equivalent. Must meet min of 16 points on Scale (Appendix 2). Potential supervisors who have limited Australian work experience may be considered if overseas rural and remote experience is comparable. |
| T7.1.3 | The supervisor has not less than five years full time experience in a rural or remote general practice or other rural or remote specialist practice. |
| T7.2.1 | The supervisor demonstrates an understanding of the ACRRM Vocational Training program and the ACRRM Primary Curriculum. |
| T7.2.6 | The supervisor must demonstrate a commitment to teaching. |
| T7.2.9 | The supervisor organises own clinical workload to be compatible with teaching commitments. |
| T7.3.1 | The supervisor is familiar with a range of teaching methods and select appropriately from these to assist the registrar's learning. |
| T7.3.4 | The supervisor utilises a wide range of educational resources, including the ACRRM Primary Curriculum and RRMO, to assist the registrar to achieve specific learning goals. |
| T7.4 & (all sub-indicators) | The Supervisor is committed to supporting registrars. |

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**Integrated Accreditation Criteria developed by Ms Stephanie Walker and Ms Liza Armstrong, endorsed by WA GPTAP**

**May 2012**
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</table>
| **FUNCTION 5: Feedback and Assessment**
  - Interns/PGY2s receive continual and constructive feedback on their performance |
| **T14** The trainer must assist the registrar in the development of a learning plan by week 4 of each six months of training. | 5.1 Assessment of the intern/PGY2 is based on the achievement of objectives, expectations and standards, clearly understood by both supervisors and junior doctors. | 7.2.6 The supervisor agrees to meet with the registrar early in the post to discuss and appraise the registrar’s skills and experience and develop a learning plan. |
| | 5.2 The parent health service clearly explains the criteria, process and timing of assessment and feedback to both the practice and the intern/PGY2. | 8.3.4 The teaching plan includes an outline of how the supervisors will assess the performance of the registrar and manage feedback. |
| | 5.3 The intern/PGY2 receives progressive and informal feedback throughout the GP rotation from GP supervisors. | |
| | 5.4 The intern/PGY2 receives formal formative mid-term feedback during each rotation. | |
| | 5.5 The intern/PGY2 receives formal feedback on the rotation as a whole from the GP supervisor. | |
| **T43** Trainers will be asked to provide feedback on education in relation to standards T14, T15, T16, T5. | 7.2.7 The supervisor conducts formative assessment of the registrar, in accordance with their stage of training. | |
| **T45** Trainers will be asked to provide feedback on support in relation to standards T17, T34. | 8.8.1 The teaching post provides formal feedback on the progress of the registrar to the training provider and ACRRM on request. | |
| **T47** Trainers must be in a position to provide feedback on workload in relation to standards T38, T39, T40. | 5.6 The practice identifies poor performing interns/PGY2s and develops appropriate remediation and/or support programs in conjunction with the parent health service. | |

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<td><strong>FUNCTION 6: Program Evaluation</strong></td>
<td>The general practice formally evaluates the HMOs program in a continuous improvement framework.</td>
<td><strong>FUNCTION 7: Facilities and Amenities</strong></td>
</tr>
<tr>
<td>T42 Registrars will be asked to provide feedback on education in relation to standards T15, T16, T9, T14.</td>
<td>6.1 The parent health service and/or RTP has formal processes in place for interns/PGY2s to provide confidential feedback on their rotational experiences that are known to both the practice and the junior doctor.</td>
<td>8.8.2 The teaching post consents to registrars in the ACRRM Vocational Training program providing feedback to the training provider and ACRRM on the training environment provided by the post and the supervisors.</td>
</tr>
<tr>
<td>T44 Registrars will be asked to provide feedback on support in relation to standards T19 (orientation), T21-24 (support and supervision).</td>
<td>6.2 The practice is provided with the intern/PGY2 feedback on their rotational experience by the parent health service and/or RTP.</td>
<td>8.8.3 The teaching post regularly seeks registrar feedback on the quality and suitability of the training environment provided by the post.</td>
</tr>
<tr>
<td>T46 Registrars will be asked to provide feedback on workload in relation to standards T27, T30.</td>
<td>6.3 The practice ensures evaluation feedback is incorporated into continuous improvement of orientation, education and training of the junior doctor.</td>
<td></td>
</tr>
<tr>
<td><strong>FUNCTION 7: Facilities and Amenities</strong></td>
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<td></td>
</tr>
<tr>
<td>T29 The facility must provide adequate consulting space for the registrar.</td>
<td>7.1 The general practice provides facilities and accommodation for interns/PGY2s in accordance with PGPPP Guidelines including a designated consulting room and appropriate accommodation if applicable.</td>
<td>8.4.1 The teaching post provides a dedicated patient consultation room for the registrar that is suitably equipped (see ACRRM standards for full list).</td>
</tr>
<tr>
<td>T31 There must be a set of reference materials and patient information materials available in the facility that can be accessed by the registrar whenever consulting and without interrupting another clinician who is working.</td>
<td>7.2 The general practice has appropriate decision support and electronic (e.g. email, phone) systems to support their clinical work and provides appropriate orientation to support their use.</td>
<td>8.2.1 The teaching post provides access to telephone, fax, the internet and email.</td>
</tr>
<tr>
<td>T32 The facility must ensure that a private space is provided for teaching purposes and that systems are in place to protect teaching time from interruptions (see also T33 re: special training environments).</td>
<td></td>
<td>8.2.2 The training post provides access to a range of relevant clinical resources.</td>
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<td></td>
<td>8.2.3 The teaching post provides appropriate computer equipment for accessing and updating patient records.</td>
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<td>8.2.5 The teaching post provides access to equipment for participation in education activities.</td>
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<tr>
<td></td>
<td></td>
<td>8.4.2 The teaching post provides onsite or have immediate access to a range of essential equipment (see ACRRM standards for full list).</td>
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<tr>
<td></td>
<td></td>
<td>8.4.3 The teaching post provides clear and adequate systems for clinical records and registers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8.4.4 The teaching post provides adequate access to diagnostic and medical services.</td>
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</tbody>
</table>