Network principles for prevocational medical training

Learning model
Network model
Governance
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Suggested citation:

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ISBN 978-0-9871936-8-1

Cover image: The hospital system contains a galaxy of possibilities for junior doctors. The cover shows galaxy M101 as imaged by the Hubble space telescope and other terrestrial telescopes. This giant spiral disk of stars, dust and gas is 170,000 light-years across, or nearly twice the diameter of our Milky Way galaxy. M101 is estimated to contain at least one trillion stars. About 100 billion of them could be similar to our Sun. NASA image from http://hubblesite.org/newscenter/archive/releases/2006/10/image/a/

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About this document

This guide is addressed to directors of education and training and others responsible for managing prevocational training networks.

It describes a learning model (how and what trainees learn) and a network model (what a network needs to deliver the learning model) for prevocational medical education and training in New South Wales. It also describes the structures governing the network system from the State level to the training sites.

Effective networked training requires open communications and collaboration between clinicians and administrators working in a diversity of settings. This guide suggests ground rules for cooperation when managing issues that arise in a complex work and training environment.

Background

Prevocational medical training in New South Wales has been run on its current networked training model since 2007. Networked training was established on these core principles:

- patient safety and quality care is paramount
- equity of access to high quality care for patients is supported by a well trained and fairly distributed workforce
- the medical workforce deserves equity of access to excellent medical training
- medical workforce development is a core business of health services
- teaching and training are integral and rewarding parts of medical practice.

In 2010, the Health Education and Training Institute (HETI) commissioned an external review of the networks to see how well the prevocational program was working. The report of the review team recommended that HETI establish

- a learning model for the networks which:
  - promotes the implementation of the Australian Curriculum Framework for Junior Doctors (ACF)
  - promotes the concept of the prevocational training years as experiential-based with a heavy emphasis on clinician-led learning involving patient encounters.


The Prevocational Training Council (HETI's clinician-led governance committee for the prevocational program) endorses this recommendation. Everybody involved in prevocational training — trainees, supervisors, directors of training, JMO managers and others — needs a clear understanding of the aims of the training program and the purposes of training networks.

About HETI

As an outcome of the Director-General’s Governance Review on the future directions for NSW Health completed in October 2011, the Clinical Education and Training Institute was restructured to become the Health Education and Training Institute (HETI).

HETI has an enhanced focus on clinical and non-clinical education and training for the health system. HETI will establish itself as a national leader in people development within the health sector in NSW.

The role of HETI is to work closely with local health districts and other health organisations and clinical training providers to develop and deliver education and training across the NSW public health system. Supporting clinical training networks will continue to be a core activity of HETI.
# Section one: the learning model

## Prevocational medical education and training

is based upon adult learning principles

<table>
<thead>
<tr>
<th>Seven principles of adult learning</th>
<th>… and their implications for the prevocational program</th>
</tr>
</thead>
</table>
| 1 Adults are internally motivated and self-directed | - Trainees have primary responsibility for the direction and pace of their own learning. The program facilitates learning, but it is appropriate for trainees to manage many aspects of their training personally.  
- Trainees should be responsible for recording their objectives and progress in a journal. Self-assessment should be encouraged and developed.  
- Trainees and their representative organisations should play a role in structuring the program.  
- The program should place the curriculum and all resources needed to plan training into the hands of trainees as well as supervisors, directors of training and administrators. |
| 2 Adults bring life experience to learning experiences | - The previous experience and existing knowledge of trainees can be used to enrich learning opportunities.  
- Senior clinicians should take the time to establish what trainees already know as the starting point for teaching.  
- Trainees play an important role as teachers themselves. |
| 3 Adults are goal oriented | - Trainees are more motivated to learn when they see that the lesson will help them reach their personal objectives.  
- Assessment should be meaningful and rewarding. The outcomes of successful learning (including registration and career progression) should be explicit.  
- Advancement should be linked to the achievement of goals. |
| 4 Adults are relevancy oriented | - Learning on-the-job is central to prevocational training.  
- Formal teaching should relate closely to the work demands and career objectives of trainees.  
- The system’s goals for training (e.g., safety, efficiency, excellent patient care) need to be made relevant to trainees.  
- Case studies and problem-based learning can be used to demonstrate the relevance of clinical knowledge. |
| 5 Adults are practical | - Lectures should focus on the practical aspects of the subject.  
- Simulated learning environments assist in bridging the gap between theoretical knowledge and immediate clinical application.  
- Opportunities for teaching and learning have to be integrated into clinical practice at patient encounters, ward rounds and ward handovers, and when clinical procedures are being performed. |
| 6 Adult learners like to be respected | - Trainees should be treated with the respect they are expected to show to others.  
- Trainees should be integrated into mutually supportive clinical teams.  
- Procedural fairness should be demonstrated in all decisions affecting trainees. |
| 7 All learners benefit from feedback | - Learners should expect feedback about their strengths and areas for improvement.  
- Providing feedback is necessary for developing confident and competent clinicians.  
- Providing feedback can ameliorate uncertainty and stress in trainees. |
The learning cycle

The learning model for prevocational training adopts the learning cycle modelled by Kolb.\textsuperscript{1} Applied learning requires trainee doctors to move through the complete cycle — they need to conceptualise, experiment, do, and review. Learners exhibit preferences as to their preferred starting point: for example, some prefer to begin by doing some hands-on activity, while others like to start with observation or abstract learning. Clinical training must provide an environment which supports all stages of the learning cycle (not just the concrete experience stage represented by clinical duties) so that each trainee has the opportunity to maximise their learning across all competencies and integrate these into their professional practice.

Through spiralling over the clinical ground through term after term, trainees acquire higher levels of learning. Clinical judgement, professional behaviour and good communication become hardwired through repeated and extended experience. As they repeat and extend their experience, the number of entrustable professional activities — that is, clinical responsibilities that they can perform independently — increases.

\textit{Prevocational medical training: repeated experience in a supportive context leads to competence across widening clinical domains.}

What should prevocational trainees be learning?

The learning outcomes required of prevocational doctors are described in the Australian Curriculum Framework for Junior Doctors (ACF).

The ACF is built around three learning areas: Clinical Management, Communication and Professionalism. These areas are subdivided into categories, each of which is further subdivided into learning topics. Within each learning topic, the ACF describes the workplace-performance outcomes that prevocational doctors are expected to acquire.

The ACF is about more than what doctors know, it is about what they actually do at work.

The learning required of prevocational doctors is learning for performance: the intended outcome is that the doctor performs the behaviours described in the ACF in their daily work. More than proving individual competencies, the important learning outcome is the capability to integrate competencies consistently in workplace performance.

The appropriate assessment of these learning outcomes is to measure the extent to which the prevocational doctor performs the behaviours described in the ACF in their daily work.

The ACF and supporting resources are available online:
www.cpmec.org.au/Page/acfd-project
Workplace-based training

Supervised clinical work is the essential and major part of training and education for prevocational trainees.

The most important lessons in clinical practice do not come from instruction, but from observation, experience, and reflection upon daily activities.

In much on-the-job learning, trainees may not be conscious of the learning taking place because the focus is on work performance. It is one of the roles of supervisors and directors of training to ensure that trainees realise the professional development potential of their daily experiences.

On-the-job learning is extended and reinforced by:

- self-directed learning
- e-learning
- simulation and workshops
- the network lecture series
- term-specific teaching.

Each of these elements of the learning model are described in more detail over the next few pages.
A learning model for prevocational medical training and education

Supervised clinical work:
- Clinician-led patient interactions
- Opportunistic learning
- Situational learning
- Experiential learning
- Observation and feedback

Curriculum:
- Framework: ACFJD
- Term objectives described in term description
- Individual trainee objectives (trainee journal or learning plan)

Trainee assessment:
- Workplace-based assessment
- Trainee observation by supervisors
- Self-assessment (trainee journal or skills audit tool)
- Team-based assessment
- Mid-term formative appraisal
- End-term summative assessment

Program evaluation:
- Trainee term evaluation forms
- Monitoring of trainee outcomes

Self-directed learning:
- Individual responsibility in a supportive environment

Curriculum:
- Framework: ACFJD
- Term objectives described in term description
- Individual trainee objectives described in trainee journal

Trainee assessment:
- Self-assessment
- Observation by DPET

Program evaluation:
- Observation by DPET
- Evidence of self-directed learning: eg, journal

e-Learning:
- State-coordinated
- A support to training activities
- An aid to self-directed learning

Curriculum:
- Framework: ACFJD
- See also JMO Forum recommendations

Trainee assessment:
- Online record of participation and results

Program evaluation:
- Participation records
- Trainee evaluation forms
- Monitoring of trainee outcomes

Simulation and workshops:
- Network-coordinated
- ALS, DETECT and core skills

Curriculum:
- Framework: ACFJD

Trainee assessment:
- Trainee observation by educators
- Self-assessment

Program evaluation:
- Participation records
- Trainee education evaluation forms
- Monitoring of trainee outcomes

Network lecture series:
- Network-coordinated, facility-based lectures

Curriculum:
- Framework: ACFJD
- JMO Forum unified lecture series
- Network-led curriculum planning

Trainee assessment:
- Participation records

Program evaluation:
- Participation records
- Trainee education evaluation forms
- Monitoring of trainee outcomes

Term-specific teaching:
- Lectures, journal club, M&M, etc
- Trainee presentations

Curriculum:
- Framework: ACFJD
- Term objectives described in term description

Trainee assessment:
- Participation records
- Assessment of trainee presentations by supervisors and peers

Program evaluation:
- Participation records
- Trainee education evaluation forms
- Monitoring of trainee outcomes

Supervised clinical work is the major part of training and education
Learning model part 1: Supervised clinical work

Key elements

**Clinician-led patient interactions:** Trainees are learning the application of their skills with real patients. It is the variability and unpredictability of individual patient encounters that trainees have to learn to manage. Clinical supervisors ensure that trainee-patient interactions are safe and that patient care is optimal while trainees learn. The main learning comes from opportunities to apply clinical reasoning and through receiving feedback on their performance from observers.

**Opportunistic learning:** Opportunities for learning are abundant but unpredictable. Supervisors need to be prepared to seize the moment.

The winning project from the 2010 CETI Leadership Program was a proposal for a systematic method of connecting teachers and trainees when opportunities for demonstration and practice of procedural skills arise in the workplace. Directors of training need to encourage a learning culture in the workplace that maximises the use of opportunities for learning.

**Situational learning:** Handovers, rounds, consultations, procedures — the lessons for trainees have to be situated in the working day. The time and staff resources allocated to clinical activities need to be sufficient for the associated educational and training components.

**Experiential learning:** The supervisor plays a key role in effective experiential learning.

An effective supervisor knows when to give trainees direction, and when to give them freedom of action. To move the trainee from consciously incompetent to consciously competent, the supervisor must actively calibrate the level of support provided. Studies suggest that junior doctors value supervisory support of two kinds:

“Hands-on” supervision — interactions with clinicians who are expert in areas where they need help

“Hands-off” supervision — being trusted to act independently, being given space to deploy their nascent skills and test their growing clinical abilities.

Trainees also value an intermediate zone that allows them to shift back and forth between monitored (hands-on) and independent (hands-off) practice.

— The Superguide

**Directors of Prevocational Education and Training (DPETs) should:**

- encourage senior clinical staff to see the examinations and procedures they perform as valuable teaching opportunities
- encourage all senior clinicians and supervisors to provide frequent and timely feedback to the learner
- encourage junior clinical staff to seek learning opportunities and advertise their need for experience
- develop systems to connect trainees with opportunities to observe and experience new clinical cases and procedures
- encourage trainees to keep a record of their observations and experiences, and ask to see this record as part of their review of trainee progress
- ensure that trainee learning is conducted in an environment of supervision that guarantees patient safety.

DPET resource

The DPET guide.

Curriculum

Framework: Australian Curriculum Framework for Junior Doctors (ACF)

The ACF describes comprehensive learning outcomes for prevocational training under the domains of clinical management, communication, and professionalism. It articulates about 180 capabilities that trainees should possess, as well as nearly a hundred specific practical tasks they should be able to perform, and 77 clinical problems and conditions they should be able to assess.

In clinical practice, the ACF capabilities have to be learned and performed in an integrated manner. Any patient encounter will require simultaneous exercise of many capabilities from all three domains.

Term objectives described in the term description. Every accredited training term in NSW must have a written term description which outlines the work responsibilities and training expectations for the term. The term objectives should be written with reference to the ACF, and should define the subset of capabilities, specific skills, and clinical conditions that the trainee can reasonably expect to learn during the term. It is the responsibility of term supervisors to ensure that term objectives are achievable, and that their achievement is monitored.

DPETs and the network committee should take an overview of term allocation to ensure that each trainee is allocated to a mix of terms that collectively provides exposure to the full set of ACF capabilities.

Individual trainee objectives: Trainees should use the ACF as a self-assessment tool to identify strengths, weaknesses and opportunities for learning. Throughout their traineeship, they should set personal objectives related to the clinical opportunities currently available to them, their current learning needs, and their intended career pathway. It is highly recommended that trainees keep a written record of their personal learning objectives, clinical experiences, and reflections upon practice.

Personal learning objectives are essential, but not sufficient. The goal of prevocational training is to ensure that all doctors are ready for safe and effective independent clinical practice, and this readiness will be assessed by the trainee’s supervisors, who therefore have a leading role in deciding what the trainee needs to learn.

The individual curriculum for each trainee should be decided in a dialogue between trainee, supervisor and DPET.
Trainee assessment

**Workplace-based assessment:** As far as possible, assessment should be based on real work activities, or accurate simulation of work activities. The goal of formative assessment is to give trainees feedback that will help them improve their real-world performance. The goal of summative assessment is to measure their level of performance in actual clinical practice.

Workplace-based assessment can be unstructured, based on general observation of work activity, but there is evidence that repeated, specific, structured assessments (eg, mini clinical examinations, direct observation of procedural skills) is more reliable.

**Trainee observation by supervisors:** The key to meaningful assessment is direct observation of trainee performance. Term supervisors are charged with the responsibility to assess trainee performance. They can and should talk to other members of the clinical team about the trainee, seeking their observations and opinions, but this cannot be a substitute for direct observation.

**Self-assessment:** Self-assessment was introduced as a formal component of prevocational assessment with the new progress review forms in 2009 after consultation (especially with trainees) indicated that this was desirable. Doctors must be able to recognise their strengths and limitations if they are going to provide safe and effective patient care. Skill in self-assessment is fundamental to self-directed continuing medical education, which in turn is essential for maintaining competence and improving professional practice throughout a clinical career.

DPE Ts and supervisors can encourage self-assessment by:

- modelling self-awareness and reflective practice themselves
- inviting trainees to comment on their own performance and using trainee self-assessment as the starting point of dialogues about performance (“How do you think you went with that?”)
- asking to see trainee logbooks, journals or other written evidence of reflective practice.

**Team-based assessment:** Term supervisors should seek the opinion of other team members about the performance of trainees and use this information to augment their own observations. Team-based assessment works best in clinical teams that practise open communications and mutually respectful professional discourse.

**Term orientation:** For assessment purposes, Term Supervisors should arrange (at least) three meetings with each prevocational trainee in each term. The first of these occurs at term orientation in week 1, when the Term Supervisor reviews the term description with the trainee and discusses:

- the major focus and goals of the clinical unit and the expectations of the trainee’s role
- term learning objectives and skills training goals
- supervision needs and the process of performance assessment
- the trainee’s current level of knowledge and experience (the trainee should be invited to show evidence, and an individual learning plan for the term should be developed).

**Mid-term formative appraisal:** HETI asks that trainees and term supervisors complete a mid-term formative appraisal form in week 5 of each training term. The trainee completes their written self-assessment before meeting with the Term Supervisor. Self-assessment provides a basis for discussing progress and planning the future direction of training during the term. The trainee is asked to outline personal strengths and achievements and identify weaknesses or needs for further development. The Supervisor then offers feedback in the same manner, and completes their written appraisal of the trainee.

There is no pass or fail mark in formative assessment, but if performance problems are identified in
this appraisal, the DPET should be informed and a remediation plan should be developed with the trainee.

**End-term summative assessment:** HETI asks that trainees and term supervisors complete an end-term summative assessment form in the final week of each training term. The failure to obtain a satisfactory overall summative assessment has possible implications for the trainee by delaying progress to the next level of training. However, it is not a requirement or an expectation that all trainees will achieve a high grade on every assessment item at the end of every term. It is expected that PGY1 trainees may perform less well than PGY2 trainees, and that, for all trainees, performance will improve from term to term.

Decisions about trainee progression are guided by end-term assessments, but not determined by them. DPETs observe the progress of trainees from term to term and make recommendations accordingly. It is important that Term Supervisors contribute to this process by making accurate assessments of trainees under their supervision.

**Program evaluation**

It is a requirement of HETI’s accreditation standards for prevocational training that all training facilities conduct a continuous evaluation of the effectiveness of their program. In relation to monitoring the effectiveness of supervised clinical work as a key element of the program, DPETs have a range of formal and informal methods for gathering evaluation data. In particular:

**Trainee term evaluation forms:** HETI asks that DPETs oversee continuous evaluation of training terms by means of trainee term evaluation forms. A recommended form is provided by HETI. DPETs should also gather term evaluation feedback through their regular meetings with trainees.

**Monitoring of trainee outcomes:** The quality of trainee outcomes reflected in the mid-term and end-term assessment forms, the results of other assessments, and feedback from clinical team members, is a measure not only of trainee performance but also of the effectiveness of the prevocational training program. DPETs need to be alert to the possibility that trainee underperformance or lack of improvement in performance may be attributable to inadequate supervision.
Learning model part 2: Self-directed learning

In one sense, all education and training in the prevocational program involves self-directed learning. Only the commitment and the engagement of the trainee with their supervisors and patients transforms teaching, experience, guidelines, simulations and so on into an integrated understanding of clinical practice.

One of the most important lessons of prevocational training is that clinical practice requires a permanent commitment to professional development and lifelong learning. This requires trainees to seek (and act on) feedback from supervisors and other clinicians.

The purpose of supervised clinical practice is to support the development of an independent practitioner who is self-regulating, committed to evidence-based practice, and therefore committed to lifelong learning.

An essential skill to be practised, developed and tested during prevocational training is self-assessment. Safe clinicians:

- are aware of their skills and their limitations
- know what they do well, and when they are better referring a patient to someone with a different skill set
- can identify their weaknesses, and are able to plan and carry out actions to reduce those weaknesses
- know when to seek help or further training
- know where to find advice and further information.

Key elements

Self-directed learning is an individual responsibility, but DPETs and supervisors can help inculcate appropriate attitudes and behaviours to support it.

Supervisors should ensure that trainees can bridge the gap between theory and practical experience so that they can solve problems using both reflection in action and reflection after action. Supervisors can help trainees understand their current level of competence and point trainees to methods of building competence that are appropriate to their current stage of development.

Curriculum

- Framework: ACF
- Term objectives described in term description
- Individual trainee objectives described in trainee journal or learning plan.

Trainee assessment

1. Self-assessment in trainee journal or similar record
2. The ACF includes several capabilities related to self-directed learning and professional development. These capabilities should be assessed by DPETs and supervisors. For example, the DPET should assess each trainee's abilities in self-assessment. Does the trainee show insight and accurate assessment of abilities? Does the trainee pursue opportunities for learning?

Program evaluation

1. Do trainees keep journals, logbooks or other evidence of self-directed learning?
2. Are DPETs and supervisors open to requests from trainees for individual training opportunities?
Learning model part 3: e-Learning

e-Learning (online or internet-enabled learning) is a relatively new and underdeveloped part of the prevocational training program, but HETI will be increasing its role in developing good e-learning to support clinical education and training.

e-Learning cannot replace face-to-face teaching. It is a support to other learning methods.

Good e-learning can:
- reinforce knowledge and attitudes required in professional practice
- connect learners with their peers and teachers across gaps in time and space
- provide learning opportunities for trainees that they can access at their own convenience
- allow trainees to rehearse clinical situations before a real-life encounter
- practise clinical reasoning
- practise professional communication skills
- work in virtual teams.

Key elements

1 State-wide coordination. At present, different sites or health districts are developing or gathering e-learning resources in independent systems, which results in duplication of effort and inconsistency of approach across the state. HETI will work with local health districts to create a coordinated system that encourages a uniformly-high standard of e-learning across the state, minimises duplication of effort, and encourages sharing of learning resources.

2 Support to lectures. The unified lecture series developed by the JMO Forum (see below) can be enhanced by e-learning support, which could include:
   - associated readings
   - recorded lectures
   - lecture slides, teacher notes and learner notes online
   - multiple choice questions to test knowledge
   - discussion forums for follow-up questions and debate
   - demonstration videos
   - case studies.
   - HETI hopes to engage the support of the prevocational networks in building this e-learning support to the lecture program.

3 Self-directed learning. e-Learning is self-paced learning. The objective for e-learning development is to create online resources that are engaging and rewarding.

4 Connectivity. Engaging and rewarding e-learning should connect clinicians in a large and responsive learning community, reducing the isolation of trainees in remote locations.
Curriculum

- Framework: ACF
- JMO Forum unified lecture series. See an outline of the lecture series at <www.heti.nsw.gov.au/prevocational#trainers>. We hope that, over time, each network will assist HETI in developing e-learning support to each of the topics in the lecture series.

Trainee assessment

- Online record of participation and results.

Program evaluation

- Participation records.
- Trainee evaluation forms completed online.
- Monitoring of trainee outcomes.

What is the JMO Forum unified lecture series?

In 2010, the education working group of the NSW JMO Forum published “Proposal for a unified lecture education series for Junior Medical Officers” (www.heti.nsw.gov.au/prevocational#trainers). The proposal was based on consultation with JMOs across NSW to identify desired topics and learning outcomes for lectures. The group referred to the Australian Curriculum Framework for Junior Doctors and developed a lecture series of 41 topics: “the topics chosen from the Australian Curriculum Framework for delivery in the lecture series were allocated into one of the five terms of the clinical year. Those topics considered to be of greatest importance early in the year (primarily those centred around common after-hours problems encountered on ward overtime shifts) were placed in term one, with the topics becoming increasingly more specialised heading through to term 5.”

There have been criticisms of the lecture outlines (some topics too large to cover in a single lecture) and of the proposed order of lectures, but the Prevocational Training Council endorses the lecture series as a good model for prevocational education programs in NSW. The lecture series has been adopted or adapted by most of the networks in NSW, as it provides an excellent framework for structuring the education program. The JMO Forum’s education group continues to keep the lecture series under review.
Learning model part 4: Simulations and workshops

Key elements
Practical workshops and simulation-based training should be coordinated at a network level to ensure that all trainees receive appropriate training in:
- advanced life support
- managing the deteriorating patient (the DETECT program)
- other core skills and practice protocols deemed essential within the network.

Curriculum
- Framework: ACF
- ALS and DETECT.

Trainee assessment
- Trainee observation by educators (both structured and informal)
- Self-assessment in trainee journal or similar record.

Program evaluation
- Participation and assessment records
- Trainee education evaluation forms
- Monitoring of trainee outcomes.
Learning model part 5: Network lecture series

Key elements
- The Network Committee for Prevocational Training coordinates and monitors formal education programs across the network to ensure that trainees do not have gaps or unnecessary repetition as they rotate through training sites. Different networks achieve this in various ways:
  - all trainees attend one site for educational sessions
  - videoconferencing is used to link trainees at remote sites
  - recorded lectures are provided to remote sites from one centre
  - each site provides its own educational sessions, with network oversight to ensure that trainees receive essential sessions regardless of where they are on rotation.

Curriculum
- Framework: ACF
- JMO Forum unified lecture series
  (see page 12)
- Network-led curriculum planning.

Trainee assessment
- Participation records

Program evaluation
- Participation records
- Trainee education evaluation forms
- Monitoring of trainee outcomes.

What rate of trainee participation is required?
Some training sites report difficulties getting prevocational trainees to attend lectures.

The Prevocational Training Council recommends that it is appropriate to require attendance at:
- all core training activities, which include DETECT (approach to the deteriorating patient), basic and advanced life support courses, communication workshops (including breaking bad news) and any other session deemed core training by the Network Committee for Prevocational Training
- all of intern orientation week and all term orientation activities
- a percentage (to be determined by the Network Committee for Prevocational Training) of all other educational sessions.

Inadequate attendance can be deemed a failure to pass the training term.

Enforcing attendance is only acceptable if the network and the training facility meets organisational requirements:
- the educational program must be regularly scheduled and publicised
- educational presenters should be appropriately qualified and prepared
- term supervisors and other clinical team members must understand that releasing prevocational trainees for their scheduled education sessions is required in all but exceptional circumstances
- the pagers of prevocational trainees should be held for them by the JMO unit or some other appropriate party so that educational time is protected.
Learning model part 6: Term-specific teaching

Key elements
The content and method of term-specific teaching varies from term to term, but can include lectures, journal club, morbidity and mortality meetings, procedural skills training sessions, trainee presentations and other educational methods appropriate to the clinical specialty of the term.

Not every site in a network needs to be able to provide the full network lecture series. Often the term-specific teaching of a training site is its special strength (eg, the paediatrics lectures and workshops provided at Children's Hospital Westmead). While trainees are on rotation at some sites, it may be appropriate for them to attend network lectures at another site, or attend by videoconference or internet link.

Curriculum
- Framework: ACF
- Term objectives described in the term description. These should themselves reflect the learning outcomes of the ACF, but may be phrased in terms of specific activities of the clinical unit that the trainee is working in during the term.

Trainee assessment
- Participation records
- Assessment of trainee presentations by supervisors and peers
- Workplace-based assessments and the mid-term and end-term assessment forms (see page 8).

Program evaluation
- Participation records
- Trainee education evaluation forms
- Monitoring of trainee outcomes.
Learning model: summary

The learning model for prevocational training acknowledges that

- trainees all have different learning styles
- assessment will always drive learning.

The immersive intern experience develops:

- clinical knowledge and skills in a wide range of settings
- skills in organisation and project management
- a positive professional identity based on professional practice and responsibility.

The second prevocational year:

- consolidates this experience and ensures that trainees have acquired the range of skills for medical practice that subsequent, more specialised, vocational training may not provide
- provides an opportunity to explore career choices.

Successful completion of prevocational training in NSW requires:

- Satisfactory performance in 10 training terms, including the three core terms required for Medical Board registration (medicine, surgery and emergency care), as well as terms providing bedside care out of hours, and preferably including a general practice training term and both rural and metropolitan experience.

- Satisfactory attendance at formal educational events organised within the training program. See ‘What rate of trainee participation is required’ on page 14.

The Prevocational Training Council recommends that each network provide a Certificate of Completion of Prevocational Training at the end of the second year of training. This certificate should list:

- The ten training terms that the trainee completed with satisfactory performance
- Mandatory training that the trainee completed in a satisfactory manner
- Any other achievements of the trainee that the network can attest to, such as participation in hospital or network committees.

Such a certificate, co-signed by the Chair of the network committee and the director of medical services at the trainee’s home hospital, will be a useful document for the trainee in future years. It may provide an added incentive to trainees to complete all five terms of their second year.
**What is meant by ‘satisfactory performance’?**

The mid-term assessment is formative. Formative assessment provides feedback on performance and assists junior doctors with planning future learning. There is no pass or fail mark in formative assessment.

The end-term assessment is summative. The failure to obtain an overall satisfactory summative assessment has possible implications for the junior doctor by delaying progress to the next level of training. However, it is not a requirement or an expectation that all trainees will achieve a high grade on every assessment item at the end of every term. It is expected that PGY1 trainees may perform less well than PGY2 trainees, and that, for all trainees, performance will improve from term to term.

Decisions about trainee progression are guided by end-term assessments, but not determined by them. Directors of Prevocational Education and Training observe the progress of trainees from term to term and make recommendations accordingly. It is important that Term Supervisors contribute to this process by making accurate assessments of trainees under their supervision.

**Network training environment**

For this learning model to be effective, each network must provide an appropriate training environment. Clinical systems including appropriate clinical oversight, infrastructure arrangements, education and support staff, and appropriate workplace conditions must all be aligned and continuously maintained to provide an appropriate learning environment accredited for prevocational training.

The details of these network requirements are outlined in the next section of this document.
No single health care facility can provide all the training and experience required to prepare new doctors for the diverse range of medical practice, so facilities are organised into networks that cooperate to deliver training to a group of prevocational trainees.

From an educational perspective, the key requirement of a network is that it should be capable of delivering all the elements of the learning model. In practical terms, several sets of factors need to be considered in composing networks:

| Training components | • ability to deliver the curriculum outlined in the Australian Curriculum Framework for Junior Doctors  
|                     | • sufficient core terms in medicine, emergency medicine and surgery  
|                     | • an appropriate mix of specialty terms  
|                     | • an appropriate mix of training settings (general practice and community settings, large and small hospitals, and a range of patient types)  
|                     | • a lecture series for trainees coordinated at a network level  
|                     | • specific teaching in each training term  
|                     | • supervisors who understand the importance of teaching and providing feedback to trainees  
|                     | • a workplace culture supportive of training and education, with training and support for all levels of the workforce and a commitment to continuous professional development  |
| Infrastructure      | • physical amenities  
|                     | • internet access  
|                     | • educational infrastructure such as libraries, simulation training facilities, video-conferencing, lecture theatres and learning centres  |
| Geography           | • minimising the distances between networked facilities has advantages, but  
|                     | • trainees benefit from receiving training in both rural settings and metropolitan settings and  
|                     | • historical links between facilities may need to be considered  |
| Size                | • at least one major metropolitan hospital  
|                     | • home hospitals for 5/10 terms of all trainees  
|                     | • rural sites for 1/10 terms for most trainees  
|                     | • general practice or community sites for 1/10 terms for most trainees  |
| Relations to the system | • minimising the number of local health districts involved in a prevocational training network is efficient  
|                     | • links to undergraduate clinical programs, vocational training programs, interdisciplinary programs influence the effectiveness of prevocational training  |
| Network governance | • cooperative relations between facilities within the network  
|                     | • cooperative planning for education and training  
|                     | • effective processes for allocation of trainees and resources  
|                     | • an effective network committee  
|                     | • effective lines of reporting  
|                     | • executive sponsorship of the network  
|                     | • effective procedures for dispute resolution  
|                     | • cooperative relations with HETI and other networks  
|                     | • capacity to implement, evaluate and improve the prevocational program  
|                     | • effective role definitions, staffing and resourcing for network committee, hospital training committees, directors of training, JMO managers, supervisors, educators, and trainees.  |
Network model part 1: Training components

Every network should be able to supply these training components for all the trainees in the network.

- Ability to deliver the curriculum outlined in the Australian Curriculum Framework for Junior Doctors (ACF). This requires:
  - directors of training, supervisors and trainees who are familiar with the ACF
  - term descriptions written using the ACF
  - a network lecture series and term-specific teaching that addresses the leaning outcomes described in the ACF.
- Sufficient core terms in medicine, emergency medicine and surgery (see core term requirements on page 21).
- An appropriate mix of specialty terms, including availability for most trainees of
  - a general practice or community term
  - paediatrics
  - psychiatry
  - obstetrics and gynaecology
  - geriatrics or rehabilitation.
  These are terms which are fundamental to general medicine and essential background to most specialties.
- An appropriate mix of training settings (general practice and community settings, large and small hospitals, and a range of patient types).
- Sufficient terms so that no trainee repeats a term (except emergency) in their 10-term, 2-year program.
- Relief terms: a maximum of 2 of 10 terms for each trainee. This includes terms in which the clinical duty is providing bedside care after hours. These terms are a valuable practical learning experience for trainees.
- All terms have to be accredited, which requires that:
  - The term description uses the ACF and sets clear and achievable training outcomes, monitoring and assessment procedures.
  - Clinical supervision is sufficient for both clinical effectiveness and the education and training of trainees. Responsibility for direct oversight of all patient care is explicit, senior supervision is active and ensures patient safety at all times, and trainees have immediate access to senior experienced clinicians.
  - The workload is appropriate to maximise both patient care and trainee development.
  - Processes for assessing trainees and evaluating each term are effective. Use of workplace-based assessment tools (including miniCEX and multi-source feedback) are strongly encouraged. Formal assessment according to the prescribed form is essential at the end of each term.
- A lecture series for trainees coordinated at a network level. See next page.
- Time available to attend formal prevocational teaching (minimum one hour weekly).
- Specific teaching in each training term. Lectures, demonstrations, journal clubs, morbidity and mortality conferences and quality assurance processes consolidate the trainee’s work experience. Teaching activities should be routinely evaluated using trainee feedback, and trainee attendance and participation at should be used as part of the term assessment of the trainee.
Specific assessable assignments as part of term-specific teaching are recommended (eg, case presentation to peers, teaching medical students).

- Supervisors who understand the importance of teaching and providing feedback to trainees. This requires that supervisors:
  - have sufficient time and resources to fulfil these responsibilities
  - are supported with training in core skills of supervision and teaching
  - are provided with feedback about their performance as supervisors.

- A workplace culture supportive of training and education, with training and support for all levels of the workforce and a commitment to continuous professional development. Good prevocational training cannot occur in a vacuum: the understanding and support of all staff from the Chief Executive down are required. This requires a significant commitment of resources, including for the Director of Prevocational Training in each facility to fulfil the responsibilities of the position description and support term supervisors and trainees.

**Network lecture series**

The education portfolio group of the JMO Forum has outlined a lecture series for JMOs to ensure that JMOs receive lectures on the most pressing topics early in their intern year, and to promote concordance between the lecture series of different training sites, so that JMOs don’t miss topics or repeat topics when they go on rotation.

The Prevocational Training Council of NSW endorses the unified lecture series as a concept, and recommends it to DPETs as an aid to coordinating JMO education across each training network. Several training sites and networks have adopted the unified lecture series for their education program. Others are adapting the series to suit local circumstances, and a third group are continuing with their own lecture programs.

The essential features of the network lecture series are:

- All trainees have access to the lectures. Usually, this is because the lectures are held at the local facility, but it can be because trainees are able to travel to another facility for lectures (eg, a trainee on a GP rotation returns to the hospital for lectures), or because trainees at a small facility are able to attend lectures elsewhere by videoconference.

- Lectures are held in protected teaching time. This means that trainees are released from clinical duty to attend, and that somebody holds their pagers for them during lectures to prevent interruptions.

- Lectures are organised locally by DPETs, but there is coordination at a network level to avoid trainees missing topics or repeating topics when they go on rotation. This may not be completely avoidable, but networks should be developing options to overcome the problem, such as recording lectures or providing online tutorials for trainees who cannot come to the live event.

- Trainee evaluations of the lectures are routinely collected and used to improve the series.

- Trainee attendance at the lectures is recorded and reported.
### Core terms for year one: medicine, surgery and emergency medicine

#### Accreditation requirements

#### Core emergency term
- **Supervision** to ensure that trainees demonstrate the ability to identify urgent priorities in the assessment, referral and management of an undifferentiated acute patient.
- **Term supervisor**: specialist emergency physician or a senior clinician with appropriate experience in emergency medicine responsible for patient care.
- Continuous clinical supervision and feedback in the department at all times.
- Supervision of bedside procedural skills by direct observation.
- Supervision of medical emergency skills to ensure that trainees demonstrate satisfactory participation in a resuscitation team. This can occur in supervised exposure to critically ill patients or in a simulated setting.

#### Core medicine term
- **Term supervisor**: specialist physician responsible for patient care.
- Appropriate caseload: considering acuity, comorbidities and patient turnover.
- **Patient management** ward rounds for the ongoing care of patients conducted with the same senior clinician (minimum PGY3) at least three times a week.
- Immediate senior clinical assistance available at all times.
- Supervision to continuously evaluate aspects of the trainee’s history-taking, physical examination skills, discharge planning and communication skills (both written and verbal).
- Supervision to ensure that the trainee safely prescribes therapeutic agents.

#### Core surgery term
- **Term supervisor**: specialist surgeon responsible for patient care.
- Appropriate caseload, considering acuity, comorbidities and patient turnover.
- **Clinical exposure** to the range of pre-operative assessment, operative procedures and post-operative care.
- Immediate senior clinical assistance available at all times.
- **Daily ward rounds** for the ongoing care of patients conducted with the same senior clinician (at least PGY3) at least three times a week.
- It is expected that the trainee ‘scrubs in’ to assist with operative procedures 1 day per week, or at least four half-day sessions in the term.

#### Trainee outcomes requiring specific assessment

#### Clinical management
- Basic life support and advanced life support.
- Patient assessment (undifferentiated patient).
- Patient safety (correct identification of the patient, infection control, hand hygiene).

#### Communication
- Working in teams.
- Patient interaction.
- Managing information (discharge summaries).

#### Professionalism
- Professional behaviour (time management).
- Teaching, learning and supervision.

#### Clinical management
- Patient safety (infection control, medication safety, know the system of health care).
- Patient assessment.
- Emergencies (deteriorating patient).
- Patient management (investigations, referral and consultation).

#### Communication
- Working in teams.
- Patient interaction.
- Managing information (handover).

#### Professionalism
- Professional behaviour (time management).
- Teaching, learning and supervision.
Network model part 2: Infrastructure

Specific infrastructure requirements for prevocational training facilities are described in the accreditation standards, but there are certain requirements worth highlighting here.

- Networks must have appropriate infrastructure and staffing to:
  - manage their trainees’ employment and welfare
  - supervise the trainees
  - provide regular feedback to trainees
  - assess the trainees
  - evaluate the program
  - keep adequate and secure records.

- Each training site should have appropriate physical amenities for the welfare of trainees.

- Trainees need access to:
  - libraries — these may be digital libraries accessible from quiet study areas.
  - simulation training facilities — not every site will provide high-fidelity simulation facilities, but trainees should have access within the network to high-fidelity simulation facilities for training in advanced life support, and low fidelity simulation training for training in teamwork, engaging with people from different cultural backgrounds and conflict resolution
  - lecture theatres and learning centres
  - the internet — both on wards and in study areas access
  - medical and mental health care for themselves.

- Video-conferencing should be available within the network to connect smaller sites with larger sites for the purposes of educational sessions and network meetings.

- Sites that take trainees on rotation far from their home hospital (ie, more than ninety minutes travel) need to provide suitable trainee accommodation. This applies to metropolitan sites taking rural trainees as well as to rural sites taking metropolitan trainees.
Network model part 3: Geography

Rural–metropolitan

All networks should include at least one major hospital, preferably a tertiary referral centre.

Most other training sites in the network should be geographically near this centre.

Minimising the distances between networked facilities reduces the travel time of trainees, and often makes it easier to share facilities and resources. Geographically-close facilities are more likely to be within the same local health network, which simplifies administration.

However, trainees receiving most of their training in metropolitan settings can benefit from receiving part of their training in a rural setting, and vice versa.

<table>
<thead>
<tr>
<th>Benefits of a rural term to metropolitan trainees</th>
<th>Benefits of a metropolitan term to rural trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Different patient mix</td>
<td>• Different patient mix</td>
</tr>
<tr>
<td>• Smaller teams, closer relationship with senior clinicians</td>
<td>• Larger teams, more specialised wards and techniques</td>
</tr>
<tr>
<td>• More opportunities to be hands-on</td>
<td>• More chances to see subspecialists at work</td>
</tr>
</tbody>
</table>

Therefore, it is recommended that all networks should contain both rural and metropolitan training sites.

Most rural trainees should receive at least one training term at a metropolitan tertiary referral centre out of their 10 training terms (not a relief term), and networks should try hard to ensure that this term advances the trainee along his/her intended vocational pathway.

Most metropolitan trainees should receive at least one training term at a rural centre out of their 10 training terms (not a relief term), and networks should try hard to ensure that this term gives the trainee appropriate opportunities to extend hands-on experience in clinical skills.

Local health networks

It is preferable for administrative reasons to minimise the number of local health networks involved in each prevocational training network. The need for both rural and metropolitan training sites will usually mean that two local health networks are involved in a prevocational training network. If possible, these local health networks should both be from the same cluster.

Historical links

Some training sites have historical links that merit consideration when deciding network boundaries, as they represent a tradition of goodwill and cooperation that is valuable.
Network model part 4: Size

There can be considerable flexibility about the size (in terms of trainee numbers) of a training network, but each network must demonstrate its capacity to provide good and complete training to all its trainees.

Networks must supply a home hospital for every trainee, defined as a training site where the trainee can complete five of the 10 prevocational training terms. This must include at least three terms at the home hospital in year one.

Networks will generally train an equal number of year one and year two trainees.

Smallest practical size

A small network needs to have at least:

- one major hospital, preferably a tertiary referral centre: if this is the only home hospital, it will need to be able to supply five terms in 10 for all the network's trainees
- rural placements sufficient to provide one term in 10 to most trainees
- general practice or community facilities sufficient to provide one term in 10 to most trainees.

Most networks will find it more workable to have at least one other metropolitan hospital site in the network. This is likely to be necessary to provide an appropriate range of specialty terms to trainees.
Network model part 5: Relations to the system

Links to undergraduate clinical programs, vocational training programs, interdisciplinary programs influence the effectiveness of prevocational training. Relationships which form part of the assessment of a network’s viability include:

- Vocational: links to vocational networks provide registrars and the infrastructure for appropriate prevocational terms.
- Interdisciplinary: capacity for training in teams.
- Major tertiary referral hospital: not available within each network, but each network should link to a tertiary centre within its cluster for specialty terms.
- University: a clinical school within a network strengthens continuity of training and can involve sharing staff and facilities in a mutually beneficial way.
- Administrative: links to local health network and cluster administration.
- Private sector: links to private sector sites of training will become important in future.
Network model part 6: Network governance

When constructing a network, network governance is the vital element in ensuring that prevocational training is effective and continuously improving.

Essential elements of effective governance

- Cooperative relations between facilities within the network. A prevocational training network is a peer-to-peer network, not a hub-and-spoke network, irrespective of relative size.

- Cooperative planning for education and training. Trainees are trained at multiple sites, and there needs to be a network-level overview of what training they are receiving. Repeating the same lecture on rotation to a new training site is almost as significant a waste of critical training time as missing major, core topics. DETECT, Advanced Life Support and specific communication courses such as breaking bad news need to be coordinated by the network to ensure that no trainees miss out.

- Small sites may have gaps in local expertise required for education and training, and the network should work to overcome these difficulties. There are several possibilities:
  - videoconferencing
  - online learning
  - travelling to a central location for lectures
  - using small sites for specialised training, and ensuring that all trainees receive core training at large sites.

- Education and training resources need to be shared within the network in whatever manner maximises their effectiveness for trainees.

- Effective processes for allocation of trainees. The impact of a missing staff member is proportional to the size of the staff, and an effective network needs to have responsive procedures for managing staff allocation fairly.

- A shared commitment to the welfare of all trainees, requiring good communication and handover at all levels of prevocational support staff and a routine agenda item for close attention at network meetings.

- An effective network committee. The network committee for prevocational training must:
  - meet regularly, with an appropriate agenda, minutes, chair and secretary
  - have committed representation from all training sites within the network
  - actively involve trainees.

HETI has published recommended terms of reference for the network committee – see Appendices.

- Effective lines of reporting — both to HETI and to health service administration of each local health district and general practice regional training provider in the network. Without clear lines of reporting, problems identified within the network can remain unsolved.

- Executive sponsorship of the network. Senior administration has to grasp the importance of the prevocational training program to the effective delivery of patient care and continuous quality
improvement. Investment in education and training returns dividends to the health service in improved patient care, improved staff performance and morale, reduced staff turnover and absenteeism, and greater efficiency of work practices. Prevocational training networks deserve executive support, and they need this support to function.

- Effective procedures for dispute resolution. Network members will not always agree and a network needs to establish a mutually respected procedure for dispute resolution as part of its governance structure.

- Cooperative relations with HETI and other networks. HETI provides funding and other support to networks, as well as accrediting all prevocational training sites and terms. Cooperative relations with HETI are essential for the smooth running of the network. Cooperation with other networks is useful for:
  - sharing the development costs of education and training, such as workshops, guidelines, lectures and online resources
  - providing extra opportunities to trainees through term swaps or trainee swaps
  - solving gaps in the network's training capacity or workforce by negotiation with another network.

- Capacity to implement, evaluate and improve the prevocational program.

- Effective role definitions, staffing and resourcing for the network committee, hospital training committees, directors of training, JMO managers, supervisors, educators, and trainees. For example, each hospital's General Clinical Training Committee needs to know how its role articulates with the role of the network committee.

- Further details of network governance are given in section three of this guide.
Working towards the network model

Most prevocational training networks are not far from fulfilling all of the ideal specifications of the network model — but nobody's perfect!

We hope that all prevocational training networks will review themselves against the network model and develop a plan to improve their capacity to deliver networked prevocational training.

Some networks may aspire to become larger, taking in more training sites in order to broaden the range of training experiences available within the network.

HETI's accreditation standards and processes, which currently focus on individual training sites, will be developed to measure the effectiveness of networks.

Network ‘specialisation’

While there are core features required by the learning model and the network model, there is also room for individual networks to develop a unique character based upon particular strengths.
Section three: governance

National structures

The Commonwealth government provides funding, policy guidance and support for a range of clinical education and training activities, particularly in general practice. The Commonwealth funds the Prevocational General Practice Placements Program to provide general practice training for prevocational trainees.

Health Workforce Australia (HWA, www.hwa.gov.au) is the Commonwealth agency charged with managing the national health workforce development agenda. Several of its programs will have a growing influence on clinical education and training in NSW. For example, under the Clinical Supervision Support Program, HETI has been funded to audit and then develop clinical supervision training capacity in NSW. HWA’s Simulated Learning Environments program is increasing the availability of clinical simulation-based training. HWA is a potential funding source for projects to enhance and develop clinical training capacity.

The Australian Medical Council (AMC, www.amc.org.au) is an independent national standards body for medical education and training. Its purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community. It does not provide clinical education and training, but does assess overseas-qualified medical practitioners seeking registration to practise medicine in Australia.

The Australian Health Practitioner Regulation Agency (AHPRA, www.ahpra.gov.au), which includes the Medical Board of Australia (MBA), manages the registration of medical practitioners. The MBA sets national standards for internship that have to be met by all state jurisdictions. AHPRA and the MBA have no direct role in providing education and training. In NSW, AHPRA relies on HETI to set standards for the training and assessment of prevocational trainees, and to accredit prevocational training sites and training terms. AHPRA relies on the employers of interns to certify that interns have satisfactorily completed their internship and are eligible for general medical registration.

The medical specialist colleges play an important role in education and training of medical specialists. However, there is no college for prevocational trainees. (In NSW, HETI plays a role similar to that of a college for prevocational training.)

The Confederation of Postgraduate Medical Education Councils (CPMEC, www.cpmec.org.au) is an association of the organisations in Australia and New Zealand that are responsible for prevocational training. The NSW organisation is HETI. CPMEC works on projects for the development of prevocational training, most notably the Australian Curriculum Framework for Junior Doctors and the Prevocational Medical Accreditation Framework.
NSW state structures

The NSW Ministry of Health (www.health.nsw.gov.au) sets policy for the NSW public health system as a whole, and controls the distribution of State funds to the public health system. This includes funding for prevocational medical education and training.

The provision of health services is organised by local health districts and specialty health networks (eg, the Children’s and Paediatric Services network). Most prevocational training networks cross local health district and specialty health network boundaries, requiring cooperation between different administrative units.

The Health Education and Training Institute (HETI, www.heti.nsw.gov.au) is the leading statewide agency for health workforce education and training in the NSW public health system (see below).

Other NSW Health agencies also play a role in education and training. For example, the Clinical Excellence Commission (CEC, www.cec.health.nsw.gov.au) developed the DETECT program, and the clinical networks of the Agency for Clinical Innovation (ACI, www.aci.health.nsw.gov.au) support professional development activity for multiprofessional groups specialised in various clinical domains (eg, aged health, anaesthesia perioperative care, and so on).

The role of HETI

As an outcome of the Director-General’s Governance Review on the future directions for NSW Health completed in October 2011, the Clinical Education and Training Institute was restructured to become the Health Education and Training Institute (HETI).

The role of HETI is to work closely with local health districts and other health organisations and clinical training providers to develop and deliver education and training across the NSW public health system. Supporting clinical training networks is a core activity of HETI.

HETI pursues excellence in health education and training and workforce capability to improve the health of patients and the working lives of NSW Health staff.

HETI’s vision is a world class NSW health workforce supporting excellent patient centred care.

HETI Medical Directorate

As well as the Prevocational Training Program, HETI’s Medical Directorate includes programs in Hospital Skills (for generalist medical officers working in NSW hospitals), Surgical Skills, Basic Physician Training, Emergency Medicine, Paediatrics, Psychiatry, Radiology, Cardiology, and Medical Administration.

The Medical Directorate operates in three units:

- General Medical Training Unit: (Prevocational Training, Hospital Skills and Surgical Skills) — responsible for the continuing professional development of doctors employed in NSW Health who are not enrolled as trainees, members or fellows of a specialist college.
- Standards, Accreditation and Allocation Unit: (Prevocational Training) — responsible for allocating interns to training positions and accrediting training facilities for prevocational training.
- Specialist Medical Training Unit: provides a growing range of programs for doctors employed in NSW Health who are trainees enrolled in college training programs.
Other HETI directorates

- Nursing & Midwifery Directorate
- Rural & Remote Directorate
- Oral Health Directorate
- Centre for Learning & Teaching (which supports innovation in educational methods across all directorates, and includes the Team Health program in interprofessional learning).

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Best contact (shown in rising order of staff seniority)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevocational education and training, JMO assessment forms, DPET reports, the Prevocational Training Council and the JMO Forum.</td>
<td>Prevocational Training Support Officer, Prevocational Training Program Coordinator, Program Manager, General Medical Training Unit</td>
</tr>
<tr>
<td>Prevocational accreditation information (term accreditation, facility accreditation, accreditation surveys), the Prevocational Accreditation Committee and the Prevocational Workforce Advisory Committee.</td>
<td>Network Support Officer, Network Coordinator, Program Manager, Standards, Accreditation and Allocation Unit</td>
</tr>
<tr>
<td>Intern allocation enquiries.</td>
<td>HSP Support Officer, HSP Coordinator, Program Manager, General Medical Training Unit</td>
</tr>
<tr>
<td>Hospital Skills Program, training for CMOs, Surgical Skills program.</td>
<td>Talk to the relevant Program Support Officer or Program Coordinator in Basic Physician Training, Cardiology, Emergency Medicine, Medical Administration, Paediatrics, Psychiatry, Radiology, or to the Program Manager, Specialist Medical Training Unit</td>
</tr>
<tr>
<td>Specialist medical training</td>
<td>Learning and Teaching Coordinator, Interprofessional Practice, Centre for Learning and Teaching</td>
</tr>
<tr>
<td>Interprofessional learning, Team Health, the New Starters program</td>
<td>If your enquiry is about a specific e-learning module, talk to the Program Support Officer or Program Coordinator of the associated program.</td>
</tr>
<tr>
<td>HETIMoodle, e-learning, new technologies in clinical education</td>
<td>High level enquiries and proposals: Director of Learning Innovations and Future Technology, Centre for Learning and Teaching</td>
</tr>
</tbody>
</table>

HETI: 02 9844 6551
info@heti.nsw.gov.au
www.heti.nsw.gov.au
Role of local health districts

Each local health district (LHD) is responsible for managing and developing the clinical workforce it needs to serve its community. Education and training of staff is one of the essential functions of health services at the local level.

There is potential for conflict within prevocational training networks that cross LHD boundaries: one of the functions of the Network Committee for Prevocational Training is to anticipate potential conflicts and develop methods of managing them.

Prevocational trainees are employees of the LHDs, and are managed by LHDs in accordance with the relevant employment award and NSW Ministry of Health policies.

Managing the education and training of a trainee who is having difficulty achieving learning outcomes is a task for DPETs, GCTC and NCPT, assisted with advice from HETI. However, any alleged breaches of discipline relating to misconduct, serious performance issues or inappropriate behaviour involving staff of health services need to be addressed and resolved within the context of the relevant legislation, industrial instruments and the principles of procedural fairness. Disciplinary matters should be referred to medical administration for management according to PD2005_225, A framework for managing the disciplinary process in NSW Health.

Role of regional general practice training providers

Regional general practice training providers deliver training towards the fellowships offered by the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine for registrars enrolled in the Australian General Practice Training Program (AGPT). In relation to prevocational training, a regional training provider:

- coordinates and supports an integrated general practice prevocational education and training program within its participating general practices
- provides adequate staff with appropriate clinical and educational expertise to plan, coordinate and administer the program
- monitors, evaluates and improves key aspects of the program
- ensures the trainees are supported by a Director of Prevocational Education and Training
- supports prevocational trainees, monitors their wellbeing and encourages them to take responsibility for their self-care
- identifies and supports under-performing prevocational trainees
- ensures all doctors providing clinical supervision and training to prevocational trainees are educated and supported in that role
- ensures the availability of appropriate accommodation.

For more information about the Prevocational General Practice Placements program and its relationship to hospital-based training, see “General practice training terms” on page 40.
Role of DPETs

The Director of Prevocational Education and Training (DPET) directs the training of prevocational medical trainees at each training site, and has a more continuous involvement with trainees than their supervisors, who change from term to term.

The DPET:

- develops, coordinates and promotes the clinical training of prevocational trainees, in association with prevocational trainee staff management, the General Clinical Training Committee (GCTC) and the Network Committee for Prevocational Training (NCPT).
- advocates for trainee welfare within the health system.
- supports term supervisors and prevocational trainees independently of line management, and helps solve problems that can arise during training (e.g., underperformance, mismatch of expectations, trainee distress, communication issues between trainee and team).
- coordinates the assessment of trainees, co-signing all end-term assessments along with the term supervisor. At home hospitals, the DPET or the Director of Medical Services certifies prevocational trainees as eligible for general registration upon the satisfactory completion of their internship.
- evaluates training terms, using the term evaluations completed by trainees and other information, and provides feedback to term supervisors. The DPET oversees the annual review of term descriptions by term supervisors and helps create new training terms and to improve the quality of existing terms.
- participates in the education of prevocational trainees and promotes professional responsibility and ethics among prevocational trainees.

The DPET is responsible for providing a structured education program for prevocational trainees and evaluating its effectiveness. The education program is usually conducted in regular weekly sessions attended by all prevocational trainees. The JMO Management Unit provides administrative support to the program, but the DPET is responsible for the educational content and choice of presenters. The DPET encourages the participation of trainees in the education program, and helps to ensure that trainees are released from clinical duties in order to attend. Using formal and informal feedback from trainees, the DPET evaluates and improves the education program each year.

The DPET plays a major role in the planning, delivery and evaluation of prevocational orientation programs, including acting as a resource for clinical teachers.

For more information about the role of the Director of Prevocational Education and Training, see the DPET Guide (www.heti.nsw.gov.au/prevocational#trainers) and HETI's DPET Position Description (page 50).

GP DPETs

Each general practice regional training provider appoints a GP DPET who oversees the prevocational trainees who are in general practice placements managed by that organisation.

Unlike hospital-based DPETs, GP DPETs may not be working at the same site as the trainees. They are also outside the hospital/NSW Health administrative umbrella. Liaison between hospital-based and general-practice-based DPETs is important, to ensure that trainees are appropriately monitored and managed as they move from one training site to another. The relationship is similar to that between DPETs at home hospitals and rotation hospitals. GP DPETs also need established working relationships with JMO Managers at the hospitals.
GP DPETs must be involved in the planning of prevocational training networks. Like hospital DPETs, they must be invited to meetings of the Network Committee for Prevocational Training, and must receive the minutes and agendas of these meetings.

It is a good idea for networks to provide regular opportunities for DPETs, JMO Managers and others involved in prevocational training to meet and get to know each other.

**Role of JMO management units**

The JMO management unit in a hospital is the centre for administration of employment, training and education of junior doctors. The JMO unit is the point of continuous contact for prevocational trainees throughout their time at a hospital, and JMO managers are well placed to monitor trainee welfare. The JMO unit works closely with the hospital DPET and will liaise with the general practice DPET who is responsible for trainees on rotation from the hospital to general practice.

The JMO unit supports and monitors trainees, manages their rosters, rotations and leave requests, advocates for quality training terms and good supervision, and ensures that training accreditation standards are met.

**Role of General Clinical Training Committee**

Each prevocational training hospital must have a General Clinical Training Committee (GCTC) to ensure that trainees are clinically competent for safe practice and provide quality patient care.

The GCTC advises on education and information resources needed to support education programs, and provides appropriate advice on other matters relating to the delivery of medical education and training.

The GCTC provides support to the DPET and oversight of the DPET role. For example, the GCTC should ensure that there is an appropriate succession plan for the DPET.

For more information, see the GCTC terms of reference in the appendices.

**Role of Network Committee for Prevocational Training**

Each prevocational training network must establish a Network Committee for Prevocational Training (NCPT) to support the efficient running of training in a fair and transparent manner.

The purpose of the committee is to develop safe, high quality training of prevocational trainees through good governance and management of the training program based in the network.

Some NCPT’s form subcommittees to manage details of work (eg, an education subcommittee to coordinate network-wide education), or working groups to manage particular projects.

In effect most of this book is about the issues that the NCPT manages. The NCPT terms of reference (see appendices) is a good summary of its responsibilities.

**Trainee representation**

All network and hospital committees for prevocational training must include trainee representation. To encourage trainee representation, actively engage trainees in the work of the committee. Don’t just have trainee reps as tokens: give them tasks and expect input. It may be helpful to have an active trainee subcommittee that meets separately.
Other roles

Education Support Officers and DPET Assistants: The role of an education support officer is to develop, coordinate and evaluate education training programs and educational activities, liaising with the DPET, GCTC and NCPT as required. A DPET assistant performs a similar role, but with more emphasis on providing administrative assistance to the DPET. In many hospitals, these roles are performed by JMO managers or other staff within the JMO unit. Whoever does the job, it is essential to the development and evaluation of the education program.

HETI’s prevocational training program does not provide funding specifically for education support officers or DPET assistants, but it is one of the allowable expenses of the prevocational training grant to pay for this sort of administrative assistance. Several local health districts provide an education support officer or DPET assistant funded from general revenue.

Term supervisors: a term supervisor is needed to lead each training term. The role includes

- preparing and reviewing a term description that defines the trainee’s responsibilities and the learning objectives of the term
- defining, documenting and explaining specific knowledge and skills to be developed during the term
- determining the level and proximity of supervision that will be required for each trainee
- ensuring that systems of work and training within the term minimise risks and support the safety of staff and patients supporting trainee attendance at formal education sessions and providing effective practice-based teaching
- monitoring trainee progress and providing continual constructive feedback to the trainee
- supporting the professional development of the trainee during the term, advising on concerns, managing problems and giving career guidance
- completing a mid-term formative appraisal of the trainee’s performance and an end-term summative assessment.

Term supervisors work with the DPET to manage aspects of the professional development of trainees that run across terms.
Specific issues in network governance

Memorandum of understanding

HETI strongly recommends that all training sites within a network should document a memorandum of understanding for the allocation of trainees, taking into account any rural and regional recruits, before all recruitment is finalised for the year.

The memorandum of understanding should give effect to the principles recommended below.

Education and training principles

- Patient safety and quality of care have top priority. Trainees are trained in ways that are safe for them and for their patients. Education and training are designed to improve patient care now and in the future.
- Prevocational training is guided by the Australian Curriculum Framework for Junior Doctors and aims to produce a well-rounded doctor with the general competencies required for safe practice.
- Trainees have equitable access to training opportunities and a reasonable opportunity to follow their preferred career pathway. The networks function to share the benefits and responsibilities of being a trainee evenly among trainees.
- The network promotes sharing of resources between sites (eg, teachers, simulation centres, conferencing facilities, e-learning) to achieve efficiencies and maximise learning opportunities available to trainees.
- The education and training of trainees is coordinated at a network level to ensure that learning opportunities are optimised.

Workforce distribution principles

- All prevocational training terms must be accredited by HETI and workforce shall be distributed in accordance with accreditation requirements.
- The availability of terms, quality of supervision and the provision of education and training must be taken into account when distributing the workforce.
- The network shall consider the totality of the individual trainee's experience when making decisions about workforce distribution.
- In networks with more than one home hospital, the allocation of trainees to home hospitals must be done using a fair and transparent process. Trainees must do at least three terms at their home hospital in PGY1 and two in PGY2. New trainees must be informed of their home hospital by November before the start of the clinical year.
- Trainees belong to the network, not to their home hospitals. The network committee must share the benefits and responsibilities of having prevocational trainees evenly among training sites.
- If there is a workforce shortage, this should be shared equitably within the network, having regard to the proportional impact of a shortage. For example, generally if one of two positions in a term is vacant, this has a much larger impact than if one of five positions is vacant. Networks should have a policy on how to manage vacancies in network that take into account the number of positions at each facility and their ability to manage the vacancy at a local level.
Managing leave

The network’s memorandum of understanding should include an agreement regarding responsibilities for leave cover. Policy should take into account the critical nature of particular rotations, the number of positions at each facility, and the ability to manage the vacancy at a local level.

Leave is either planned (e.g., annual leave, maternity leave) or unplanned (e.g., sick leave or FACS leave). In principle:

- Unplanned leave under two weeks should be the responsibility of the local facility from which the trainee is absent, while unplanned leave beyond two weeks becomes a network responsibility.
- The cover for planned leave should be the responsibility of the facility which approved the leave. Generally, planned leave will be approved by the home hospital of the trainee, and should take place in a term at the home hospital. Leave within a training term must be approved by the training site hosting the term. If a home hospital approves leave for a trainee on rotation, it is the responsibility of the home hospital to cover that leave.
- Hospitals with rural preferential recruits should aim to employ sufficient numbers to cover relief, or should seek the prior agreement of the network that the network can cover relief.
- Management of leave may include planned transfer of funds between rural and metropolitan hospitals.
- Network agreements, either employing additional leave relief, or “purchasing” positions from other hospitals in the network, should be in place before the recruitment period ends to provide adequate baseline numbers.

Leave and registration requirements

When approving leave for interns, facilities and networks should bear in mind the The Medical Board of Australia standard for internship, which requires that interns are required to perform satisfactorily under supervision in the following terms:

- A term of at least 8 weeks that provides experience in emergency medical care.
- A term of at least 10 weeks that provides experience in medicine.
- A term of at least 10 weeks that provides experience in surgery.
- A range of other approved terms to make up 12 months (minimum of 47 weeks full time equivalent service).

As terms in NSW are either 10 or 11 weeks long, this suggests that a maximum of 1 weeks’ leave can be granted in a core medical or surgical term (if it is an 11-week term, otherwise no leave) and a maximum of 3 weeks’ leave in an emergency term (if it is an 11-week term, otherwise maximum leave of 2 weeks).

Rural–Regional–Metropolitan relationships

Rural and metropolitan training sites can have different perspectives on the governance of the network. There are potential disagreements on issues such as:

- Allocation of training terms (rural trainees feeling that they do not get an equal chance to do desirable training terms at metropolitan centres, and vice versa).
- Management of leave, with small sites feeling unsupported by larger sites, or larger sites feeling exploited by smaller sites.
Coordination of training  
Orientation to training  
Accommodation of trainees on rotation.  

In networks with both rural and metropolitan home hospitals, the network committee must arrange a formal agreement between sites covering:

- separate orientation at the rural or regional site for locally-based trainees in addition to any network orientation  
- accommodation arrangements for both rural and metropolitan placements  
- leave arrangements  
- term allocations.  

The underlying principles should be that the network committee  
- governs the training network in an equitable and open manner, on the basis that all training sites are partners in the network  
- allows all stakeholders (including trainees, supervisors, departmental directors and health service administrators) to participate actively in network governance  
- distributes prevocational trainees across the network in ways that share workforce equitably among sites and that share training opportunities equitably among trainees  
- ensures that core orientation activities essential to a safe start at work are provided to all trainees in the network  
- coordinates and monitor formal education programs across the network to ensure that trainees do not have gaps or unnecessary repetition as they rotate through training sites  
- promotes sharing of resources between training sites within the network to achieve efficiencies and maximise learning opportunities available to trainees.  

Rural and regional recruitment programs  

Rural preferential recruitment is a merit-based recruitment program for doctors who want to complete prevocational training in a rural setting. It helps build a sustainable rural and regional workforce by giving priority to filling rural positions. Regional preferential allocation is a similar program that gives priority allocation to trainees willing to work in designated regional areas of higher workforce need.  

These programs are important because health services in rural and regional areas continue to have medical workforce shortages that affect equitable access to healthcare.  

The purpose of these programs is to facilitate recruitment to the facility, within the networks, and not to give preference for specific terms within the network, for which all trainees should have the same opportunity of access. Rural preferential recruits should not monopolise the most desirable training terms at rural sites, but neither should they be excluded from desirable training terms at metropolitan sites. Not all rural or regional recruited prevocational trainees will pursue a generalist career —they deserve equal opportunity with other trainees to pursue their vocational interest, potentially leading to a subspecialty vocational practice in a rural or regional setting.  

A key goal for two years of prevocational training is to provide trainees with a range of experiences to inform their career decisions, and give them a deeper understanding and of how care is delivered in the range of settings, which will then enhance care for the people of NSW into the future. The PGY2 year increases the knowledge, experience and competency of all trainees, and if they have already identified their career choice the network is encouraged to help to facilitate this wherever possible.
**Term allocation**

Trainees belong to the network, not just to their home hospitals.

The network committee must share the benefits and responsibilities of having prevocational trainees evenly among training sites.

Terms can be considered “core” terms, “patient care” terms, and “specialty experience” terms.

The principle is that terms should be shared optimally for all network trainees. Not all trainees can be allocated to their first choices, but networks have a range of flexible options to do with term allocation, leave allocation, and other educational opportunities which can be used to negotiate satisfactory outcomes for the trainees and the system.

Neither rural, regional, or metropolitan trainees should have special preference in relation to desirable terms: all trainees should have equal opportunity to receive their term preferences.

HETI does not allocate terms but does have oversight of the effectiveness of these principles.

**Term to term transitions**

The allocation process must be coordinated at a network level to ensure that trainees are not rostered to an impracticable or unsafe transition from term to term. For example: it would be inappropriate for a trainee to be allocated to complete a term on Sunday night in a metropolitan hospital and then commence a term next day in a rural hospital. A safe number of hours for rest and travel must be arranged at term transitions.

**Swaps across networks**

Trainee swaps can be arranged between networks on a case-by-case basis and are supported by HETI to obtain the best opportunities for trainees. JMO Managers can use their professional network to help facilitate trainee swaps.

Swaps require the mutual agreement of the trainees and JMO management in both networks.

**Workforce shortage**

When managing workforce shortages, the potential impact on patient safety is the paramount consideration.

If there is a workforce shortage, this should be shared equitably within the network, having regard to the proportional impact of a shortage. For example, generally if one of two positions in a term is vacant, this has a much larger impact than if one of five positions is vacant. Networks should have a policy on how to manage vacancies in the network that take into account the number of positions at each facility and their ability to manage the vacancy at a local level.

A network accord about how workforce shortages will be managed is best achieved before the completion of recruitment.
General practice training terms

At a time when trainee numbers are increasing, the extra training capacity provided by general practice placements is a welcome addition to the prevocational training program. General practice training terms are valued highly by participating trainees, providing wide and varied experiences in primary health care in a supportive learning environment.

Most general practices take a single trainee at a time, and it is highly disruptive to the practice if the allocated trainee position is not filled continuously from term to term. It is important that this is acknowledged in the workforce planning of the network. In general, pulling a trainee out of a general practice placement should not be considered an appropriate option for filling an unexpected workforce shortage in a hospital. General practices that cannot get prevocational trainees on a regular basis are likely to pull out of the prevocational program altogether.

Prevocational general practice placements are organised through general practice regional training providers (the same organisations that manage general practice vocational training). Each regional training provider appoints a GP DPET who oversees the prevocational trainees who are in general practice placements managed by that organisation.

It is a good idea for networks to provide regular opportunities for GP and hospital-based DPETs, JMO Managers and others involved in prevocational training to meet and get to know each other.

Managing trainees in difficulty

If a trainee is having difficulty meeting performance requirements, within a single training term, this may be managed by the term supervisor in consultation with the Director of Prevocational Education and Training for that training site. The Trainee in difficulty handbook gives detailed guidance about how to manage the range of problems that may arise. Most difficulties will be temporary and can be remediated fairly quickly with active management.

If the trainee’s difficulties are likely to continue across more than one term and on rotation to other training sites, the situation should be discussed between the responsible DPETs as soon as possible and reviewed at the next network committee meeting.

Discussions of individual trainees are conducted in a closed session without the presence of trainees or guests. Considerations of safety and quality of patient care must have top priority, followed by the objective of giving the trainee every reasonable opportunity and assistance to remediate his or her performance.

Many strategies can be employed to help a trainee who has serious performance deficiencies:

- Providing a mentor.
- Providing extra learning opportunities.
- Providing psychosocial supports.
- Referring the trainee to a counsellor, doctor or coach.
- Allowing a period of extended leave.
- Giving the trainee a buddy to work with.
- Making the trainee supernumerary (observing and learning rather than working).
- Requiring the trainee to repeat the term.
- Shifting the trainee to a term that is less challenging (with the aim of returning to a higher level
of performance at a later time). This may include moving the trainee to a site where closer support is possible.

Performance management may require slower progress through training. An internship is normally for one year, but AHPRA grants provisional registration to interns for two years, and a few trainees may take that long to complete internship.

There cannot be a fixed rule about how much time an underperforming trainee should be given to improve performance. The answer depends on the nature and depth of any difficulties, the contributory circumstances, and the trainee's potential for improvement.

An intern who is not performing at a satisfactory level must never be recommended for general registration.

A small number of trainees will be judged incapable of achieving the standard required to continue in medical practice. The progress of trainees and the process of remediation should be thoroughly documented before any decision is taken. The management of a trainee in difficulty involves issues under employment/industrial law and it is critical that the Director of Medical Services and HR Department are involved early in the process if there is a possibility of disciplinary measures being required. The decision to terminate lies with the Local Health District (LHD) Chief Executive.

If an intern is underperforming for any reason and his/her progress to registration will be delayed, AHPRA should be informed. This is so that AHPRA is aware of the situation if and when the intern applies for a renewal of provisional registration. The appropriate contact is Kim Ayscough, State Manager, AHPRA, GPO Box 9958, Sydney 2001.

However, AHPRA does not play a role in remediating or counselling interns, or in arbitrating between interns and employers. In this respect, the Medical Board of Australia is unlike the previous Medical Board of New South Wales.

Some of the functions of the Medical Board of New South Wales continue in the Medical Council of New South Wales. If any doctor, including any intern, is impaired (eg., has a mental or physical health issue that affects his or her ability to practice), or if there are issues amounting to professional misconduct, the Medical Council of NSW is the appropriate authority to be informed, and it will investigate and recommend appropriate actions. Contact the Medical Council of New South Wales, PO Box 104, Gladesville NSW 1675, (02) 98792200, mcnsw@mcnsw.org.au.

Sometimes an intern has general performance issues which mean that progress to registration is delayed or unlikely to be achieved, but which do not amount to an impairment or professional misconduct. This is not a matter for the Medical Council of NSW. As far as possible, these underperformance issues should be dealt with by the employer, but the Prevocational Training Council at HETI is available to provide advice on the appropriate referral body and can be contacted via Craig Bingham, Program Manager, HETI, Locked Bag 5022, Gladesville 1675; cbingham@heti.nsw.gov.au, 9844 6511.

Supervisor resource

Appendices

Available on the web:
NSW/ACT prevocational training networks: the list of participating hospitals, general practices and other training sites changes frequently. An updated list is available at www.heti.nsw.gov.au/prevocational#trainees

Included below:
Network Committee for Prevocational Training terms of reference template 43
General clinical training committee terms of reference template 48
Position description: Director of Prevocational Education and Training 50
Position description: Term supervisor 53
Summary of accreditation standards 56

Note: Documents included here were correct at July 2012. To check for updates, go to <www.heti.nsw.gov.au/prevocational>. 
Network Committee for Prevocational Training (NCPT) terms of reference (template)

Purpose of committee

Each prevocational training network will establish a Network Committee for Prevocational Training to support the efficient running of training in a fair and transparent manner.

The purpose of the committee is to develop safe, high quality training of prevocational trainees through good governance and management of the training program based in the network.

Role and responsibilities

The role of the NCPT is to:

- govern the training network in an equitable and open manner, on the basis that all training sites are partners in the network
- allow all stakeholders (including trainees, supervisors, departmental directors and health service administrators) to participate actively in network governance
- distribute prevocational trainees across the network in ways that share workforce equitably among sites and that share training opportunities equitably among trainees
- ensure that core orientation activities essential to a safe start at work are provided to all trainees in the network
- promote best practice methods as standards within the network
- ensure that all trainees within the network have access to high quality education and training based upon the Australian Curriculum Framework for Junior Doctors
- coordinate and monitor formal education programs across the network to ensure that trainees do not have gaps or unnecessary repetition as they rotate through training sites
- monitor the quality of clinical supervision provided to trainees and take actions to improve supervision when required
- monitor the quality of training terms and education programs using trainee feedback
- monitor the progress of trainees as they move from term to term and site to site to ensure that difficulties are detected early and remediated consistently, and that opportunities for professional development build as trainees progress
- develop ideas and strategies to improve training within the network and to remedy identified deficiencies
- support the Directors of Prevocational Education and Training at each training site in the network
- promote sharing of resources between training sites within the network to achieve efficiencies and maximise learning opportunities available to trainees.
In networks with rural preferential recruitment sites or regional preferential allocation sites, the network committee must arrange a formal agreement between sites covering:

- separate orientation at the rural or regional site for locally-based trainees in addition to any network orientation
- accommodation arrangements for both rural and metropolitan placements
- leave arrangements
- term allocations.

Principles

The NCPT shall uphold the following principles:

Education and training principles

- Patient safety and quality of care have top priority. Trainees are trained in ways that are safe for them and for their patients. Education and training are designed to improve patient care now and in the future.
- Prevocational training is guided by the Australian Curriculum Framework for Junior Doctors and aims to produce a well-rounded doctor with the general competencies required for safe practice.
- Trainees have equitable access to training opportunities and a reasonable opportunity to follow their preferred career pathway. The networks function to share the benefits and responsibilities of being a trainee evenly among trainees.
- The network promotes sharing of resources between sites (eg, teachers, simulation centres, conferencing facilities, e-learning) to achieve efficiencies and maximise learning opportunities available to trainees.
- The education and training of trainees is coordinated at a network level to ensure that learning opportunities are optimised.

Workforce distribution principles

- All prevocational training terms must be accredited by HETI and workforce shall be distributed in accordance with accreditation requirements.
- The availability of terms, quality of supervision and the provision of education and training must be taken into account when distributing the workforce.
- The network committee shall consider the totality of the individual trainee’s experience when making decisions about workforce distribution.
- In networks with more than one home hospital, the allocation of trainees to home hospitals must be done using a fair and transparent process. Trainees must do at least three terms at their home hospital in PGY1 and two in PGY2. New trainees must be informed of their home hospital by November before the start of the clinical year.
- Trainees belong to the network, not to their home hospitals. The network committee must share the benefits and responsibilities of having prevocational trainees evenly among training sites.
- If there is a workforce shortage, this should be shared equitably within the network, having regard to the proportional impact of a shortage. For example, generally if one of two positions in
a term is vacant, this has a much larger impact than if one of five positions is vacant. Networks should have a policy on how to manage vacancies in network that take into account the number of positions at each facility and their ability to manage the vacancy at a local level.

- Leave within a training term must be approved by the training site hosting the term and coordinated at the network level.

**Committee constitution**

**Representation**

The NCPT must include:

- At least four trainee representatives from both PGY1 and PGY2, and not only from the largest site in the network
- all the Directors of Prevocational Education and Training from training sites within the network, except that general practice Directors of Prevocational Education and Training can elect to be represented jointly by a single delegate
- senior representatives of JMO management
- senior representatives of Directors of Medical Services

Other members (eg, term supervisors, local health district executive) to broaden the representation of the committee are encouraged.

All training sites must be represented on the committee, except that general practices in the network can elect to be represented jointly by a single delegate (eg, from the regional training provider)

The Chair will determine the official membership of the committee, which shall be minuted.

A HETI representative shall be invited to attend the NCPT as a non-voting observer and advisor.

**Chair**

The Chair of the NCPT will be elected annually at a meeting of the committee.

The Chair may be shared between co-Chairs with the agreement of the committee.

The Chair may appoint a Secretary, or put the Secretary position to a vote of the committee.

**Secretary**

The secretary will prepare documentation in conjunction with the Chair for each meeting, distribute documentation for each meeting, liaise with members as required and document minutes of the meeting.

**Distribution of agendas and minutes**

Agendas and minutes of NCPT meetings will be distributed to:

- trainee representatives from both PGY1 and PGY2
- all the Directors of Prevocational Education and Training from training sites within the network (including all general practice Directors of Prevocational Education and Training)
senior representatives of JMO management
senior representatives of Directors of Medical Services
HETI.

Quorum for meetings
A quorum requires:

- that 80% of training sites are represented by at least one official member, and
- that JMOs, medical administration, JMO management and DPETs are represented, except that:
  - a quorum will not require that a general practice representative is present, and
  - for the purposes of a quorum, small rural sites (ie, rotation sites, not rural home hospitals) should be allowed to delegate representation, provided that the delegate is briefed with a report from the rural site.

Exclusions from meeting and minutes
The NCPT shall regularly include an agenda item to discuss the management of individual trainees in difficulty, and the JMO representatives on the committee must absent themselves from the meeting for this item.

The minutes of the agenda item to discuss the management of individual trainees in difficulty shall not be distributed by the Secretary, but will be kept for the reference of the Chair.

Voting
As required.

Frequency of meetings
The NCPT will meet at least once per training term (minimum five meetings per year).

Notice of meetings
The NCPT shall set the annual schedule of meetings (time, date and place) at the beginning of the year. The Secretary shall ensure that the schedule is communicated to all members of the NCPT at the beginning of the year. The schedule of meetings should be publicised to trainees, supervisors and others involved in prevocational training in order to encourage their participation in meetings.

The Secretary will also provide a reminder to all NCPT members at least one week before each meeting. This notice shall be accompanied by an agenda and the minutes of the last meeting.

Formal reporting
The NCPT shall report to:

The Chief Executive of each Local Health District involved in the prevocational training network, or his/her nominated delegate

The Chair of the Prevocational Training Council at HETI.
Formal reporting shall include:

An annual written report of NCPT activities and achievements.

Specific data about: the number of prevocational trainees in the network, their distribution by training site and term, vacancies, and progression.

The minutes of the NCPT.

**Endorsement**

These terms of reference endorsed by:

[List should include Chief Executive of each Local Health Network involved in the prevocational training network and the Chair of the Prevocational Training Council at HETI.]

Date of last revision: July 2012

Date of next review: July 2013

**Responsible officer for next review: Prevocational Program Coordinator**

Copies of the endorsed terms of reference should be provided to all NCPT members, the Chief Executive of each Local Health Network involved in the prevocational training network and the Chair of the Prevocational Training Council at HETI.
General Clinical Training Committee terms of reference (template)

Purpose of committee
To support the mission of the Clinical Education and Training Institute (HETI), by ensuring that trainees are clinically competent for safe practice and provide quality patient care.

Role and responsibilities

Advisory functions
- Advise on education and information resources needed to support education programs
- Provide appropriate advice on other matters relating to the delivery of medical education and training, as required by the hospital

Operational functions
- The Committee will conduct its activities in accord with the rules of the hospital and its terms of reference
- Develop, implement, monitor and evaluate all orientation, training and educational programs for doctors in training
- Ensure that each trainee rotation, including secondments, is consistent with HETI guidelines
- Regularly review and evaluate the training, education, experience and working conditions of each trainee
- Review hospital performance according to the HETI standards
- Determine the specific orientation, training and educational needs of prevocational trainees
- Review and evaluate the performance of Term Supervisors and the Director of Prevocational Education and Training and
- Ensure there is a Director of Prevocational Education and Training succession plan

Membership
The membership is to include a broad range of expertise and backgrounds. The wide membership and effective functioning of the committee will ensure that all relevant departments of the hospital develop a sense of responsibility for the education, training and development of their trainees.

Chair
Position: To be nominated.

Responsibilities: The Chair provides leadership to the GCTC and promotes a cohesive and effective environment. Key roles and responsibilities of the Chair include:
- assisting staff and the Committee to understand their role, responsibilities and accountability
- assessing the performance of Term Supervisors and the Director of Prevocational Education and Training on a regular basis
- ensure rotations, including secondments are consistent with HETI guidelines
• providing recommendations and advice to HETI in respect to medical education, training, standards, accreditation and workforce
• disclosing interests, which may impinge upon the exercise of his or her duties as Chair of the Committee.

Committee Support Officer
Position: To be nominated

Responsibilities: This person is held accountable for the preparation of agendas, minutes, the distribution of minutes and committee papers and follow-up on matters raised.

Minutes of meetings are to be kept and circulated to members of the Committee and the senior management of each hospital in the network after each meeting.

Other members
The committee will include representatives of:
• Hospital management
• Trainees (prevocational and vocational)
• Junior medical officer management
• The Medical Staff Council
• Term supervisors
• Director of Prevocational Education and Training
• Representatives from associated universities, colleges and other training programs (as appropriate)

Ex Officio & Co-opted or non-voting members
The Committee may co-opt members to the Committee and/or establish working parties as may be necessary

Conduct of meetings
Quorum: 50% + 1
Voting: As necessary
Frequency: The committee will meet at least quarterly
Duration:
Time:
Location:
Standing agenda items:

Formal reporting
The Committee is responsible to senior hospital management. The senior hospital management will ensure that the committee has authority for a range of relevant activities and that it is provided with adequate secretarial and administrative support.

Endorsed by
Committee or organisation:
Date:
Position description: Director of Prevocational Education and Training

Name of hospital: To be completed by employing hospital

Responsible to: Hospital executive through the General Clinical Training Committee (GCTC)

Version: January 2011

Mission of hospital
(2-3 sentences to be completed by employing hospital)

Role of DPET in achieving the mission of the hospital
(2-3 sentences to be completed by employing hospital)

Key relationships
- Regular liaison with Prevocational Trainees and Term Supervisors
- Liaison with Attending Medical Officers, the General Manager and administrative staff as required.

Key roles and responsibilities

The role of the Director of Prevocational Education and Training is to direct the education and training of prevocational medical trainees in the hospital. In performing this role, the fundamental responsibility of the Director of Prevocational Education and Training is to ensure patient safety at all times.

Specific responsibilities of the role:

1. Ensuring that the principles of prevocational education and training are attained by:
   - supporting a culture of professional development
   - providing a structured education program and evaluating its effectiveness
   - developing, coordinating and promoting the clinical training of prevocational trainees in association with JMO staff management and the General Clinical Training Committee
   - providing fair and transparent term allocations and workload
   - providing effective term and hospital orientation
   - overseeing ongoing and constructive assessment and feedback processes
   - identifying and supporting trainees with special needs
   - providing for adequate and appropriate supervision
   - providing adequate education and information resources
   - assisting the hospital in maintaining its accreditation status with HETI
   - participating in the education of prevocational trainees
   - promoting professional responsibility and ethics among prevocational trainees
   - being a resource for clinical teachers.

2. Looking after the personal and professional welfare of prevocational trainees, particularly those experiencing difficulties.
3 Being an advocate for the professional development of trainees by:
   ● ensuring procedural fairness
   ● maintaining independence from line management
   ● addressing system-wide issues.

4 Liaising and attending meetings with relevant groups and individuals in the training and education of trainees including:
   ● Term Supervisors
   ● Network Committee for Prevocational Training (NCPT)
   ● General Clinical Training Council
   ● Directors of Medical Services
   ● Visiting Medical Officers
   ● JMO Managers and administrative staff
   ● Hospital Executive
   ● Other DPETs within the Network
   ● HETI.

5 Managing the DPET funding through the Director of Prevocational Education and Training cost centre.

6 Developing a DPET succession plan.

Skills, knowledge and experience – selection criteria

1 Medical graduate with clinical postgraduate qualifications
2 A clinical appointment to practice at the hospital
3 Qualifications, appointment and experience at a level sufficient for communicating on authoritative terms with senior consultants acting as term supervisors
4 A commitment to and confidence in improving the quality of education and training offered by the hospital
5 An understanding of the principles of adult education and professional development
6 A genuine interest in postgraduate medical education, a willingness to develop expertise in this area, and a demonstrated understanding of the importance of the continuum of medical education as a lifelong professional commitment
7 Established collaborative links with administration and for medical staff council
8 A commitment to the mission of HETI and the ability to present and explain HETI’s goals.

Evaluation
The General Clinical Training Committee (GCTC) will undertake an annual performance review of the Director of Prevocational Education and Training. The performance review will be based on:

   ● Feedback from prevocational trainees, term supervisors and medical administration
   ● Evaluation of activities undertaken by the Director of Prevocational Education and Training
   ● Performance indicators (to be developed in consultation with the Director of Prevocational Education and Training).
Appointment process

A formal letter is to be sent to the Chair of the Prevocational Training Council at HETI from the Executive of the hospital with specific input from the General Clinical Training Committee (GCTC) with a recommendation for a new DPET (including his or her curriculum vitae). The Prevocational Training Council reviews the hospital's recommendation, advises the hospital of their consideration and sends a letter of welcome to the new DPET.

Verification

This section verifies that the position holder and supervisor have read the above position description and are satisfied that it accurately describes the position.

Position Holder

Signature
Date

Supervisor

Signature
Date
Position description: Term Supervisor

Name of hospital: To be completed by employing hospital

Reports to: Director of Prevocational Education and Training

Mission of hospital

(2-3 sentences to be completed by employing hospital)

Role of Term Supervisor in achieving the hospital mission

(2-3 sentences to be completed by employing hospital)

The Term Supervisor is responsible for the welfare of prevocational trainees allocated to their team or unit. Their key roles are ensuring appropriate supervision for patient safety, providing training to meet the learning objectives of the term, monitoring trainee progress and assessing trainee performance.

Key relationships

- Prevocational trainees and attending medical officers
- Director of Prevocational Education and Training
- Chair of the Network Committee for Prevocational Training
- Chair of the General Clinical Training Committee
- General Manager
- Administrative staff as required

Key roles and responsibilities

Patient safety

- Employs strategies to ensure the safety of care, including combinations of graded supervision, training and personal support for the prevocational trainees assigned to the term.

Trainee welfare

- Coordinates trainee activities across the term.
- Determines the level and proximity of supervision required for each prevocational trainee in each work situation.
- Ensures that the systems of work and training minimise risks and support the safety of prevocational trainees.
- Discusses issues such as grievances and career guidance with prevocational trainees.
- Encourages prevocational trainees to develop progressively increasing independence.
**Education and training**

- Prepares and reviews a term description in consultation with other attending medical officers in the team, the Director of Prevocational Education and Training, Junior Medical Officer Management and prevocational trainees. The term description describes the responsibilities and accountabilities of the prevocational trainee, specifies the skills required by the prevocational trainee to function safely and defines the specific knowledge and skills to be gained or enhanced during the term.
- Discusses training goals and expectations with the trainee at the beginning of term and ensures that a clinical orientation to the term is provided.
- Develops the educational program available to trainees during the term, supports attendance by prevocational trainees at educational events and provides effective practice-based teaching.
- Monitors the progress of prevocational trainees and provides continuous constructive feedback to guide their professional development.
- Encourages attending medical officers to provide continuous teaching, supervision and constructive feedback to prevocational trainees.
- Provides formal documented assessment at mid-term and the end of term. These two formal assessments begin with the trainee’s self-assessment and are developed in consultation with attending medical officers, registrars, nurses and other professional staff. Assessment includes planning and documenting actions to improve trainee performance.
- Intervenes when necessary to correct gaps or weaknesses in the knowledge or skills of prevocational trainees.
- Informs the Director of Prevocational Training if a prevocational trainee appears to be experiencing difficulty with work or the training program.

**Skills, knowledge, experience competencies and behaviours**

The Term Supervisor must be an attending medical officer (AMO) at the hospital with AMO responsibility for providing patient care within the scope of the term.

Term Supervisors must have:

- an understanding of the concepts of adult education, performance monitoring and quality improvement
- superior interpersonal skills
- a commitment to the mission of the Health Education and Training Institute (HETI) and the ability to present and explain HETI goals.

**Performance evaluation**

The performance of the Term Supervisor will be evaluated annually by the General Clinical Training Committee (GCTC) with reference to:

- DPET feedback
- Prevocational trainee feedback
- Efficiency of activities
- Performance indicators (to be developed by the GCTC)
Verification

This section verifies that the position holder and supervisor have read the above position description and are satisfied that it accurately describes the position.

Position Holder

Signature.................................................................

Date......................................................

Manager

Signature.................................................................

Date......................................................
# Summary of HETI standards of education, training and supervision for prevocational trainees

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>Goal 2</th>
<th>Goal 3</th>
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<tbody>
<tr>
<td><strong>The hospital ensures prevocational trainees have the appropriate knowledge, skills and supervision to provide quality patient care</strong></td>
<td><strong>The hospital provides a wide range of educational and training opportunities for prevocational trainees to ensure that they are competent and safe</strong></td>
<td><strong>The hospital promotes the welfare and interests of prevocational trainees</strong></td>
</tr>
<tr>
<td><strong>1.1 Hospital Orientation</strong>&lt;br&gt;The hospital provides an effective orientation for prevocational trainees</td>
<td><strong>2.1 Professional Development</strong>&lt;br&gt;The hospital supports and promotes a culture of professional development</td>
<td><strong>3.1 Prevocational Trainee Management</strong>&lt;br&gt;The hospital provides effective organisational structures for the management of prevocational trainees</td>
</tr>
<tr>
<td>1.1.1 The hospital provides an orientation to all prevocational trainees. (At the start of their PGY1 year and to a hospital)</td>
<td>2.1.1 The hospital assesses the professional development needs of prevocational trainees, taking into account the needs of the hospital</td>
<td>3.1.1 The hospital provides sufficient resources to manage prevocational trainees.</td>
</tr>
<tr>
<td>1.1.2 At orientation the hospital ensures that the prevocational trainees have clinical information and skills required to commence work</td>
<td>2.1.2 The hospital identifies and provides the resources to fulfil the professional development needs of prevocational trainees.</td>
<td>3.1.2 The hospital manages Junior Medical Officer grievances effectively</td>
</tr>
<tr>
<td>1.1.3 The hospital evaluates orientation to the hospital and utilises the information to improve the quality of hospital orientation</td>
<td>2.1.3 The hospital ensures that all prevocational trainees have access to career guidance and opportunities for professional development</td>
<td>3.1.3 The hospital has an effective process for rostering prevocational trainee staff.</td>
</tr>
<tr>
<td><strong>1.2 Term Orientation</strong>&lt;br&gt;The hospital provides an effective orientation for prevocational trainees at the commencement of each term</td>
<td><strong>2.2 Training and Service Requirements</strong>&lt;br&gt;The hospital ensures that both training and service requirements are addressed in all terms</td>
<td><strong>3.1.4 The hospital is responsible for actively participating in the management of the network.</strong></td>
</tr>
<tr>
<td>1.2.1 The hospital provides the prevocational trainee with a written term description at, or immediately before, the commencement of each term.</td>
<td>2.2.1 Time is allocated within the working week exclusively for prevocational trainee education and training. The hospital has systems to ensure that this time is quarantined from service responsibilities.</td>
<td>3.1.5 The hospital evaluates prevocational trainee management to improve quality of prevocational trainee management.</td>
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<tr>
<td>Goal 1 – continued..</td>
<td>Goal 2 – continued..</td>
<td>Goal 3 – continued..</td>
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</table>
| 1.2.2 The term supervisor provides an orientation to all junior medical officers at the commencement of each term. | 2.2.2 The balance and mix of terms (glossary) allocated to each prevocational trainee provides a two-year program of general training. | 3.2 Prevocational Trainees with Special Needs  
The hospital identifies and supports prevocational trainees with special needs |
| 1.2.3 At the commencement of each term, the hospital ensures that the prevocational trainee has the appropriate knowledge and skills for safe practice for the term | 2.2.3 The hospital monitors and evaluates training and workload in and across all terms | 3.2.1 The hospital is effective in the early identification of prevocational trainees with special needs. |
| 1.2.4 The Hospital ensures that prevocational trainee’s receive an effective handover at the commencement of each term | 2.3 Formal Education Program  
The hospital provides prevocational trainees with an effective education program | 3.2.2 The hospital provides structured support for prevocational trainees with special needs coordinated at term, hospital and network level as appropriate. |
| 1.2.5 The hospital evaluates orientation to each term and utilises the information to improve the quality of orientation. | 2.3.1 The hospital provides a formal and structured education program | 3.2.3 The hospital and network routinely monitors and evaluates the identification and support for prevocational trainees with special needs and uses the information gained effectively. |
| 1.3 Supervision  
The hospital provides prevocational trainees with adequate and appropriate supervision. | 2.3.2 The hospital evaluates the adequacy and effectiveness of the formal education program and utilises the information to improve the program | 3.3 Safe Practice  
The hospital provides an environment that supports the safety of prevocational trainees |
| 1.3.1 The hospital provides adequate numbers of appropriately qualified medical staff to supervise prevocational trainees in all work situations | 2.4 Clinicians as Teachers  
The hospital provides effective clinical teaching and trains and evaluates clinicians in their role as teachers | 3.3.1 The hospital provides duty rosters that balance the service needs of the hospital with safe working hours for prevocational trainees. |
<p>| 1.3.2 The hospital ensures that there is effective clinical supervision of all prevocational trainees during normal hours | 2.4.1 The hospital ensures that all clinicians who are responsible for teaching are aware of their responsibilities. | 3.3.2 The hospital complies with its occupational health and safety obligations to prevocational trainees. |
| 1.3.3 The hospital ensures that there is effective clinical supervision of all prevocational trainees outside normal hours | 2.4.2 The hospital has processes to develop the teaching skills of clinicians who provide training to prevocational trainees | 3.3.3 The hospital evaluates the safety of working conditions of prevocational trainees and uses the information to improve safety |</p>
<table>
<thead>
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<tbody>
<tr>
<td>1.3.4 The Hospital ensures that all doctors providing clinical supervision to prevocational trainee's (including casuals and locums) are educated and supported in that role</td>
<td>2.4.3 The Hospital provides effective clinical practice-based teaching.</td>
<td>3.4 Promoting prevocational trainee Interests</td>
</tr>
<tr>
<td>1.3.5 The hospital educates prevocational trainees to identify their limitations and to acknowledge when help is required.</td>
<td>2.4.4 The hospital evaluates the effectiveness of clinical practice-based teaching provided for prevocational trainees, and utilises the information gained to improve the effectiveness of teaching.</td>
<td>The hospital promotes prevocational trainees' interests through representation and advocacy.</td>
</tr>
<tr>
<td>1.3.6 The hospital evaluates the adequacy and effectiveness of prevocational trainee supervision in all situations and uses the information to improve the quality of supervision</td>
<td>2.5 Assessment and Feedback</td>
<td>3.4.1 The hospital engages prevocational trainees and their advocates in decision making</td>
</tr>
<tr>
<td>The hospital provides prevocational trainees with ongoing constructive assessment and feedback</td>
<td>2.5.1 The hospital clearly explains the criteria, process and timing of formal assessment to prevocational trainees at the commencement of each term.</td>
<td>3.4.2 A General Clinical Training Committee is established and appropriately constituted with delegated authority. The committee meets regularly and complies with its terms of reference.</td>
</tr>
<tr>
<td>2.5.2 The hospital ensures that all doctors supervising prevocational trainees provide regular, informal feedback by speaking to prevocational trainees about their performance throughout the term.</td>
<td>3.4.3 The Director of Clinical Training supports and advocates effectively for prevocational trainees.</td>
<td>3.4.4 The hospital provides adequate support for the Director of Clinical Training</td>
</tr>
<tr>
<td>2.5.3 The Term Supervisor undertakes formal assessment and feedback using the HETI Progress Review Form at mid-term and at the end of the term.</td>
<td>3.5 Supporting prevocational trainees</td>
<td>The hospital supports prevocational trainees in taking responsibility for their self-care and provides access to personal support mechanisms to improve the well-being of prevocational trainees.</td>
</tr>
<tr>
<td>2.5.4 The hospital encourages prevocational trainees to take responsibility for their own performance, and to seek feedback from their supervisors in relation to improving their performance.</td>
<td>3.5.1 The hospital supports prevocational trainees in taking responsibility for their personal health and well being.</td>
<td></td>
</tr>
<tr>
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<tr>
<td>2.5.5 The hospital ensures that the performance of prevocational trainees is monitored across all terms in the hospital and the network and appropriate action taken when any problems are identified.</td>
<td>3.5.2 The hospital evaluates (glossary) the effectiveness of programs promoting self-care and uses the information to improve its support processes.</td>
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</tr>
<tr>
<td>2.5.6 The hospital evaluates systems for assessment and feedback about prevocational trainee performance within the hospital, and utilises the information gained.</td>
<td>3.6 Physical Amenities</td>
<td>The hospital provides a physical environment and amenities that support the well being of prevocational trainees</td>
</tr>
<tr>
<td><strong>2.6 Education and Information Resources</strong>&lt;br&gt;The hospital provides education and information resources that assist prevocational trainees to acquire knowledge and develop skills essential to the delivery of safe patient care</td>
<td>3.6.1 The hospital provides comfortable, clean, safe and accessible overnight accommodation for prevocational trainees rostered on-call or otherwise requiring such accommodation.</td>
<td></td>
</tr>
<tr>
<td>2.6.1 The hospital provides prevocational trainees with easy access to a range of education and information resources appropriate to their educational needs and the clinical needs of the hospital.</td>
<td>3.6.2 Secondment hospitals provide comfortable, clean, safe and accessible accommodation for prevocational trainees. As prevocational trainees have extended stays in this accommodation, a higher level of amenity is required.</td>
<td></td>
</tr>
<tr>
<td>2.6.2 The hospital provides prevocational trainees with information about, and training in, the use of information resources.</td>
<td>3.6.3 The hospital provides an accessible, safe, comfortable recreational area with a range of amenities.</td>
<td></td>
</tr>
<tr>
<td>2.6.3 The hospital evaluates access to and the range of information resources and utilises the information gained to improve these.</td>
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For more information about HETI’s accreditation standards and accreditation process, see www.heti.nsw.gov.au/accreditation
This guide is addressed to directors of education and training, JMO managers and others involved in managing prevocational training networks.

It describes a learning model (how and what trainees learn) and a network model (what a network needs to deliver the learning model) for the future of prevocational training in New South Wales.

It also describes the structures governing the network system from the State level to the training sites.

Effective networked training requires open communications and collaboration between clinicians and administrators working in a diversity of settings. This guide sets out ground rules for cooperation.