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# A review of the accreditation framework for prevocational training within NSW

## Report – August 2013

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# Foreword

It gives me great pleasure to submit the report on the review of the accreditation framework for prevocational training within NSW to HETI.

There is no doubt that the current period in prevocational training within Australia is characterized by significant change as the health system meets the challenges of accommodating increased numbers of medical graduates, in the context of changing governance arrangements set against the backdrop of increased demand on both health services and the senior medical staff who provide the training for and supervision of prevocational trainees.

The accreditation framework in place in NSW today is the result of the significant contribution of work and wisdom by a large number of people over the last two and a half decades. NSW can rightly be proud of the prevocational accreditation system and arguably led the country in the initial development of standards and processes for accreditation for prevocational training.

Having accreditation standards that articulate requirements for prevocational training, education, supervision and welfare has probably never been more important than it is today. Yet it is also critical that the accreditation framework is flexible, responsive to the wider system changes, and ultimately able to contribute to the delivery of high quality safe patient care within NSW – this is after all, the main game.

I was delighted to be asked to undertake this review and hope that it makes a valuable contribution to further improving prevocational education and training within NSW.

Dr Jo Burnand
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# Executive Summary

NSW, through the Health Education and Training Institute (HETI) has a well-established accreditation program for prevocational training, established two and a half decades ago that endures to the present day. The current model provides both a regulatory function (as a delegation of the MBA) in addition to comprising many elements characteristic of a quality assurance process, including self-assessment, periodic measurement with site visits, review by trained peer surveyors and encouragement towards continuous improvement.

The last decade has witnessed the emergence of a number of key factors that have impacted upon the accreditation program. These include: the establishment of a national registration authority and the Medical Board of Australia with a concomitant requirement for consistency of registration standards across the country; the work currently being undertaken by the Australian Medical Council on intern training; increased numbers of medical graduates; the emergence of alternative training placements; and increasing concerns regarding the burden of accreditation processes.

In response to the above drivers, HETI commissioned a review of the governance framework and processes within which accreditation of prevocational training programs operate within NSW. The review included: a literature review, the examination of other accreditation models in Australia and overseas, consultation with key stakeholders, and the examination of current prevocational accreditation processes within NSW. This report presents the results of the review, including the work undertaken, a summary of key findings and concludes by making a number of recommendations. The terms of reference of the review are at Appendix A.

It is very evident that a significant amount of work has been undertaken within NSW on the accreditation framework for prevocational training within NSW over several decades. The accreditation system is highly valued and there is evidence of clear support for the existence of a set of standards making the requirements for prevocational training explicit.

There were a number of issues identified with respect to the current accreditation system, primarily in relation to administrative processes, the burden of accreditation and accreditation of terms mid cycle. A number of recommendations have been made at the conclusion of this report to address concerns raised with respect to specific accreditation processes.

The examination of other accreditation models in Australia and overseas, combined with the literature review attempted to identify principles of best practice within accreditation frameworks. These principles, identified in Table 1, form the basis of a number of recommendations, but also importantly highlight what should be preserved in the accreditation framework going forward.

The current NSW accreditation framework is a process-based model of accreditation designed to measure the systems and processes thought to provide effective training for doctors. It is very evident that international models have moved or are moving toward outcome based accreditation systems. Outcomes-based models are viewed as more flexible, able to adapt to changing environments and circumstances, and encourage (rather than constrain) innovation. Ultimately outcomes based models are designed to measure the outputs of a training program, ie whether safe and competent doctors are being trained.

Accreditation systems are but one component of a complex structure supporting the delivery of high quality medical education and training. Other components include: curriculum development; workforce requirements; education and training governance; role of supervisors and educators; and assessment processes. Well-designed accreditation systems can support these components and arguably might be used as a lever for reform. The comprehensive process of reform underway in the US, the UK and more recently NZ, including in each case, work on the accreditation framework and standards, clearly highlight this.

With respect to NSW, whilst there appeared to be a clear mandate for change expressed by many stakeholders, it was arguably not of the magnitude required to move the accreditation framework toward an outcomes based model. The full engagement of key stakeholders in testing and implementing the recommendations contained within this review will be critical and a staged approach of reform will be required. The recommendations have therefore been divided on the basis of suggested timing of implementation.

One of the key features of the early recommendations is addressing currently identified issues, whilst concomitantly undertaking the preliminary work in preparation for the eventual transformation to an accreditation system based on an outcomes approach. This will place the prevocational accreditation system in NSW in line with international models and provide a basis for alignment of other medical (and potentially other health professional) education accreditation systems in the future.

In the short term (during the next twelve months):

- That the governance and accountability of the delivery of prevocational education and training should be clarified for the system at large. This should unambiguously place the responsibility and accountability for prevocational education and training with the site in which it is delivered. The senior executive position(s) within the facility who are responsible for ensuring compliance with the prevocational accreditation standards should be clearly identified. This will require collaboration between HETI, MoH, LHDs and other training sites with clear communication to all stakeholders. (8.1)

- That the accreditation process is supported by the development of an online web-based system designed to capture all current data sets with provision to expand to include trainee surveys, trainee assessments, and (potentially) clinical portfolios in the future. Whilst It is acknowledged that the implementation of a fully integrated electronic system will take longer than twelve months, the capacity for online collection of data is regarded as critical to reducing the burden of accreditation on the system at large and should be given some priority. (8.2)

- That the processes for accreditation of terms mid survey cycle be streamlined. The out of session provisional accreditation of terms by the Chair of the PAC, recently introduced as a mechanism of fast tracking applications, is supported. (8.3)

- That the current term description template used by the PAC to accredit terms is renamed (potentially as an 'application form for provisional accreditation of a new term') and modified to only include the information that is required by the PAC on which to base a decision for provisional accreditation. (8.4)

- That the requirement for a term description for each prevocational term be preserved, but that facilities be permitted to develop their own term description templates. The standards will need to be revised to reflect required elements of a term description whilst removing the mandate of the requirement to use the HETI template. (8.5)

- That prevocational trainees be engaged with and educated about the role of the accreditation framework and processes and required to participate in the evaluation of the training environment as an expected component of their professional responsibilities. (This would provide a platform for the future implementation of Recommendation 8.11) (8.6)

- That the proposed move to a four year accreditation cycle be supported with a staged transition for sites who have attained 3 year accreditation status over 2 consecutive cycles with appropriate response to any provisos in the interim. (8.7)

- That those sites on four-year accreditation cycles be expected to submit a concise progress report containing the following elements: (i) significant changes since the last survey; (ii) summary of new terms (provisionally accredited mid cycle); (iii) new developments and initiatives; and (iv) action taken against recommendations. A proposed accreditation model is depicted below. (8.8)

- That the membership of the Prevocational Accreditation Committee be reviewed to ensure appropriate representation. This may include broadening the membership to include representatives of expanded training settings in addition to consumer representation. The revised membership should also have provision for inclusion of members with particular expertise in medical education and/or accreditation/quality assurance. (8.9)

- That the terms of reference of the Prevocational Accreditation Committee be reviewed to ensure it complies with the requirement for independence (refer to Domain 2 Quality Framework for the Review of Intern Training Accreditation Bodies which requires that **"***Decision making about accreditation of programs is independent and there is no evidence that any area of the community, including government, health services, professional associations has undue influence*.") (8.10)

- That a validated online trainee survey designed to evaluate the clinical training environment (such as PHEEM or equivalent) is adopted and piloted with a view to full implementation in NSW within the next two years. (8.11)

- That consideration is given to the public reporting of accreditation surveys in ways that foster and reward excellence and innovation in medical education and training across NSW. (8.12)

- That the composition and size of survey teams be evaluated to ensure the efficient use of human resources on site visits. This would include review of membership of program staff on site visits as a standard practice. Teams should generally be comprised of between two to four people with an absolute maximum of six for the larger facilities. If trainee surveyors are to be included on a survey team, this should be discussed with the team leader (8.13)

In the longer term (within the next two years)

- That the accreditation standards document be rewritten, restructured and aligned with the draft AMC National Intern Training Standards with a more specific focus on the domains of governance and the learning environment. (8.14)

- The new standards should have provision for mandatory standards and be supported by the development of policies. Policies should be readily accessible and promoted to all stakeholders, particularly prevocational trainees and their clinical supervisors. Where possible, the new standards should be languaged in such a way that supports the eventual transition to an outcomes, rather than process, focus. (8.15)

- That the pre-survey instrument be reconfigured in line with the standards document with an emphasis on continuous collection of evidence, including collated trainee surveys and other evidence as determined by HETI, (this would include Network and GCTC minutes, annual DPET report, collated trainee assessment data) (8.16)

- That once the pre-survey instrument and standards documents have been finalised, the pre-survey process is modified to allow for preliminary assessment against the standards and identification of issues to be considered at the survey visit, in collaboration with the training facility. A proposed model is depicted below. (8.17)

- That once 8.12 is in place, survey visits are reduced to one day and provide for targeted examination, in collaboration with the training facility of the identified issues. (8.18)

- That once training sites have established continuous data reporting systems, consideration be given to the development of thresholds which trigger targeted intervention (including potentially a site visit) within the survey cycle to deal with emergent urgent issues. (8.19)

- That all training sites on a four year accreditation cycle be required to submit a concise progress report, with the elements identified in 8.8. (8.20)

Beyond two years but within the next five:

- That work is undertaken within NSW on identifying the outcomes expected of trainees during the prevocational training period and that once completed, this is reflected in the accreditation standards. (8.21)

- That in line with the trainee survey, consideration is given to the development of an online trainee portfolio which follows the trainee throughout their prevocational training period and allows for capture of information on the clinical experience of each trainee. This work should be undertaken in consultation with Colleges to ensure alignment with their processes. The collated data of clinical portfolios should be reviewed as part of the evidence used as a basis for making decisions about accreditation at both the term and facility level. (This could be an extension of the work undertaken on the development of an App for the ACF as an example) (8.22)

# 1. Introduction to the review

## 1.1. Background

The Health Education and Training Institute is a public health organization established under the Health Services Act 1997 to ensure training and workforce development with the NSW Health Service is of an appropriate standard and meets the operational and service needs of the NSW public health system.

Functions of HETI include setting standards for education and training, (including some aspects of medical training) in addition to accrediting training facilities and sites for prevocational education and training.

The latter function, as it pertains to postgraduate year one trainees is a delegated function of the Medical Board of Australia which requires that provisionally registered doctors in their first year of medical practice work within rotations that meet specific standards thereby ensuring appropriate levels of clinical exposure, education, training and supervision.

NSW has a well-established program for the accreditation of prevocational placements at both the PGY1 and PGY2 levels and initially led the rest of the country in the development of both the standards by which facilities and sites are accredited, in addition to the governance arrangements of the prevocational training accreditation process itself.

The last decade has witnessed the emergence of a number of key factors that have impacted upon the accreditation program. These include:

1. The establishment of a national registration authority and the Medical Board of Australia (MBA) with a concomitant requirement for consistency of registration standards across the country.
2. The work currently being undertaken by the Australian Medical Council (AMC) who has been asked by the MBA to provide advice on:
   - Standards for intern training;
   - What should be expected of interns at the completion of the period to enable the MBA to grant general registration;
   - How the AMC might apply a national framework for intern training accreditation to the current state-based accreditation processes of postgraduate medical councils to ensure that appropriate and consistent standards are in place in all jurisdictions.

   [This work has particular relevance to the Review and further information is provided under Section 1.2.]
3. Increased numbers of medical graduates and the requirement to identify training posts that provides appropriate clinical exposure, education, training and supervision.
4. Primarily in response to increasing numbers of medical graduates, the emergence of alternative training placements, sometimes in non traditional settings, (for example terms in community, public health and general practice settings, radiology and pathology terms, and more recently terms in private hospitals) all of which must be accredited for prevocational training.
5. Work undertaken by the Confederation of Postgraduate Medical Education Councils (CPMEC) on the Australian Curriculum Framework for Junior Doctors (ACF) and the Prevocational Medical Accreditation Framework for the Education and Training of Prevocational Doctors (PMAF).
6. Emerging concerns regarding the burden of accreditation processes at all levels – the facility, the survey term, the Prevocational Accreditation Committee (PAC) and HETI program staff. This is particularly with respect to the sustainability of current processes within the context of healthcare services facing increasing service demand and fiscal pressures.

Whist there has been previous reviews of the prevocational accreditation standards (see section four), the above drivers call for a major review (the Review) of the governance framework and processes within which accreditation of prevocational training programs operate within NSW.

## 1.2. National framework and governance arrangements

Following the introduction of the Health Practitioner Regulation National Law, the Medical Board of Australia is now responsible for granting general registration to Australian medical graduates who have completed an intern year. The Board has developed a standard for granting general registration, due to be implemented from the commencement of 2014, which outlines the requirements for general registration, including the terms which must be completed and sign off processes.

During the last two years, the Board has worked with the Australian Medical Council (AMC) to develop a national framework for the intern year. An AMC Working Party on Internship (the Working Party) has overseen the work. The Working Party have developed a number of documents including; (i) global outcome statements for the intern year, (ii) national standards for intern training, and (iii) draft guidelines for rotations during the intern year. In line with current practice in each jurisdiction, all intern training programs and positions will undergo periodic accreditation against the national standards.

A new feature of the national framework is that bodies which accredit intern training programs, (which in the case of NSW, is HETI), will also undergo periodic review by the AMC. To this end, the Working Party has completed a draft Quality Framework for Review of Intern Training Accreditation Bodies, which takes into account the Australian Health Practitioner Regulation Agency (APHRA) Quality Framework for Accreditation, CPMEC's Prevocational Medical Accreditation Framework (PMAF) and the World Health Organization/World Federation for Medical Education Guidelines for Accreditation of Basic Medical Education.

As the AMC has traditionally been responsible for accrediting medical schools and Colleges, the plan for review of accrediting bodies of intern training programs will move toward reducing a longstanding governance gap in terms of oversight of the standard of medical education and training programs across the career trajectory. It should be noted however that despite the fact that many of the accreditation bodies that currently accredit intern training, also accredit PGY 2 posts, there is currently no intention to expand the AMC's oversight to the PGY 2+ year. The AMC's mandate, as provided by the Medical Board, has been on the intern year only.

During 2013, pilot reviews of the South Australian Medical Education and Training and the Postgraduate Medical Education Council of Tasmania will be undertaken. Following this a schedule of reviews for the remaining PMCs (which will include HETI) will be developed for 2014 and 2015. In the interim, it is anticipated that the AMC will advise the Medical Board on a process to provide initial recognition of those PMCs (or equivalent) prior to their review.

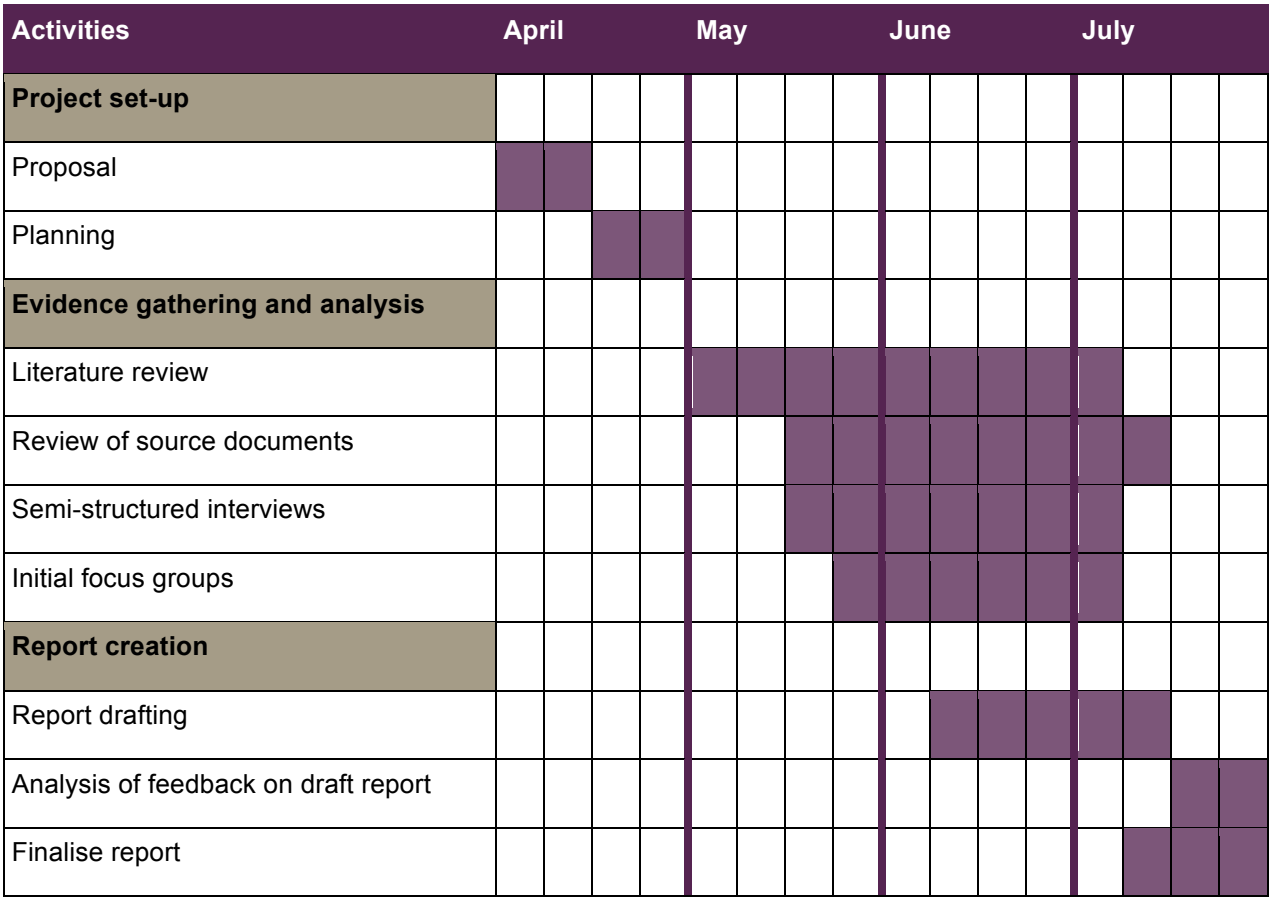
Given that it is anticipated that HETI will undergo a review by the AMC against the draft Quality Framework for Review of Intern Training Accreditation Bodies within the next two years, an important component of the Review was mapping the current HETI prevocational standards against the AMC draft Framework and standards. This is dealt with in detail under section four.

# 2. Methodology

## 2.1. Overview

The accreditation framework for prevocational training and education within NSW was reviewed during the period May – July 2013. Figure 1 provides a summary of the timeline for the Review. The terms of reference for the Review are detailed in Appendix A.

**Figure 1: Timeline of review**




The Review gathered information, evidence and opinion using the following methods:

- Literature review – 66 articles relevant to accreditation of prevocational training were summarized and analysed.
- Document review – source documents were summarized and analysed.
- Examination of accreditation models within Australia and New Zealand as well as overseas.
- Detailed comparison of the HETI Standards of Education, Training and Supervision for Prevocational Trainees Version 4.4 (the Standards) against accreditation standards from other jurisdictions.
- Detailed mapping of draft AMC National Intern Training Standards against the Standards.
- Analysis of the NSW prevocational accreditation framework and process against the draft AMC Quality Framework for Review of Intern Training Accreditation Bodies

- Semi-structured interviews and focus groups with key stakeholders
- Preparation and submission of initial draft report with recommendations.
- Analysis of feedback on draft report.

A list of participants in the Review (semi-structured interviews and focus groups) can be found at Appendix B.

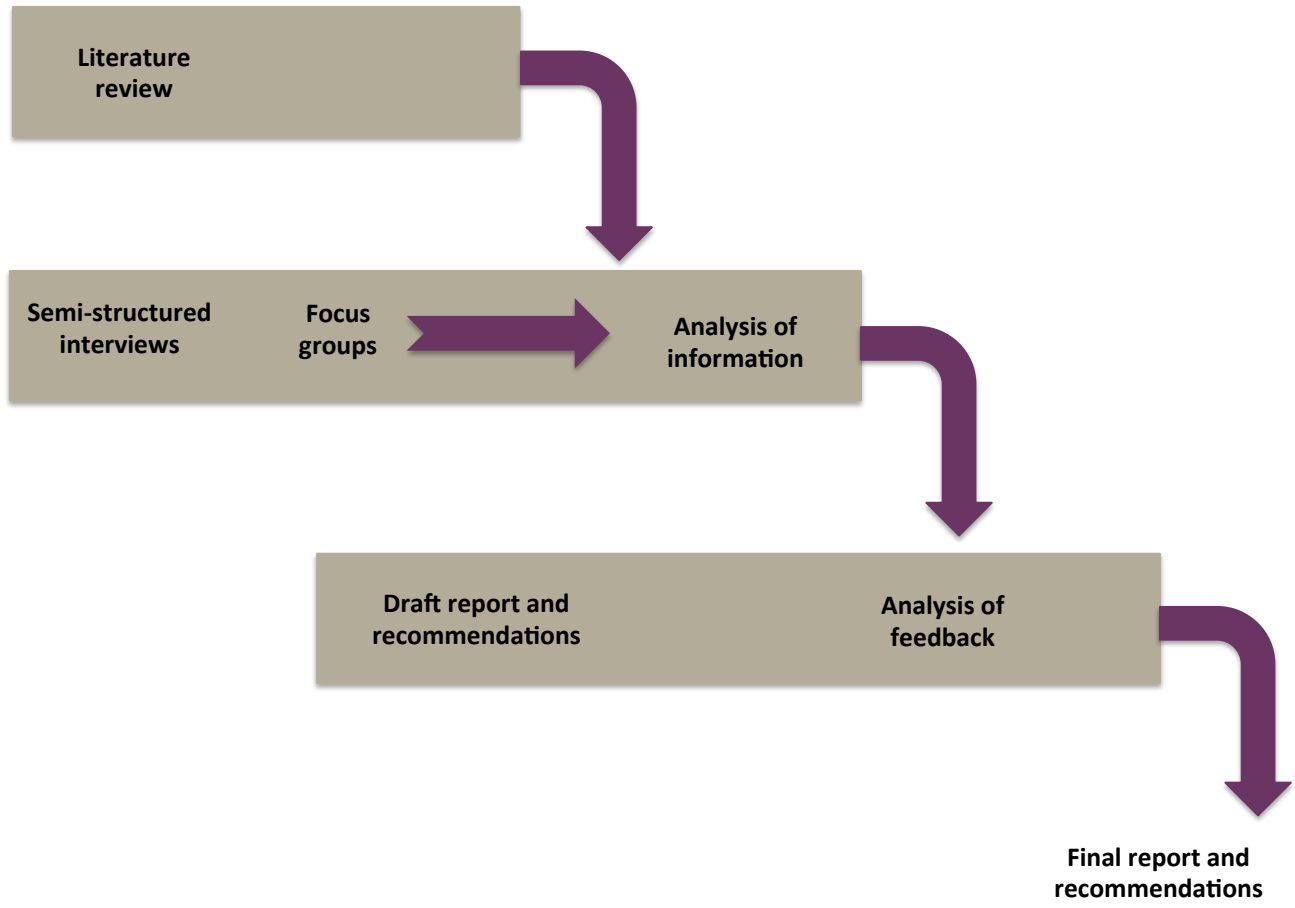
A list of source documents can be found at Appendix C. This includes documents sourced from websites and other jurisdictions as part of the examination of other models.

A summary of selected articles obtained through the literature review can be found at Appendix D.

Whilst it is acknowledged that there is considerable variation within Australia and overseas with regards to the use of terms within the context of prevocational training, this report uses NSW terminology. A list of abbreviations can be found at Appendix H.

The Review used a comprehensive process[1] of collection of data and information, including opinion throughout the review process. A summary of the methodology is provided in Figure 2. Further detail regarding the precise methodology of each component of the Review is articulated in the following sections.

**Figure 2: Overview of methodology**




[1] Professor Sir John Temple, Time for Training A Review of the impact of the European Working Time Directive on the quality of training. May 2010. UK.

## 2.2. Key assumptions

The following key assumptions underpin the review process:

2.2.1. High quality education and training of medical trainees supports the delivery of safe and quality patient care, both now and for the future.

2.2.2. The accreditation process measures the attainment of minimum standards (regulation function) but should also encourage continuous improvement (quality assurance function).

2.2.3. The Health Education and Training Institute (HETI) will be responsible for the accreditation of prevocational training posts at both the PGY1 and PGY2 levels within NSW.

2.2.4. The responsibility for the quality and delivery of the education and training programs for prevocational trainees should unambiguously rest with the facilities and sites in which training is delivered.

## 2.3. Literature review

The literature review was conducted in parallel with the semi-structured interviews and initial focus groups. A total of 66 articles were identified in the peer reviewed journals and professional associations as being relevant to this review. The identified articles and key findings were summarized. A more detailed description of the methodology of the literature review is provided in section three.

## 2.4. Source documentation review

In addition to the literature review, a number of source documents were identified as being relevant. These included HETI documents in addition to documents from equivalent accreditation programs in both Australia, New Zealand and overseas.

## 2.5. Consultation process

Selected individuals representing a broad cross section of key stakeholders were invited to participate in the consultation process. These individuals included HETI program staff, senior health service executive and management staff, senior clinicians, PAC and PvTC Committee Members, JMO Managers, prevocational trainees, HETI survey team leaders and surveyors, in addition to representatives from interstate PMCs.

The consultation process was conducted through semi-structured interviews and focus groups. Semi-structured interviews were conducted one on one, generally face to face but in some instances by telephone. Focus groups included representatives of key stakeholder groups. Each interview and focus group was audiotaped, transcribed and subsequently analysed for key themes.

# 3. Literature review

## 3.1. Search methodology

The literature review was undertaken in May 2013 and updated in July 2013. Electronic databases using Medline were searched for articles written in the English-language literature since 2000, using combinations of the following terms: “accreditation”, “Internship and Residency”, “Education, Medical, Graduate”, “quality assurance”, “Educational Measurement/or Environment”, “Reference Standards”, “learning environment” and “Medical Staff, Hospital”. A manual search of the references of selected articles was also conducted and relevant articles (including some articles pre 2000) were added.

Whilst the focus of the literature review was on accreditation of postgraduate medical education, some articles describing accreditation of undergraduate medical programs or hospital wide- accreditation processes were also included where they were deemed particularly relevant to the Review.

The approach adopted was intentionally broad given that the purpose of the literature review was to support the terms of reference of the Review. The focus was on identifying other accreditation models, examples of best practice and common challenges involved in accreditation programs of medical education and training.

Selected pieces included studies, theme and opinion pieces, editorials and letters. Following an assessment of abstracts for relevancy to the terms of reference of the Review, a total of 66 publications were included in the final literature summary (see Appendix D).

## 3.2. Key themes arising from the literature

Whilst the number of formal studies in this field is quite limited, there is evidence of a significant increase in publications since 2010, compared with the decade prior to that, perhaps reflecting an emerging interest in the systems and processes supporting accreditation and regulation of postgraduate medical education and training across the globe. This is particularly the case in publications arising from the United Kingdom, North America and Canada. The majority are theme articles, opinion pieces and editorials, rather than formal studies.

Australia’s contribution to this body of literature is also limited with only a few papers of relevance being cited. The first two examine adaptations of the Postgraduate Hospital Education Environment Measure (PHEEM) in the Australian context (Gough et al, 2010, Denz-Penhey et al 2009), another paper explored the strengthening of accreditation processes undertaken by the Royal Australasian College of Surgeons (Collins, 2008) and a much earlier publication describes the initial development of the prevocational training accreditation processes in NSW (Rolfe et al 1998).

A number of key themes have emerged in the literature:

### 3.2.1. The current period is characterized by significant change and reform of accreditation systems.

Many authors highlight the current period as being one of significant change and reform with respect to accreditation systems across the globe (Boelen et al 2009, Nauta 2012, Huggan et al 2012, Burch 2011). This is perhaps not surprising and reflects a worldwide trend towards increasing regulation and accountability, meeting the community’s expectation of ensuring high standards of medical education and training are established and maintained in the context of broader changes to the health care system. As Alwan comments “the objective of accreditation is to adapt medical education to changing conditions of health care delivery and to prepare doctors to meet the needs and expectations of society” (Alwan, 2012).

In the United States, the ACGME embarked on a major program of reform that commenced in 1999 and continues to the present day, and moves toward an outcomes-based, rather than a process based accreditation system. Many papers emerging from North America address

aspects of these changes (Mitka 2013, Weiss et al 2013, Scott 2012, Nasca 2012) and some are highlighted in more detail in the following sections.

Likewise a significant amount of reform has been undertaken in Canada (Maniate 2010, Maudsley 1986, Cassie et al 1999) and the UK (Irvine 2006, Leung 2002, Cooke et al 1999).

Other papers highlight reforms in medical education and training, including the concomitant introduction or reform of accreditation processes in a number of other countries, including: Singapore, (Huggan et al 2012); Japan (Teo 2007); South Asia (Amin 2010), the Netherlands (Houben et al 2011 and South Africa (Linegar et al 2012).

### 3.2.2. There are a number of shared challenges.

Many papers highlight the changing medical education paradigm; fiscal pressures; greater external regulation and the subsequent response of accreditation systems to these. (Bannon, 2006 plus others) Some authors have provided historical accounts of the development and implementation of accreditation processes (insert reference).

Beatty and colleagues describe a response to the increasing burden of multiple accreditation processes at the Northern Ontario School of Medicine through the development of an accreditation collaborative, (Beatty et al 2012)

### 3.2.3. Concern about the erosion of (or threat to) the apprenticeship model and how accreditation requirements may be used to ensure maintain the quality of postgraduate medical education and training.

There has been considerable attention paid to the implementation of duty hours directives in both North America and the United Kingdom and the potential impact on medical education and training, particularly in the context of reduced hours and subsequent changes to training time, clinical exposure and contact time with senior medical staff (Bannon, 2006)

### 3.2.4. The relationship between the delivery of quality postgraduate medical education and patient safety.

Some authors have drawn links between the delivery of quality medical education and training and safe patient care, with respect to both undergraduate (Browne 2012) and postgraduate training (Farnan et al 2012, Weiss et al 2013) and the relationship with accreditation processes.

### 3.2.5. Significant attention is being paid to governance.

Significant attention is being paid to governance with clear accountability and responsibility resting in the facility or site in which the education and training is being delivered, (Hoff et al 2004). One North American paper explored the rationale for pursuing a new model of graduate medical education governance, identifying ‘critical success factors’ (Curry et al 2008).

In North America, given that the failure to meet ACGME accreditation requirements can result in loss of funding for training programs, there are clear incentives for compliance. In this system the accreditation standards may be used as a lever for broader reform. Many authors have published on their institution’s responses to accreditation requirements in specific areas, including: clinical handover (DeRienzo et al 2012), duty-hours reform (Insert reference) and the introduction of clinical learning portfolios (Donato et al 2012).

### 3.2.6. Significant attention is being paid to what constitutes the optimum learning environment and how this is best measured.

This recognises the requirement for medical training to be delivered across a range of clinical settings, requiring a degree of flexibility in the way in which the quality of training in a given program is measured.

Feedback from trainees regarding their experiences is highly valued and considered a critical component of accreditation processes. Roff and her colleagues developed a 40-item inventory, the Postgraduate Hospital Education Environment Measure (PHEEM) which, they argue, may be a useful instrument in the quality assurance of medical education, (Roff et al 2005, Roff 2005).

A number of other publications have focused on measurement by trainees of the clinical learning environment using the PHEEM or other validated instruments, (Boor et al 2007, Thrush et al 2007, Silber et al 2006, Holt et al 2010).

Miles and colleagues reviewed a number of studies in which a similar instrument, the Dundee Ready Education Environment Measure (DREEM) was used and argued that it is regarded as a useful tool albeit that the methods and analysis of DREEM data are inconsistent across the range of settings in which it is used (Miles et al 2012).

In a Canadian paper, the authors developed a set of principles based on residents' perspectives of what was important in creating the "ideal" postgraduate medical education system and argue that these principles could be used as a template for quality assurance in postgraduate medical education (Maniate et al 2009).

### 3.2.7. There is increasing interest in an outcomes based, rather than process based accreditation system.

Work undertaken in the US by the ACGME in partnership with a number of other bodies has moved to an outcomes based accreditation system and this is reported in a number of papers (Leach 2004, Batalden et al 2002, Lurie et al 2009, Musick 2006). Further information about these changes is provided in section five.

Some authors have highlighted the significance of these changes with respect to discipline specific programs such as internal medicine (Goroll et al 2004), cardiology (Bashmore et al 2008) and plastic surgery (Bancroft et al 2008).

### 3.2.8. Additional comments

In a paper on accreditation of health care organisations, the authors aimed to describe global patterns and characteristics of healthcare accreditation organisations. They make the point, which has particular relevance for accreditation of postgraduate medical programs, that many countries are now trying to strike a balance between the regulatory approach [to investigate and enforce] with the 'collegial' approach [to educate and elevate] and that the world is moving from 'soft' to 'hard' quality improvement, (Shaw et al 2013).

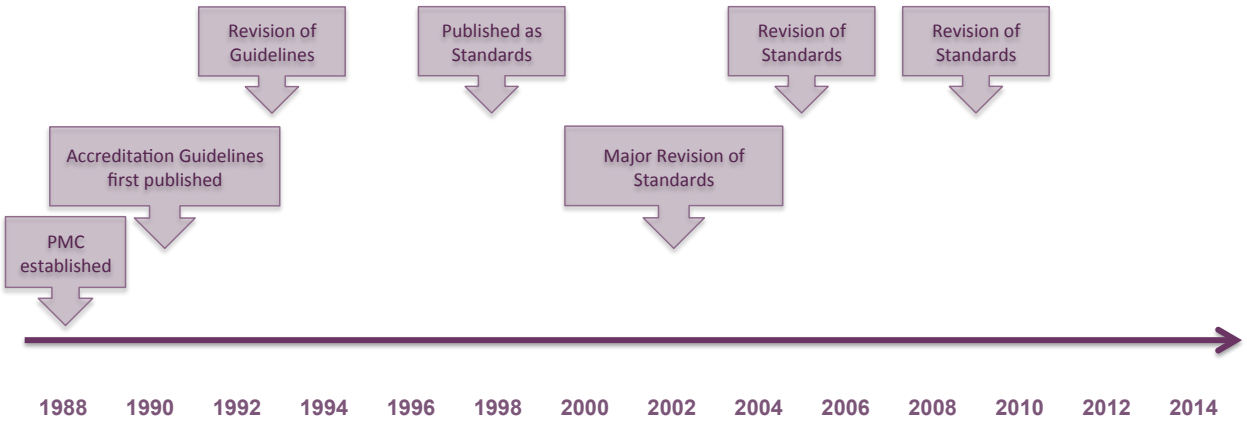
Other papers raised issues with regards to actual processes of accreditation, particularly in the context of changes to the accreditation system. Hunt et al compared the accreditation decisions made by the Liaison Committee on Medical Education (LCME) in the US before and after the standards were reformatted, (Hunt et al 2012). Tzarnas questions whether or not smaller residency programs (in plastic surgery) are at a disadvantage with regards to the accreditation process, drawing the conclusion that there is no statistically significant disadvantage to the smaller programs (Tzarnas 2012).

# 4. Current accreditation processes within NSW

## 4.1. Historical context

The Postgraduate Medical Council of NSW (PMC) was established in 1988 following a review[2] commissioned by the Secretary of the NSW Department of Health in 1987, in response to concerns regarding the distribution, supervision, training and support of junior doctors within NSW.

**Figure 3: Timeline of development of NSW prevocational accreditation framework**




The same review also made a recommendation with respect to setting objectives and establishing standards for training within the first two postgraduate years. In making a recommendation for the establishment of a body to oversight the training and education of doctors in the early postgraduate years, including setting standards, the authors of the review emphasized *"The primary need is practical training in clinical medicine and the emphasis must therefore be at the patient's bedside."*

Whilst accreditation of facilities commenced in the year following the establishment of the PMC, this was initially largely informal and it was not until 1990 that the original version of the current standards, was published as the Accreditation Guide: Guidelines for the Accreditation of junior Medical Staff Posts in Public Hospitals and Associated Health Services. In the following years, the documents were further refined (1993) prior to being published as Accreditation Standards in 1998. In 2002, a major revision of the Standards was undertaken with major changes to the overall structure (goals, standards, criterion) and the rating scale. Further minor revisions of the standards were undertaken in 2005 and 2009, although the structure and rating scale from the 2002 revision has endured to the present day.

In 2008, CETI (Clinical Education and Training Institute, now HETI) modified the accreditation program, including the development of a separate set of standards, to accommodate the requirement to accredit prevocational training placements in general practice in large numbers, following the establishment of a federally funded program, the PGPPP (Prevocational General Practice Placement Program). Following their initial development in 2008, the current standards, General Practice Education and Training Standards – General Practice and GP Supervisors – Version 3, have undergone several refinements.

[2] Reid Harris and Associates, Review of hospital junior medical staffing in NSW, December 1987

## 4.2. Legislative framework

The accreditation framework for prevocational training in NSW exists as a delegated function of the Medical Board that requires that all interns provisionally registered with the Medical Board of Australia work in facilities that are accredited.

A PMC (HETI in the case of NSW) makes a recommendation to the Board about whether to approve a position for intern training. The Board subsequently approves intern positions following this assessment. The registration standard for granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training provides further details on the requirements.

In the case of the second postgraduate year, the NSW Ministry of Health as the employer requires that doctors in their second postgraduate year only work in terms accredited by HETI. This recognises the critical importance of a further closely supervised generalist year.

## 4.3. Survey process

The NSW prevocational accreditation process has a number of elements common to quality assurance accreditation systems: self assessment by the facility against a set of predefined standards; the submission of supporting documentation and evidence; a site visit by a team of trained peer surveyors, (usually comprising a senior clinician, medical administrator and junior doctor); and the completion of a report documenting the survey team's findings, including recommendations for further improvements. Figure 4 (previous page) provides an overview of the current survey process.

The standards document forms the basis of the survey self-assessment that is completed by the facility several months prior to the survey visit. There is an expectation that the survey self-assessment and written evidence is submitted to HETI six weeks prior to the survey visit. HETI program staff determines the composition of the survey team. Once the team leader has been appointed and the documentation received, the team leader generally takes on responsibility for liaising with the facility, particularly with respect to the organisation of the survey timetable.

It is expected that all members of the survey team will read the documentation prior to the survey visit. Generally the survey team either teleconference or meet immediately prior to the survey visit to identify any particular areas of focus for the survey visit.

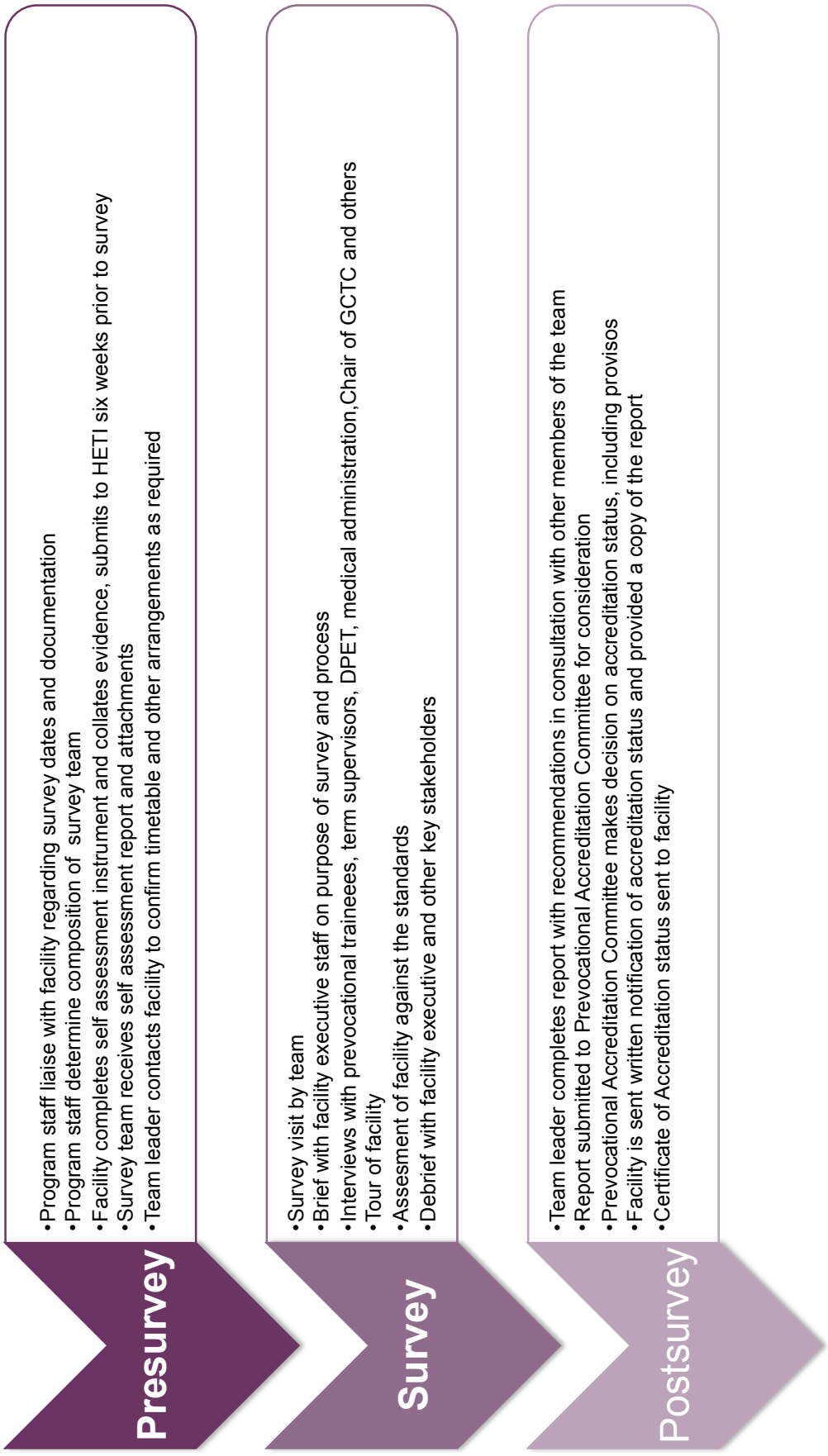
The survey visit is generally conducted over one to two days, depending on the size of the facility. Visits to general practices are usually conducted over a couple of hours. The survey visit commences with a meeting with the facility executive and other key stakeholders, in which the purpose, scope and survey process is outlined.

The rest of the survey visit comprises interviews between the survey team and key stakeholders including prevocational trainees, term supervisors, the DPET, the Chair of the GCTC, medical administration and JMO management, and others. A tour of the facility is also included. Following the completion of the interviews, the survey team meets to discuss their findings and agree a rating for each criterion. At the conclusion of the survey, the survey team once again meets with the hospital executive (and other key individuals) to provide a summary of the key findings. The survey team does not provide an indication of likely accreditation status – this is a decision made by the PAC.

Following the survey visit, the team leader completes the report, in collaboration with the survey team. The survey report is submitted to the PAC for consideration and this committee makes a determination on accreditation status. Accreditation status is awarded on the basis of length of accreditation, within the range of six months and three years. There is provision to withdraw accreditation of specific terms deemed not to be meeting the standards, though this is generally regarded as an action of last resort.

In considering the report, including the recommendations, the PAC may determine that a response to issues identified at survey considered to be of particular concern, is required by the facility prior to the next accreditation visit. There is an expectation that provisos will be responded to by the facility within a given timeframe, stipulated by the PAC, usually between three and six months. Failure to meet the terms of the provisos can result in a reduction in length of accreditation status or the withdrawal of accreditation of a term.

**Figure 4: Overview of accreditation process**



## 4.4. Standards

The structure of the standards document is hierarchical, with 3 goals, underneath which sit 15 standards. The three goals are as follows:

**Goal 1**: The hospital ensures prevocational trainees have the appropriate knowledge, skills and supervision to provide quality patient care.

**Goal 2**: The hospital provides a wide range of educational and training opportunities for prevocational trainees to ensure that they are competent and safe.

**Goal 3**: The hospital promotes the welfare and interests of prevocational trainees.

15 standards support these three goals and are in the following areas:

- Hospital orientation
- Term orientation
- Supervision
- Professional development
- Training and service requirements
- Formal education program
- Clinicians as teachers
- Assessment and feedback
- Education and information resources
- Prevocational trainee management
- Prevocational trainees with special needs
- Safe practice
- Promoting prevocational trainee interests
- Supporting prevocational trainees
- Physical amenities

Underpinning each standard, are a number of criteria that are the specific actions required to achieve each standard, against which the facility is measured. Specific requirements (which articulate mandatory actions) or guidelines follow each criterion, providing further information for facilities.

The rating scale provides for four rating points as follows:

- **Low achievement** – requirements of standard/criterion scarcely met. Minimal effort made by the hospital to address the standard/criterion.
- **Moderate achievement** – requirements of the standard/criterion are generally met in most circumstances.
- **Extensive achievement** – requirements of the standard/criterion are well met in the majority of circumstances and have been for some time.
- **Outstanding achievement** – requirements of the standard/criterion are fully met in all circumstances and have been for some time. Innovation and improvement are evident.

The rating is determined by simultaneous assessment across the following five variables: strength of evidence, consistency of application, maintenance over time, sustainability of infrastructure and quality improvement. Detailed information regarding the application of ratings is provided within the Standards document.

## 4.5. Prevocational Accreditation Committee

The purpose of the PAC is to manage and advise HETI on the accreditation of all NSW and ACT[3] prevocational trainee terms, facilities and prevocational networks in which prevocational training is delivered. The functions of the PAC are outlined in detail in the Terms of Reference and include: management and oversight of the survey system; review of accreditation reports and making decisions about accreditation status of facilities; selection and training of surveyors; setting standards and associated policies, in addition to a number of other strategic functions.

Members of the PAC are selected on the basis of relevant past or current experience from a broad range of stakeholders, including medical students, prevocational trainees, DPETs, term supervisors, JMO managers and medical administrators. Consideration is given to ensuring that the Committee has a balance of experience, qualifications and representation from across all local health districts. In addition there is a requirement for: one member-delegate from the NSW Medical Board; one nominee of the HETI Management Committee; and two nominees of the Prevocational Training Council. Terms are generally held for a three-year period, renewable once.

The PAC is supported by the prevocational training program staff, performing the role of secretariat, in addition to a number of other duties in relation to prevocational training.

## 4.6. AMC Review of Intern Training Accreditation Bodies

As indicated in the introduction to the review, bodies which accredit intern training programs, (which in the case of NSW, is HETI), will undergo periodic review by the AMC against the Quality Framework for Review of Intern Training Accreditation Bodies. It is anticipated that HETI will undergo a review by the AMC within the next two years.

In reviewing the current accreditation framework within NSW, it was important to contextualize this in terms of these changes to the governance arrangements and future role of the AMC with respect to prevocational training. This review therefore undertook to provide (i) an overview of the NSW Accreditation framework mapped against the (draft) Quality Framework for Review of Intern Training Accreditation Bodies and (ii) a mapping of the NSW Standards against the (draft) AMC Intern Standards.

Whilst it should be noted that both the AMC documents are still in draft format and will remain so until after the pilot reviews in South Australia and Tasmania are completed, the analysis provides an indication of areas requiring further work.

The Overview of the NSW Accreditation Framework mapped against the draft Quality Framework for Review of Intern Training Accreditation Bodies is provided at Appendix E.

Based on the current AMC draft, a significant amount of work will be required, particularly in the domains of Governance (Domain 1) and Independence (Domain 2) in addition to work on specific areas including: the revision of policies; access to information on the website; and evaluation of the accreditation system, to ensure compliance with the AMC Quality Framework.

Detailed comments regarding specific areas requiring further work based on the draft document are provided in the Table and this will need to be reviewed once the AMC documents are finalised, anticipated to be in late 2013.

Table 3 provides details of the mapping of the NSW Standards of Education, Training and Supervision for Prevocational Trainees against the draft AMC National Intern Standards (Appendix F). The relationship between the AMC National Intern Standards document and the Standards document for a given jurisdiction is yet to be fully realised. This work is developmental and ongoing.

What is clear is that the AMC will review intern accreditation bodies and there is an expectation that all prevocational training facilities accredited by those intern accreditation bodies will be compliant with the national guidelines and standards (Domain 4: under the AMC Quality Framework for Review of Intern

[3] At the time of the review, the ACT Health Directorate had indicated that the ACT would undertake responsibility for accreditation of prevocational terms within the ACT from late 2013.

Training Accreditation Bodies). It is therefore critical, that in setting the standards for accreditation of NSW facilities, the NSW standards have full and unambiguous coverage of the AMC standards.

Whilst most standards within the AMC National Intern Standards are covered within the current NSW document, albeit with variations in structure and languaging, it is the reviewer's view, that several gaps exist and a number of areas require strengthening to ensure complete alignment. These include: governance (all standards); educational expertise (1.3.1); intern training program (3.1.2, 3.2.1); assessment of learning (5.1.2, 5.1.4, 5.2.5, 5.2.7); implementing the education and training framework- junior doctors (7.2.3, 7.4.2, 7.5.2); and implementing the training framework – delivery of educational resources (8.2.1). Further specific comments on this can be found in Table 3, though this will require review once the AMC documents have been finalised.

## 4.7. Further comments

- It is very evident that a significant amount of work has been undertaken within NSW on the accreditation framework for prevocational training within NSW. The accreditation system is highly valued and provides a solid platform for further development and reform
- The accreditation framework is comprised of elements characteristic of a quality assurance process, including self-assessment, periodic measurement with site visits and review by trained peer surveyors.
- The current framework is a process-based model of accreditation designed to measure the systems and processes thought to provide effective training for doctors. This is in contrast to an outcomes-based model that is designed to measure the outputs of a training program, ie whether safe and competent doctors are being trained.
- Sophisticated accreditation systems tend to evolve over time from process-based to outcomes based models. Outcomes-based models are more flexible, able to adapt to changing environments and circumstances, and encourage (rather than constrain) innovation.

# 5. Other prevocational accreditation models

## 5.1. Within Australia and New Zealand

All states and territories within Australia in addition to New Zealand have well-developed accreditation standards for prevocational training. Table 2 (Appendix F) provides a comparison of each jurisdiction's accreditation framework. Table 3 (Appendix G) provides a comparison of each jurisdiction at the standard and criterion level. This section provides a summary of some of the key features by jurisdiction.

Common features to all prevocational accreditation systems within Australia include the traditional methods of broader accreditation systems: the provision of a pre-survey instrument completed by the site being accredited; a site visit by a team (although the composition of the team varies, though is generally comprised of trained peer surveyors) and a report being completed following the site visit which is considered by a governance committee prior to a recommendation on accreditation status being made. Most jurisdictions now accredit at the training post level although generally accreditation status is awarded to the facility.

All jurisdictions have standards that are supported by a range of policies and documents. Most have policies or guidelines covering the following areas:

- Appeals
- Change in circumstances
- Accreditation of terms mid-survey cycle
- Accreditation guide. Some [NSW, Victoria] have separate documents for surveyors, health services and general practices. Others have a combined document.

There is variation in the number of sites being accredited by the relevant accreditation body. This ranges from 2 facilities and a small number of PGPPP placements in the Northern Territory to a much larger number of facilities in NSW, Victoria and Queensland.

There are also differences in maximum length of the accreditation cycle with some jurisdictions having three years and others (Queensland, Northern Territory and South Australia) recently moving to four years, in line with the AMC guidelines.

There is also variation in approaches to public reporting of accreditation status; posts being accredited (many also accredit PGY2 positions and some have provision for accreditation of IMG positions); and the requirement of periodic review mid survey cycle (Queensland and the Northern Territory). South Australia and Victoria have provision for collection of data directly from trainees (via an online trainee survey) prior to an accreditation visit. Further details are provided about this under the relevant section below.

The duration of site visits ranges from less than half a day in some training sites (South Australia, New Zealand) up to three days for some larger facilities (Victoria). Generally site visit duration is between one and two days, depending on the size of the training facility/Network being accredited.

The following sections provide an overview of the key elements by jurisdiction.

### 5.1.1. Victoria

Victoria have recently revised their accreditation standards and associated documents. They have maintained a process-based accreditation model with processes similar to other jurisdictions within Australia.

The Victorian standards are structured around 7 key functions: (i) Health service culture and support for HMOs; (ii) Orientation; (iii) Education and Training; (iv) Supervision; (v) Feedback and Assessment; (vi) Program Evaluation; and (vii) Facilities and Amenities. The standards are supported by a range of policies.

Whilst Victoria have trialed the use of a trainee survey (PHEEM) to collect views from trainees about their education and training, it should be noted that this instrument has been implemented by a group of Medical Education Support Officers and is separate to the accreditation process. The use of the PHEEM as a validated instrument was highlighted in the literature review, (see section 3.2.6). The Victorian accreditation program does collect trainee views, using a questionnaire on survey monkey, which is distributed electronically to facilities in the lead up to an accreditation site visit. The results of the survey are collated by accreditation program staff and sent to the survey team for review prior to the survey visit.

### 5.1.2. Queensland

PMCQ have recently reviewed their accreditation processes and a number of changes were undertaken, including a revision of the standards document and the introduction of action plans that facilities are required to submit mid survey cycle demonstrating progress against recommendations (periodic review).

The process has also moved from having a partial professional review team to one that is based on peer review. Team size in the Queensland model can range from between 3 to 10 members to 10 for the larger training facilities.

### 5.1.3. South Australia

South Australia has also reviewed their accreditation standards and the current document is similar to that used in Queensland and the Northern Territory. South Australia have also adopted the use of an on-line survey, introduced approximately three years ago, which collects information from trainees about their experience of the education and training at a particular site. This survey is distributed to trainees prior to an accreditation visit. South Australia have recently revised a number of policies and documents in preparation for the AMC review.

### 5.1.4. Western Australia

Western Australia has an eight page standards document written in prose style that outlines the requirements expected to be attained. The derivation of the Standards appears to be a compilation from standards of other jurisdictions, including NSW, and is quite comprehensive. The processes used in Western Australia are generally similar to the other Australian jurisdictions.

### 5.1.5. Tasmania

Tasmania utilises the same standards and processes adopted by Victoria. Given the small number of sites and size of Tasmania, many supporting processes have historically been largely informal. Tasmania is one of the pilot sites for the AMC review and this has triggered a move toward more formal processes and policies being implemented.

### 5.1.6. Northern Territory

The Northern Territory has responsibility for accrediting 2 hospitals and a small number of prevocational general practice placements. The Northern Territory uses the same standards and processes adopted from the Queensland model, although there have been minor modifications to reflect the local context.

### 5.1.7. Australian Capital Territory

Whilst ACT facilities have historically been accredited by NSW, the ACT Health Directorate has recently signaled an intention to undertake their own accreditation from October 1 2013. Given the timing, this was considered out of scope to the current review and planned changes to the ACT system were not evaluated.

### 5.1.8. New Zealand

There are a number of key differences with respect to the New Zealand accreditation system compared with equivalent systems in Australia. Whilst many features of the survey process itself are similar (self-assessment, site visit, report), one of the key differences lies in the fact that the Medical Council of New Zealand, (MCNZ), the NZ equivalent of the medical board, is responsible for the accreditation of facilities for intern training.

The site visits are undertaken by the MCNZ, following which a report is submitted to the Education Committee for consideration. The report findings are published on the MCNZ's website with details provided under the following headings:

- Compliance with Medical Council requirements
    - Strength and areas of excellence
    - Areas requiring improvement
- Specific matters affecting or likely to affect accreditation
- Specific matters to be drawn to the attention of the Chief Executive
- Matters recommended for continued review by the intern supervisor

The New Zealand Medical Council has recently embarked on a major reform of prevocational training, which commenced in 2011 and is continuing at the present time. Proposed reforms are broad ranging and include: the implementation of a curriculum framework; the implementation of a professional development plan and E-portfolio; and a framework for assessment and standards for accreditation of clinical attachments. Consultation is currently being undertaken on these reforms, with planned implementation by November 2015.

### 5.1.9. Challenges and future directions

Based on discussions with many of the other postgraduate medical councils (or equivalent), it is clear that most other prevocational accreditation bodies have recently reviewed and restructured their standards. Expressed challenges include maintaining the quality of medical education and training as a priority with health services in the context of increasing demand and fiscal constraints.

There continues to be widespread support for a collaborative approach to accreditation processes with promotion of the quality assurance function. Some interviewed spoke of the role of the AMC in fostering this approach.

There was no evidence presented to the reviewer that suggested that there were immediate plans to undertake further major reform of accreditation processes in other jurisdictions within Australia. In particular, there was no indication of a move towards outcomes based accreditation processes evident elsewhere in this country.

## 5.2. International experience

### 5.2.1. United Kingdom

Work in the United Kingdom has been characterised by significant reform and change, particularly over the last decade, with a number of reviews been undertaken. The Foundation Program was established in 2005, designed to give trainees a broad general experience Work in the United Kingdom has been characterized by significant reform and change, particularly over the last decade, with a number of reviews been undertaken. The Foundation Program was established in 2005, designed to give trainees a broad general experience during their first two postgraduate years. In the UK, responsibility for the delivery of education and training of foundation doctors rests with the Deaneries.

The oversight for quality assurance (the UK terminology for accreditation) currently rests with the General Medical Council. Formerly this function had been undertaken by the Postgraduate

Medical Education and Training Board (PMETB) which had been established as an independent statutory body in 2005 with responsibility for: establishing standards and requirements for postgraduate medical education and training; making sure that the standards and requirements were met through Quality Assurance, and; developing and promoting medical education and training across the UK. The PMETB was merged with the GMC in April 2010.

The standards and outcomes for postgraduate medical education and training are articulated in a single document *The Trainee Doctor*, published in February 2011, which articulates expectations for foundation and specialty, including general practice, training.

The standards for postgraduate training are structured under the following 9 domains:

- Patient safety
- Quality management, review and evaluation
- Equality, diversity and opportunity
- Recruitment, selection and appointment
- Delivery of approved curriculum including assessment
- Management of education and training
- Support and development of trainees, trainers and local faculty
- Educational resources and capacity
- Outcomes

The Quality Improvement Framework (2011) articulates how the GMC quality assures medical education and training in the UK from 2011-2012. It is noted that the GMC is currently undertaking a review of their quality assurance of medical education and training. This review commenced in 2011 and is due for completion in late 2013. In addition, they are reviewing the standards.

One of the key features of UK is the national training survey that asks all doctors in postgraduate training what they think about the quality of their training. The survey has an impressive response rate. In 2013, it was 97.7% up from 95% in 2012 and 87.0% in 2011. This equates to 52,797 doctors in training completing a survey, of which 14,459 were in their foundation years. This national survey provides information to the GMC and other key stakeholders about the quality of the learning environment.

Also worthy of mention with regards to the UK system is the considerable amount of concomitant work being undertaken on developing a curriculum for the foundation years in addition to work on trainee assessment.

### 5.2.2. Canada

The responsibility for setting standards for postgraduate medical education and accrediting facilities in Canada rests with The Royal College of Physicians and Surgeons of Canada (RCPS) and the College of Family Physicians of Canada (CFPC). Like the UK, Canada has also been reviewing and reforming the postgraduate medical education with a focus on producing physician, who *"by the end of their training, possess the clinical expertise necessary to practice medicine on the principles of quality, safety, professionalism and patient-centred and team-based care."*[4]

In the recently published review *The Future of Medical Education in Canada*, one of the 10 recommendations was to align the accreditation standards across the learning continuum, designed within a social accountability framework and focused on meeting the healthcare needs of Canadians. In this, Canada appears to be moving toward an outcome based accreditation system.

[4] *The Future of Medical Education in Canada* (2012)

### 5.2.3. United States

The Accreditation Council for Graduate Medical Education (ACGME) is a private, nonprofit organisation that accredits over 9,000 residency programs in 135 specialties and subspecialties that educate about 116,000 residents. Its mission is to improve health care by assessing and advancing the quality of resident physician's education through exemplary accreditation. The work of reviewing specific programs and making accreditation decisions is carried out by 27 Residency Review Committees (RRC), one for each major specialty, as well as one for the transitional year program (closest equivalent of the prevocational training period).

ACGME field staff representatives conduct one-day site visits to programs once every two to five years and write objective narrative reports about the programs they visit, based on lengthy interviews with the program directors, faculty and residents, as well as a review of supporting documents. The RRCs meet to review the reports, along with data provided by the programs to make decisions of the appropriate accreditation action for that program.

The ACGME has a set of program requirements for graduate medical education in the transitional year. These include many of the domains common to our accreditation standards but also include specific outcomes (see below) expected of doctors completing their transitional year.

One of the key features of the US system has been the move to an outcomes based accreditation system. Central to this work, which commenced in 1999 and is ongoing, has been the development of core competencies (refer to Box 1). Residency training programs are required to demonstrate that their residents have the core competencies and clinical skills to provide quality patient care and the ability to respond to ongoing developments in health care delivery. Each specialty training program is now working toward developing educational milestones that are measured by levels of competence, with most using the Dreyfuss model (novice to expert) as a basis.

The Next Accreditation System commenced on July 1 2013 for a number of specialties with the expectation that the remainder of the programs, including the transitional year would commence in 2014. In the interim, the ACGME have published a draft version of the Transitional Year Milestone Project (May 2013) that articulates a framework by which a resident might be assessed for a number of domains. As with the specialty programs, it is intended that this information will be aggregated to the level of the program and form part of the data set on which accreditation decisions will be based.

**Box 1: American Council of Graduate Medical Education (ACGME) Core Competencies**

**ACGME Core Competencies**

☐ Patient Care

☐ Medical knowledge

☐ Practice-based learning and improvement

☐ System-based practice

☐ Professionalism

☐ Interpersonal skills and communication

As a component of the next accreditation system (NAS), the ACGME has established the Clinical Learning Environment Review (CLER) to assess the graduate medical education learning environment of each sponsoring institution and its participating sites with a focus on the following six areas: patient safety; quality improvement; transitions in care; supervision; duty hours oversight, fatigue management and mitigation; and professionalism.

## 5.3. Further comments

- Although international models have different levers in terms of governance (particularly with respect to the role of universities in graduate medical education) and funding arrangements, there are a number of features that provide potentially useful lessons for Australia.
- It is very evident that international models have moved or are moving toward outcome based accreditation systems. This is not surprising in the context of accreditation systems being developmental in nature, usually commencing with a focus on processes and in time moving to a more sophisticated and nuanced measurement of the outcome that the system is designed to measure – in this case, that education and training programs are producing competent and safe doctors.
- Accreditation systems are but one component of a complex structure supporting the delivery of high quality medical education and training. Other components include curriculum development, workforce requirements, education and training governance, role of supervisors and educators, assessment processes and so on. Accreditation systems can support these other components and arguably might be a lever for reform, but this needs to be strategic with consideration of all elements. The comprehensive process of reform underway in the US, the UK and more recently in NZ, provide examples of this.
- The work in the UK on the Foundation Curriculum (with explicit outcomes to be achieved by the trainee) as well as the work currently being undertaken in the US on the educational milestones for the transitional year should be highlighted. There is potential, using these two models, to significantly build upon the work of the ACF, particularly in the context of a focus on skills required of prevocational trainees (including competency with regards to patient safety, team work and adaptation to a changing healthcare environment).
- It is clear from the work being undertaken in the US, Canada and the UK, that there is significant focus on the governance of medical education and training in addition to what constitutes the optimum learning environment. This is particularly relevant in the context of outcome-based accreditation systems and this theme is explored further in following sections of this report.

# 6. Key findings arising from the consultation process

## 6.1. Strong support for the existence of standards

A key theme arising from the consultation process was the universal support for the existence of a set of standards governing the delivery of prevocational education and training.

Many of those interviewed, particular senior clinicians and medical administrators, made comparisons between the period prior to the standards being introduced in the late 1980s and the current environment. They acknowledged the critical role of the standards and accreditation processes in significantly improving the education, training and supervision of prevocational trainees during the intervening period.

> *"It is important that we have some minimum standards – it is important for both patient and staff safety."*
>
> *– Senior health executive*

> *"It's nice to know that there is someone other than the hospitals who are watching."*
>
> *– Junior doctor*

> *"The standards to a large part have served a very useful purpose in creating some guidance for what a group of us thought would be a system that would protect and safeguard the interest and welfare of junior doctors"*
>
> *– Senior medical administrator*

A commonly expressed view was that to remove the standards would be a retrograde step and would result in an erosion of gains made during the last two and a half decades.

Many also expressed the view that the standards are essential in terms of keeping the interests of junior doctors 'on the radar' of the hospital executive, particularly in the context of increasing service demands, fiscal constraints and multiple other competing priorities.

> *"One of the most important things that has been maintained over the years is that it is strongly trainee focused. That is the main reason why I am part of it."*
>
> *– Senior clinician and former DPET*

> *"If the standards weren't there…we would have prevocational trainees in unsafe situations out of hours…they would get a reduced range of educational opportunities…you would find great dispersions of culture of attitude toward prevocational trainees because it would be so much more personality based as opposed to the system saying this is a fundamental component."*
>
> *– Prevocational Accreditation Committee member*

> *"They (the prevocational trainees) are going to need someone looking over our shoulders…there are so many things pulling us in different directions."*
>
> *– Senior medical administrator*

Several others made the point that the accreditation standards have contributed to the engagement of senior medical staff with prevocational trainees.

*"One of the things that have come out of it is a higher responsibility for the senior medical staff and a higher level of engagement from them…in lots of areas we have been successful in getting more engagement between the senior medical staff and the JMOs."*

*– Senior clinician*

## 6.2. Clear and shared understanding of purpose of the standards

There was a high degree of concordance amongst those consulted with regards to the primary purpose of the standards. The purpose of the standards was generally viewed from a regulatory paradigm, ensuring that facilities and training sites attained a minimal level against the standards with respect to supervision, education, training and welfare of prevocational trainees.

*"The standards are looking at education and training, safe working hours and reasonable workloads, general well-being, having a good DPET and the overview of the clinical experience that a hospital can provide for you to shape you as a medical practitioner as a whole."*

*– Prevocational trainee*

*"The primary purpose is for the supervision and the education of the JMOs. They are there so that everyone has the same standard across the State."*

*– JMO Manager*

*"From a JMO perspective, the accreditation process ensures that terms are safe and allow better education at a certain standard. From a rural hospital perspective, the standards ensure that we aren't disadvantaged compared to those JMOs in the larger hospitals in terms of education and training."*

*Rural based junior doctor*

*"At the end of the day, the Medical Board of Australia wants to know that new graduate doctors have been through a training period of exposure and that they meet the requirements of general registration."*

*– Senior medical administrator*

Some expressed the view that in addition to meeting minimal requirements, the standards also encouraged facilities and sites to continuously improve the quality of education and training although there was some divergence of opinion with respect to this.

## 6.3. Strong support for many aspects of the current accreditation process

Most interviewed expressed strong support for the processes underpinning the accreditation standards, in particular site visits and the nature of the peer review process.

Site visits were viewed very positively and seen as significantly contributing to the robustness of the process. Many expressed the concern that paper-based systems of data collection were less reliable than information obtained during interviews, particularly as this pertained to information obtained from both DPETs and prevocational trainees. This is interesting given the findings in the literature review and overseas models.

The system being based largely on a peer review process was highly valued and many expressed the view that this tempered the regulatory function with a degree of pragmatism, anchoring the current standards in the context of the primary focus of training sites being on the delivery of safe patient care.

*"Using peer surveyors is good because they understand how things actually work as opposed to how it should work on paper."*

*– JMO Manager*

*"You have to go, you have to hear…and you do find out about things that are really too bad to let go."*

*– Survey team leader*

*"I have just done a survey and a lot of issues just weren't going to come up unless you went there and had discussions with JMOs."*

*– Survey team leader*

The composition of the team based on selecting an appropriate mix of senior clinicians, medical administrators and prevocational trainees, supplemented by JMO Managers and Program staff, all of whom brought different perspectives to the survey process, was also highlighted, although there were repeated concerns expressed about the increasing size of the teams (see 6. 14)

## 6.4. Ticking boxes or meaningful measurement? – A difference in views

Whilst generally there was a perception that the prevocational accreditation process was robust, particularly when compared to other accreditation processes (with many interviewed making that exact point), there were some concerns expressed about the degree to which the process is simply ticking boxes. This was a commonly expressed view by those more peripherally involved with the accreditation system (such as non surveyors, non PAC members).

*"Change occurs at a glacial pace – change is happening but not in your working time as a junior doctor."*

*– Junior doctor*

A number of those interviewed made statements to the effect that whilst the current processes were robust with respect to the identification of issues, there was a perception that there are difficulties in ensuring issues, upon identification, were effectively resolved. Some provided examples of hospitals or specific terms that have had known longstanding unresolved issues and questioned the ability of the accreditation process to definitively manage these.

*"You can use the survey to get change, but the attitude of the [hospital] hierarchy is that if it is not a proviso, if it is just a recommendation then they [the hospital] can just ignore it."*

*– JMO Manager*

## 6.5. Paper based system and manual collection of data is burdensome and resource intensive

Almost all of those involved in the consultation process expressed the view that the current paper based system and manual collection of data is highly resource intensive, too bureaucratic and burdensome on a system already under significant pressure.

*"There is way too much paperwork."*

*– JMO Manager*

*"The amount of paperwork is way too much."*

*– Director of Prevocational Training*

*"Some people have a view of throwing as much paperwork at the surveyors as you can."*

*– Surveyor*

*"There is a lot of bureaucracy around the accreditation process."*

*– Senior clinician*

This is compounded for those DPETs and JMO Managers who are new to their roles and are not experienced with the survey process. The combination of the cyclical nature of the current system (see section 6.13) combined with a relatively high turnover of DPET and JMO Manager roles (in the context of three year accreditation cycles) adds an additional burden to those experiencing their first accreditation survey.

*" It is very difficult to do the first time…trying to understand the process was quite daunting…I think I will be fine in the next accreditation visit as I know what to expect now."*

*– JMO Manager*

The argument for a change to electronic data collection systems was compelling. Many highlighted potential advantages of such a move, not just in terms of reducing the burden on the system, but importantly enhancing the capacity for ongoing (rather than intermittent) surveillance, running reports, sharing information, utilizing the same data sets for a range of accreditation processes, timely response to changing circumstances and generally improving the global oversight of prevocational education and training across NSW.

## 6.6. Prevocational trainees are not fully aware of nor engaged in the accreditation process

A somewhat surprising finding in the consultation process was that prevocational trainees have only a very limited and somewhat superficial understanding and awareness of the accreditation framework and standards. This was very evident in the focus group discussions.

The exception to this are those prevocational trainees who hold positions on HETI committees or have become junior doctor surveyors. Even representatives on the JMO forum appeared to have very little appreciation of the processes underpinning the accreditation system, nor of the standards themselves.

*"You can easily not realize that you have a voice and can give feedback and can promote changes."*

*– Prevocational trainee*

*"There is no formal feedback to the JMOs about the accreditation outcomes, or if there is, it isn't advertised."*

*– Prevocational trainee*

These comments are made in the context of an expectation that trainees (as *consumers of the education and training)* should be increasingly involved in the governance and delivery of medical education and training.

*"I think our patient and training populations are much more vocal and expect to be heard."*

*– Senior health executive*

The level of prevocational trainee engagement is particularly relevant in the context of consideration of suggested improvements to obtaining information about the quality of the training environment, which to a significant extent, rightly relies on information provided by prevocational trainees. Clearly, attention toward effective engagement of all prevocational trainees in the accreditation process is required.

## 6.7. There is confusion about the governance and accountability of prevocational training across the system

The consultation process revealed a degree of confusion regarding the governance and accountability of prevocational training within the system. This is particularly the case in facilities that have devolved department structures or no longer have Director of Medical Services (or equivalent) positions. There were views expressed that over time, the responsibility for the delivery of prevocational education and training is being delegated to positions within organisations that do not have the authority or power to effect meaningful change. Some expressed the view that there has been a sense of a gradual shift of the responsibility for prevocational education and training more centrally away from the actual sites in which training is delivered.

## 6.8. The standards are seen as constraining, rather than encouraging innovation in medical education and training

Whilst most of those consulted believed that the standards regulatory function is working very effectively, they questioned whether the quality assurance function could be further enhanced.

> *"There is a flaw in the current process as it doesn't encourage hospitals to be thinking about continuously improving."*
>
> *– Senior clinician*

> *"The [training] settings are changing and the standards need to evolve with these changes in setting."*
>
> *– Senior medical administrator*

> *"We want to make sure that the standards are being met and that accreditation is not a barrier to expanded positions."*
>
> *– Senior medical administrator*

> *"The focus was on let's just do whatever we need to pass the test, which is the minimum level...the system should be focusing on how can I make it safer? How can I enhance the educational component to produce better doctors?"*
>
> *– Senior doctor*

> *"Our thinking is constrained by the way in which we have always done things."*
>
> *– Senior health executive*

Some provided examples of the process of applying for new training terms (see 6.15) and expressed the view that the response by the PAC and HETI program staff tended to be risk adverse rather than encouraging innovation. The confusion about governance and responsibility (see 6.7) has compounded this.

## 6.9. There are some concerns about the way in which the PAC makes decisions

Following on from the points made under 6.8, and perhaps to some degree as a result of an attempt to pragmatically adapt to changing training environments, there is a perception that at times the decision making process at PAC lacks transparency. Some expressed the view that the PAC relies too heavily on the corporate memory of longstanding members and precedents rather than on clearly articulated

contemporaneous policies. Some PAC members in particular highlighted concerns about decisions being challenged by facilities and the current appeals process, which was viewed as requiring strengthening.

## 6.10. Concerns expressed about the lack of flexibility with regards to the measurement of standards across a range of training sites and networks

There was a generally expressed view, that whilst the standards are seen as very comprehensive, they are not easily applied to new training environments. Many provided the example of the response to the requirement for accreditation of PGPPP terms and the fact that this was resolved through the development of a separate set of standards and a somewhat different accreditation process.

Some consulted questioned the capacity of the current system to appropriately utilise information obtained through other accreditation processes.

Others questioned the ability of the current system to respond in a timely way to changing training environments, particularly in light of increased numbers, the requirement for expanded training settings and changes to College training requirements.

> *"I think that the accreditation process has unintended consequences – it ensures a minimum base for hospitals to train prevocational trainees but those performing at a higher level who want to follow a specialized career path are at a disadvantage as they can't get the terms they need. It can lead to holding back of people who are performing well. There is a degree of inflexibility."*
>
> *– Prevocational trainee*

## 6.11. Current cyclical nature of the accreditation process seen as promoting periods of intense activity leading up to a survey visit followed by a prolonged period of less or little focus on prevocational structures and processes.

Whilst there was general support for cyclical nature of accreditation visits (and in some cases, support for extending the maximum accreditation award to four years), there was also concern that the current process, in the absence of systematic background surveillance activity, encourages a 'boom and bust' approach to accreditation.

> *"Just before there is an accreditation visit, there is a mad flap to put things in place but it is a bit like doing an assignment the night before."*
>
> *– Junior doctor*

This is characterized by periods of intense activity leading up to a survey visit, followed by periods where there is little or less focus on structures and processes relating to prevocational training.

> *"When the information came through, there was a bit of a scramble to get the evidence together in time for the survey."*
>
> *– JMO Manager*

> *"The accreditation document should be a living document…not a last minute rush to scrape all the information together…an online document would work very well to avoid this."*
>
> *– JMO Manager*

*"Something else needs to be put in place that continuously monitors the facility's progress after accreditation to make sure it isn't all coming together right before the survey and then falling apart after the survey visit but at the same time, we have to be careful about the administrative load we put on the hospitals."*

*– Accreditation program staff member*

Many of those interviewed who are intimately involved in the delivery of prevocational education and training such as DPETs and JMO Managers had mixed views on this. Some saw an impending site visit as an opportunity for greater leverage particularly with respect to gaining resources or achieving change in the context of competing priorities in the wider healthcare system. Others viewed the cyclical nature with a degree of cynicism, such as evidenced in the quote below.

*"The accreditation cycle goes in waves, a hospital gets assessed and then everyone relaxes again up until six months before the next survey, when they pick up everything again to prepare for the next survey."*

*– Accreditation program staff member*

Some viewed the survey process as an opportunity for the organisation to focus on the needs of prevocational trainees. This was viewed as both educative in addition to being a potential lever to address critical issues.

*"The well-meaning people within the system are having trouble changing things and the survey system can give them a chance."*

*– Senior clinician and former DPET*

## 6.12. Although the composition of the survey teams is appropriate, the teams are too large and survey visits too long

Many of those consulted with longstanding involvement and experience in the accreditation processes raised the issue of creep in both the number of surveyors in a team, in addition to the amount of time that surveys now take. There were many comments in relation to the size of the survey teams.

*"I think the teams are too big. Eight people on a survey team becomes overbearing."*

*– JMO Manager*

Changes to surveyor training and associated policies were thought to have resulted in a number of prevocational trainees completing the online training and then being placed on the team as a trainee surveyors. The involvement of HETI program staff in survey visits is also contributing to the larger team size. Originally intended to provide an opportunity for new staff to become familiar with the survey process, the inclusion of program staff has now become standard practice. The increased burden on both surveyors and HETI program staff with regards to this was particularly noted.

Along a similar theme, a number of comments were made in relation to the duration of the site visit. Whilst it was acknowledged that visits of tertiary facilities, particularly those that have a large number of prevocational trainees, require with current processes, a two day site visit, many questioned whether site visit duration for other facilities could be reduced.

There were consistent views expressed on these issues with a general feeling that streamlining processes, utilization of electronic data bases and reform of the system to more targeted survey visits would allow for reduction in both team numbers and the actual time taken for a site visit.

## 6.13. Standards document contains too much duplication

Many made comments with respect to the standards document as containing too much duplication, requiring repetitive entries about the same or similar subject matter.

> *"The document used by the surveyors is fairly repetitive and it takes a long time to fill in, however it is fairly comprehensive."*
>
> *– Senior clinician*

Whilst experienced surveyors and PAC members reported appreciating the nuances of language in the standards, generally those in the wider system perceive them as still containing too much duplication. The perception here is that multiple questions are covering the same or very similar subject matter and a few consulted even went so far as to question whether this was a deliberate strategy by HETI to *"trip us up"*.

> *"I think that it is very repetitive in the actual survey that you fill out. The same questions are asked on a number of occasions but in a different fashion so if you are not careful you can be giving different answers to essentially the same question."*
>
> *– JMO Manager*

This appears to be a source of frustration and arguably contributes to a sense of tension, rather than one that fosters collaboration, between HETI accreditation program staff and the sites that deliver prevocational education and training.

## 6.14. Not all standards are equal and this should be made more transparent

There were a number of views expressed during the consultation process with respect to the fact that not all standards were seen as being equal. Some interviewed, particularly those with experience of the PAC commented that whilst the standards have not radically changed over the last decade, the system in which education and training is delivered definitely has.

> *"We have left if very unclear about what are the core requirements versus those under quality improvement or what is nice to have. For example, we don't differentiate between supervision and physical facilities. We need to unpack what are the core non-negotiable mandatory requirements."*
>
> *– Prevocational Accreditation Committee member*

Whilst it might be fair to argue that the standards were written in such a way as to allow for flexibility in interpretation, this has led a situation where there is a degree of interpretation and adaptation to the application of the standards made at the level of the PAC and this in turn has resulted in a perception to some degree of a lack of transparency of the way in which the PAC makes decisions (see also 6.9). It is clear from the consultation process that work needs to be undertaken on providing greater clarification on the standards.

Some suggested that a move to a different structure and rating scale with separation of mandatory criteria might provide a means of achieving the regulatory function whilst at the same time allowing for the quality assurance function to be maintained.

> *"We should be focusing on a bottom up approach because that will drive quality improvement. I think that the overall goal should be improvement as opposed to simply meeting the minimum standard."*
>
> *– Prevocational accreditation committee member*

## 6.15. Processes of accreditation of terms mid survey cycle requires streamlining

A number of those consulted expressed concern with regards to the current system of accreditation of terms mid survey cycle.

> *"It is very frustrating to submit and change the term description …its more bureaucratic than helpful."*
>
> *– Senior hospital manager*

> *"Half the time the JMO Manager is cutting and pasting the term description and the term supervisor just signs on it and there is information missing."*
>
> *– Prevocational Accreditation Committee member*

The term description was originally designed to provide orientation information to prevocational trainees. Over time, however, it has also become the primary document and basis on which the PAC makes a decision about term accreditation. Whilst these two functions are not necessarily mutually exclusive, they are distinct and a single template, particularly in the context of expanded settings, appears not to be effectively serving its intended purpose.

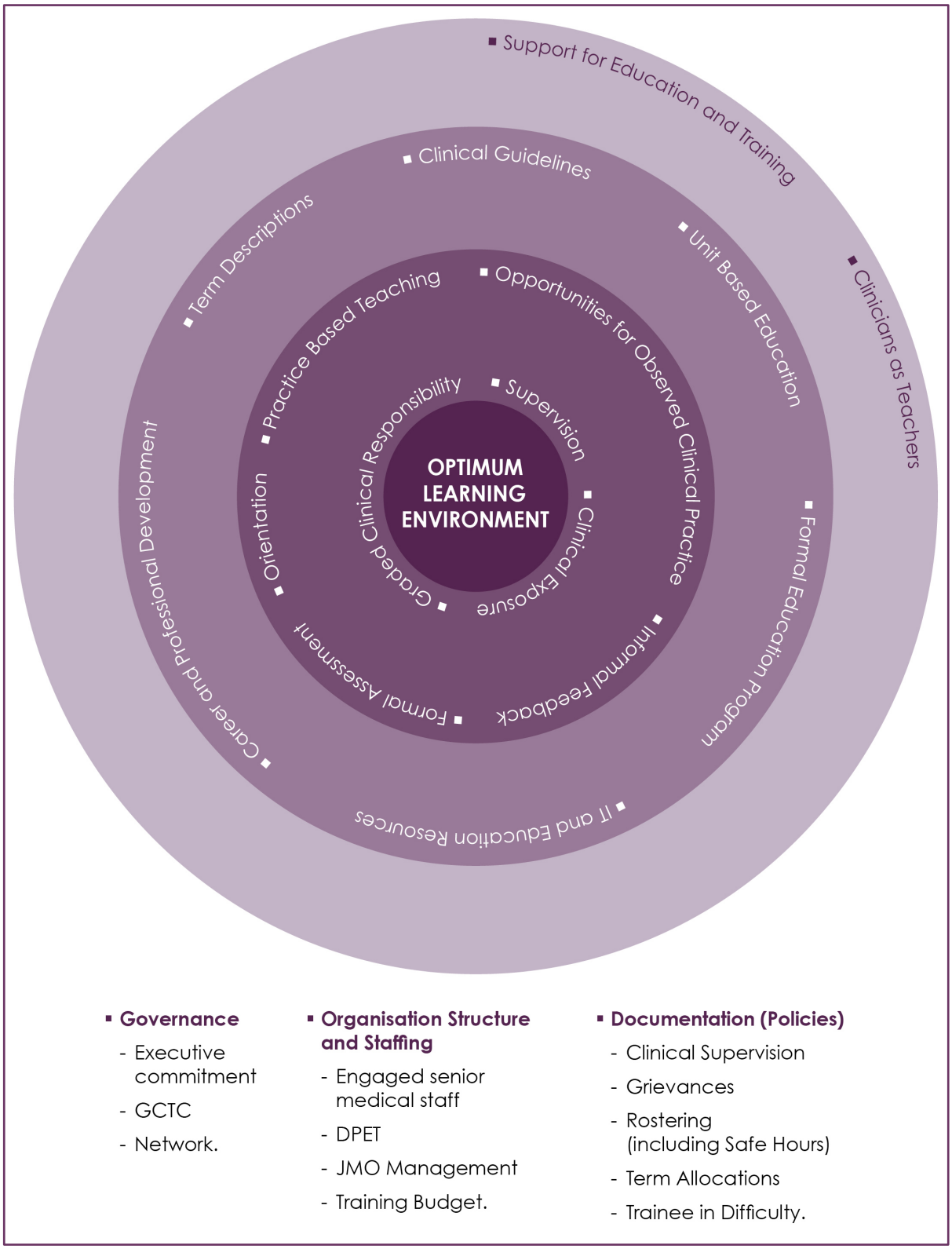
Many views were expressed during the consultation process about the term description template and processes underpinning accreditation of terms mid survey cycle and this appears to be a source of significant frustration for many stakeholders and is arguably impacting on the relationship between HETI and the sites that deliver training.

Many pointed out that although the intention in the standards is that the term supervisor is the primary author of the term description, the reality is that most of the term descriptions are written centrally. Many facilities have resorted to a cut and paste of generic information further eroding the utility of the term description as an orientation document for prevocational trainees at the individual term level. In this regard, the process is now viewed by many as cumbersome, very bureaucratic and in need of urgent review.

## 6.16. Concluding remarks

- The accreditation system is highly valued by key stakeholders and there is evidence of clear support for the existence of a set of standards making the requirements for prevocational training explicit.
- There were a number of issues identified with respect to the current system, primarily in relation to administrative processes, the burden of accreditation and accreditation of terms mid cycle. A number of recommendations have been made at the conclusion of this report to address concerns raised with respect to specific processes.
- The issue of mandatory standards was given some attention during the consultation process. It is clear that there are a number of standards that have, or should have, higher priority, particularly in the context of patient and prevocational trainee safety. Figure 5 provides a representation of elements of an optimum learning environment with the critical elements placed at the centre. The role of governance is also prominent in this model.
- Whilst there appeared to be a clear mandate for change expressed by many stakeholders, it was arguably not of the magnitude required to move the accreditation framework toward an outcomes based model. The full engagement of key stakeholders will be critical and a staged approach of reform will be required.

**Figure 5: Measuring the optimum learning environment – what matters most?**



# 7. Best practice principles

The following table provides a summary of best practice principles of accreditation identified following the literature review and the examination of other accreditation models both within Australia and overseas.

**Table 1: Principles of best practice in accreditation systems**

| Principle | Comment |
|---|---|
| Recognition that quality medical education and training is critical to the delivery of safe patient care | Medical education and training is an integral component of health care service delivery. |
| Clear governance structures | The responsibility for meeting the standards rests unambiguously with the site in which training is delivered. |
| Balance between the regulatory function and the quality assurance function | These two functions can coexist however the focus should be on quality assurance to encourage continuous improvement rather than sites simply reverting to meeting the minimum standards. |
| Cyclic accreditation processes | A longer survey cycle is encouraged in the presence of clear governance structures and continuous data gathering with capacity to respond to emergent issues. |
| Peer review process | The peer review process is designed to value and reinforce collaboration, supporting the quality assurance function and encouraging sites to engage in continuous improvement. |
| Site visits (by trained peer surveyors) | Site visits involve meetings with trainees, clinical supervisors, program directors (or equivalent) and facility leadership. They are enacted in a spirit of collaboration and respect, but one which does not shy away from the responsibility of and attention to the regulatory function (hence meeting the community expectation of ensuring that a given training site is producing safe and competent doctors). |
| Process focused accreditation systems measure optimum learning environment | Key aspects of optimum learning environments include appropriate supervision, feedback and assessment, range of clinical exposure and opportunities for clinical based learning activities. |
| Robust accreditation frameworks evolve over time, moving from process to outcomes based approaches | Process focused approaches provide a critical platform on which outcomes based approaches can be developed. |
| Transition of accreditation processes to outcomes focus whilst preserving the gains previously made | The community has the expectation that good doctors are being trained. The future emphasis of accreditation should be on sites providing evidence that this is the case (social accountability), building on the work already |

| Principle | Comment |
|---|---|
| | undertaken. |
| Accreditation processes should be streamlined, flexible and readily adaptable to measurement of requirements across a range of settings in which training is delivered | The standards should aim to reduce the administrative burden on facilities, resist the temptation to become overly prescriptive and utilise online data reporting systems. |
| The accreditation framework should encourage innovation and focus on recognizing and rewarding excellence rather than having a unilateral focus on problem identification. | This places responsibility for meeting the minimum requirements (regulatory function) with the facility in which training is delivered whilst promoting the quality assurance function. |
| Trainees are a valued source of information and should be engaged in the accreditation process. | This includes implementation of on line trainee surveys, seeking feedback from trainees at site visits, inclusion of trainees as members of the survey team and provision for trainee representation on accreditation governance committee. |
| Public reporting of accreditation results | This should be done in such a way that fosters innovation and excellence in medical education and training. |

# 8. Recommendations

In line with the Terms of Reference for the Review, a number of recommendations are made, based on best practice principles (see Table 1) identified following the literature review and examination of other accreditation models described in sections three, four and five of this report, in addition to responding to the issues raised within the consultation process (as documented in section six).

The recommendations have been divided on the basis of suggested timing of implementation and provide for a staged process of significant reform of the prevocational accreditation system within NSW.

One of the key features of the early recommendations is addressing currently identified issues, whilst concomitantly undertaking the preliminary work in preparation for the eventual transformation to an accreditation system based on an outcomes approach. This will place the prevocational accreditation system in NSW in line with international models and provide a basis for alignment of other medical (and potentially other health professional) education accreditation systems in the future.

**In the short term (during the next twelve months):**

**8.1.** **That the governance and accountability of the delivery of prevocational education and training should be clarified for the system at large. This should unambiguously place the responsibility and accountability for prevocational education and training with the site in which it is delivered. The senior executive position(s) within the facility who are responsible for ensuring compliance with the prevocational accreditation standards should be clearly identified. This will require collaboration between HETI, MoH, LHDs and other training sites with clear communication to all stakeholders.**

**8.2.** **That the accreditation process is supported by the development of an online web-based system designed to capture all current data sets with provision to expand to include trainee surveys, trainee assessments, and (potentially) clinical portfolios in the future. Whilst It is acknowledged that the implementation of a fully integrated electronic system will take longer than twelve months, the capacity for online collection of data is regarded as critical to reducing the burden of accreditation on the system at large and should be given some priority.**

**8.3.** **That the processes for accreditation of terms mid survey cycle be streamlined. The out of session provisional accreditation of terms by the Chair or representative of the PAC, recently introduced as a mechanism of fast tracking applications, is supported. Proposed model is depicted below.**

**8.4.** **That the current term description template used by the PAC to accredit terms is renamed (potentially as an 'application form for provisional accreditation of a new term') and modified to only include the information that is required by the PAC on which to base a decision for provisional accreditation.**

**8.5.** **That the requirement for a term description for each prevocational term be preserved, but that facilities be permitted to develop their own term description templates. The standards will need to be revised to reflect required elements of a term description whilst removing the mandate of the requirement to use the HETI template.**

**8.6.** **That prevocational trainees be engaged with and educated about the role of the accreditation framework and processes and required to participate in the evaluation of the training environment as an expected component of their professional responsibilities. (This would provide a platform for the future implementation of Recommendation 8.11)**

**8.7.** **That the proposed move to a four year accreditation cycle be supported with a staged transition for sites who have attained 3 year accreditation status over 2 consecutive cycles with appropriate response to any provisos in the interim.**

**8.8.** **That those sites on four-year accreditation cycles be expected to submit a concise progress report containing the following elements: (i) significant changes since the last survey; (ii) summary of new terms (provisionally accredited mid cycle); (iii) new developments and initiatives; and (iv) action taken against recommendations. A proposed accreditation model is depicted below.**

**8.9.** **That the membership of the Prevocational Accreditation Committee be reviewed to ensure appropriate representation. This may include broadening the membership to include representatives of expanded training settings in addition to consumer representation. The revised membership should also have provision for inclusion of members with particular expertise in medical education and/or accreditation/quality assurance.**

**8.10.** **That the terms of reference of the Prevocational Accreditation Committee be reviewed to ensure it complies with the requirement for independence (refer to Domain 2 Quality Framework for the Review of Intern Training Accreditation Bodies which requires that "*Decision making about accreditation of programs is independent and there is no evidence that any area of the community, including government, health services, professional associations has undue influence*.")**

**8.11.** **That a validated online trainee survey designed to evaluate the clinical training environment (such as PHEEM or equivalent) is adopted and piloted with a view to full implementation in NSW within the next two years.**

**8.12.** **That consideration is given to the public reporting of accreditation surveys in ways that foster and reward excellence and innovation in medical education and training across NSW.**

**8.13.** **That the composition and size of survey teams be evaluated to ensure the efficient use of human resources on site visits. This would include review of membership of program staff on site visits as a standard practice. Teams should generally be comprised of between two to four people with an absolute maximum of six for the larger facilities. If trainee surveyors are to be included on a survey team, this should be discussed with the team leader.**

**In the longer term (within the next two years)**

**8.14.** **That the accreditation standards document be rewritten, restructured and aligned with the draft AMC National Intern Training Standards with a more specific focus on the domains of governance and the learning environment.**

**8.15.** **The new standards should have provision for mandatory standards and be supported by the development of policies. Policies should be readily accessible and promoted to all stakeholders, particularly prevocational trainees and their clinical supervisors.**
**Where possible, the new standards should be languaged in such a way that supports the eventual transition to an outcomes, rather than process, focus.**

**8.16.** **That the pre-survey instrument be reconfigured in line with the standards document with an emphasis on continuous collection of evidence, including collated trainee surveys and other evidence as determined by HETI, (this would include Network and GCTC minutes, annual DPET report, collated trainee assessment data)**

**8.17.** **That once the pre-survey instrument and standards documents have been finalised, the pre-survey process is modified to allow for preliminary assessment against the standards and identification of issues to be considered at the survey visit, in collaboration with the training facility. A proposed model is depicted below.**

**8.18.** **That once 8.12 is in place, survey visits are reduced to one day and provide for targeted examination, in collaboration with the training facility of the identified issues.**

**8.19.** **That once training sites have established continuous data reporting systems, consideration be given to the development of thresholds which trigger targeted intervention (including potentially a site visit) within the survey cycle to deal with emergent urgent issues.**

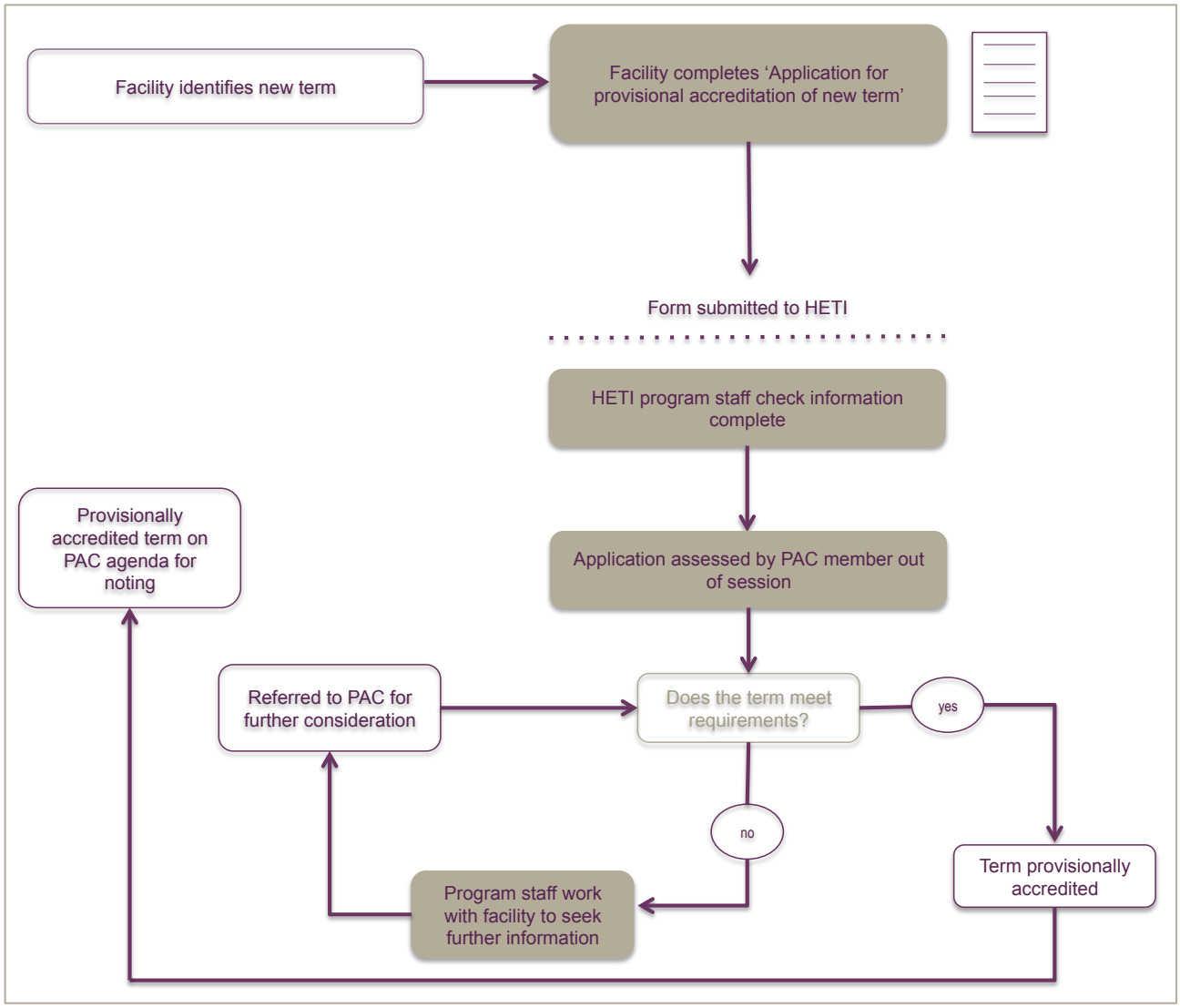
**8.20.** **That all training sites on a four year accreditation cycle be required to submit a concise progress report, with the elements identified in 8.8.**

**Beyond two years but within the next five:**

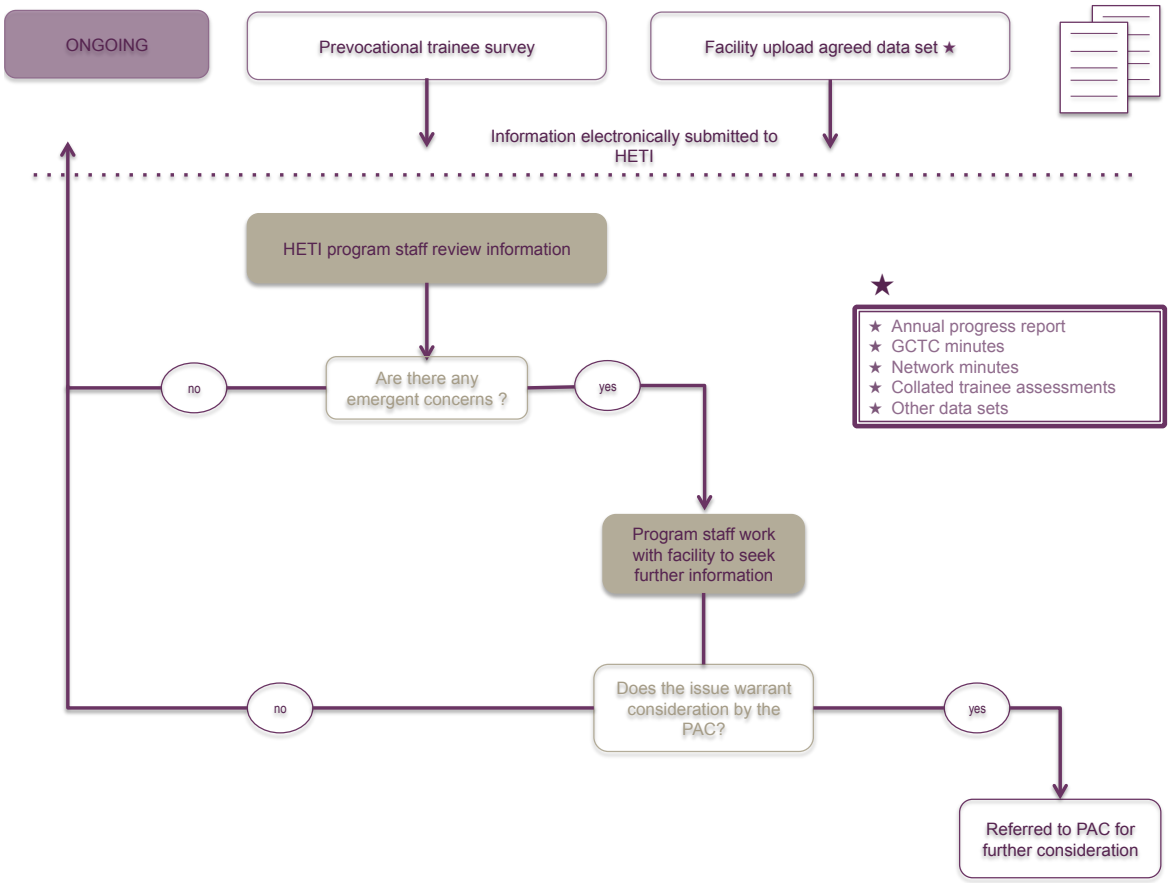
**8.21.** **That work is undertaken within NSW on identifying the outcomes expected of trainees during the prevocational training period and that once completed, this is reflected in the accreditation standards.**

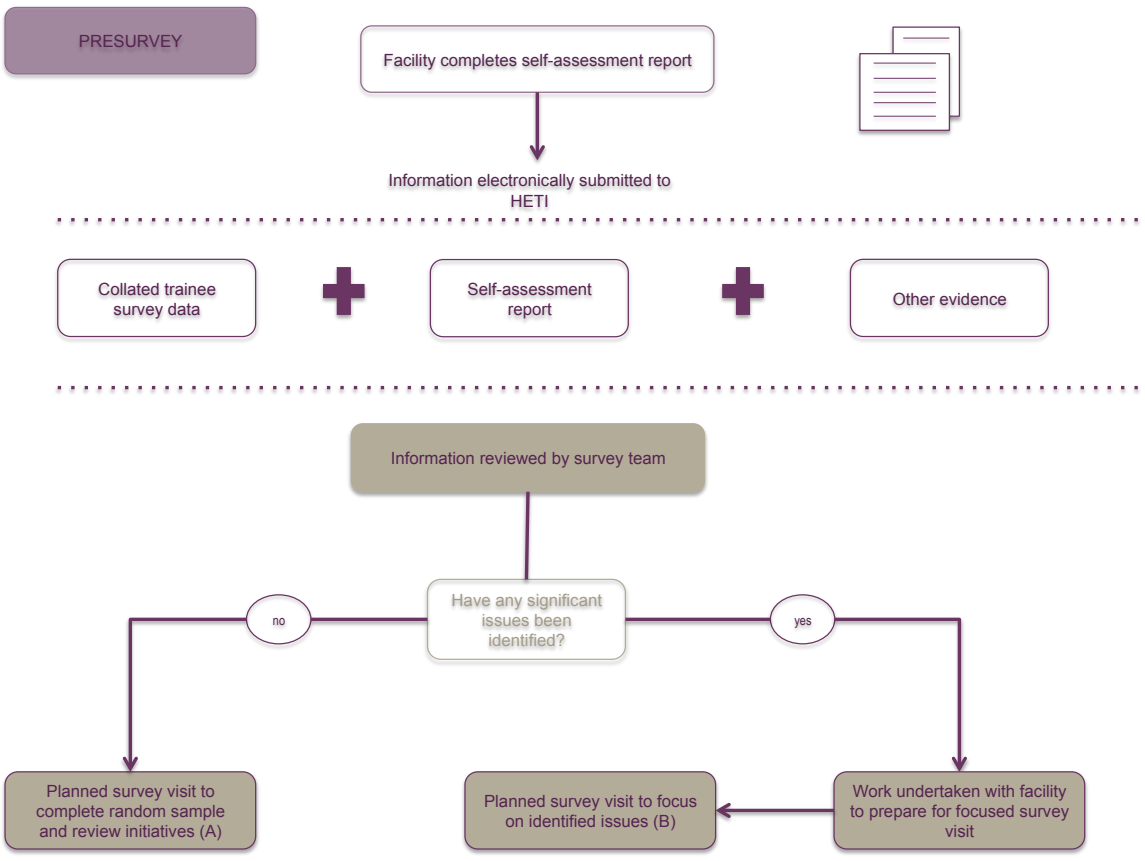
**8.22.** **That in line with the trainee survey, consideration is given to the development of an online trainee portfolio which follows the trainee throughout their prevocational training period and allows for capture of information on the clinical experience of each trainee. This work should be undertaken in consultation with Colleges to ensure alignment with their processes. The collated data of clinical portfolios should be reviewed as part of the evidence used as a basis for making decisions about accreditation at both the term and facility level. (This could be an extension of the work undertaken on the development of an App for the ACF as an example)**

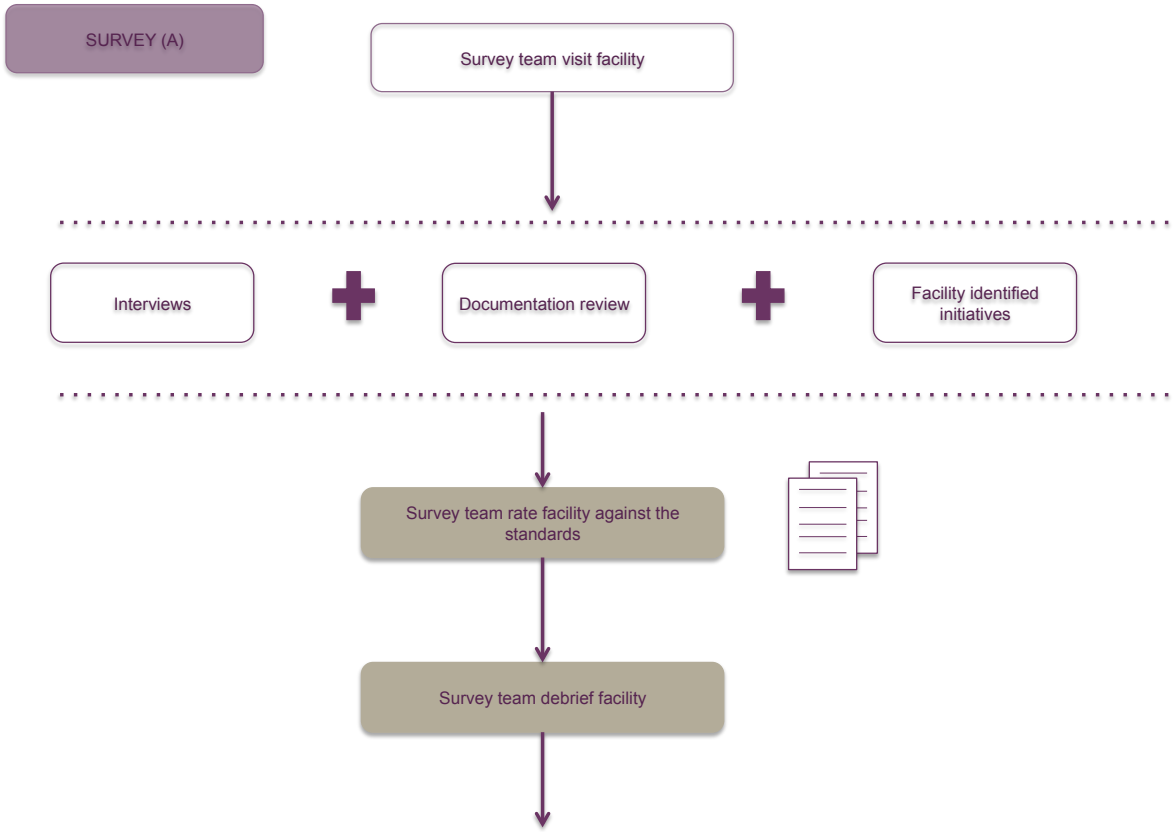
### PROPOSED MODEL OF MID CYCLE APPROVAL OF NEW TERMS (8.8)

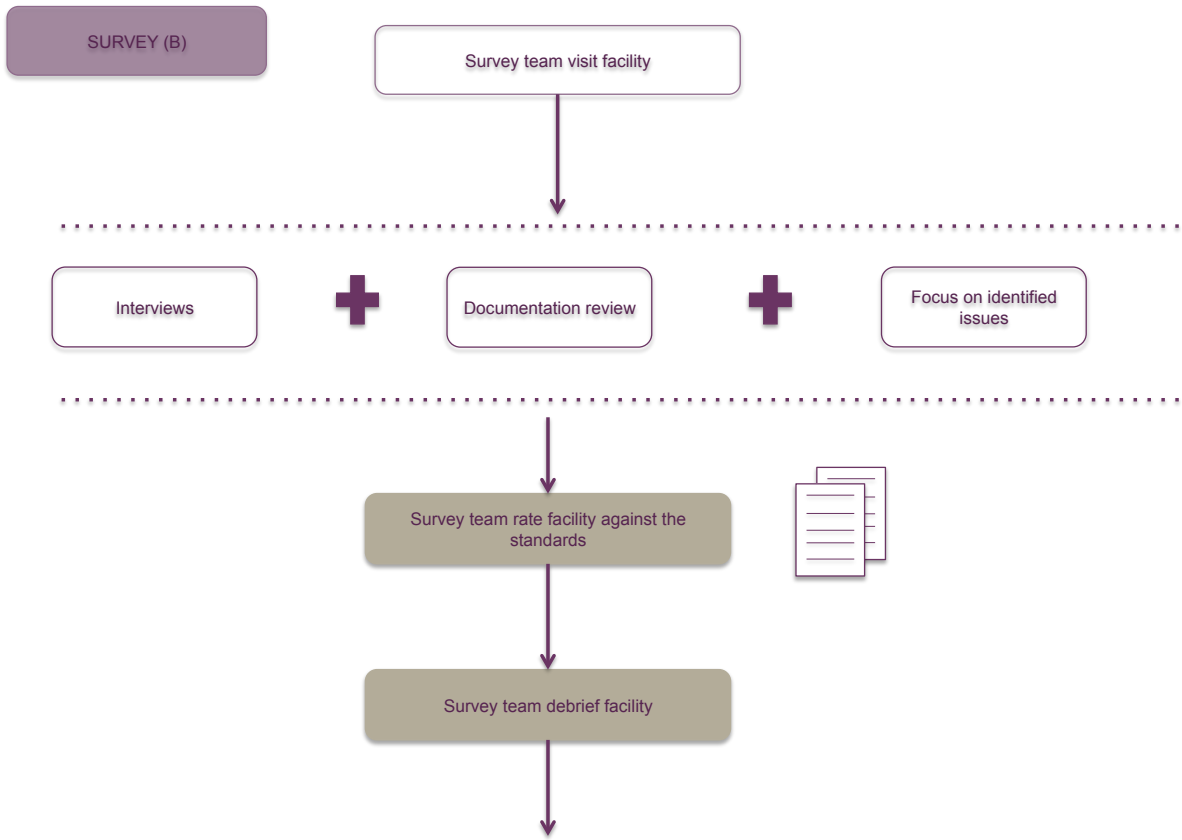


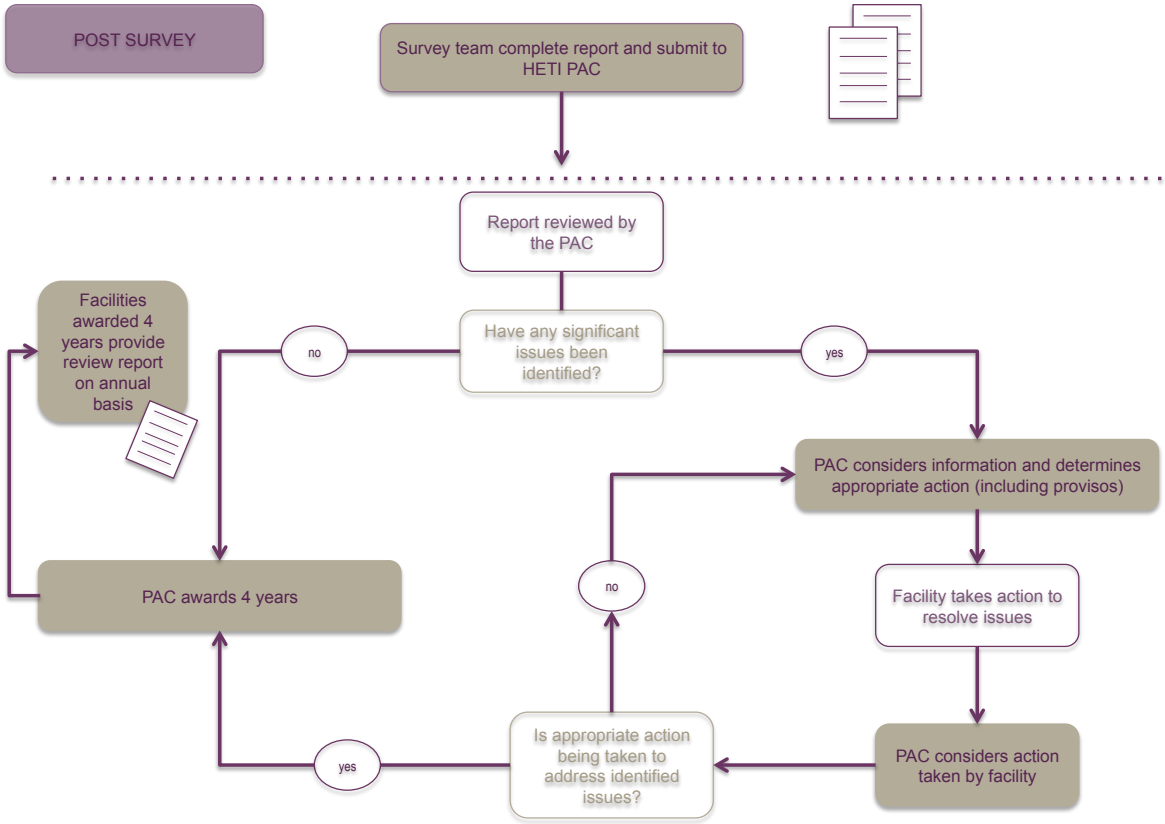
## PROPOSED MODEL OF ACCREDITATION PROCESS (8.17)




SURVEY (A)
Survey team visit facility
Interviews
Documentation review
Facility identified initiatives
Survey team rate facility against the standards
Survey team debrief facility


SURVEY (B)
Survey team visit facility
Interviews
Documentation review
Focus on identified issues
Survey team rate facility against the standards
Survey team debrief facility


POST SURVEY
Survey team complete report and submit to HETI PAC
Report reviewed by the PAC
Have any significant issues been identified?
no
yes
Facilities awarded 4 years provide review report on annual basis
PAC awards 4 years
PAC considers information and determines appropriate action (including provisos)
Facility takes action to resolve issues
PAC considers action taken by facility
Is appropriate action being taken to address identified issues?
no
yes

# Appendix A – Terms of Reference for the Review

To undertake a review of the NSW accreditation framework for prevocational medical trainees with provision of a report to the Health Education and Training Institute.

1. Review the current accreditation system for prevocational trainees being used by the Health Education and Training Institute.
2. Undertake a literature review to identify accreditation best practice.
3. Make recommendations on overarching principles required for prevocational medical accreditation.
4. Propose models of accreditation that can be used to develop a more streamlined accreditation framework in NSW. Consideration of models would need to include:
    - Flexibility across sites and service contexts, for example, large and small facilities, Networks;
    - Frequency of surveys and ratings of assessment; and
    - The development of domains for standards.

# Appendix B – List of those who participated in the Review

| Name | Position |
|---|---|
| Associate Professor Michael Agrez | Surgeon, John Hunter Hospital. |
| Dr Jonathan Ash | Prevocational Trainee, Hunter Network |
| Dr Claire Blizard | Executive Director Medical Services<br>Chair, Prevocational Accreditation Committee, Health Education and Training Institute |
| Ms Colleen Caterson | Support Officer, Prevocational Medical Training Unit, Health Education and Training Institute |
| Ms Jeanette Chadban | Manager, Hunter New England LHD Prevocational Training Network |
| Dr Lewis Chan | Urologist, Concord Hospital |
| Ms Louise Cook | Program Manager, Prevocational Medical Training Unit, Health Education and Training Institute |
| Dr Ros Crampton | Director Education, Research and Education Network, Western Sydney LHD.<br>Chair, Prevocational Training Council, Health Education and Training Institute |
| Dr Leigh Cummins | Resident Medical Officer |
| Dr David Dumbrell | Director of Medical Services, Goulburn Hospital |
| Ms Dale Erwin | Director Medical Workforce, HNE LHD |
| Professor Kevin Forsyth | Chair, South Australian IMET |
| Dr Alison Freeth | Junior doctor |
| Ms Brianna Gerrie | Manager, Junior and Senior Medical Staff Units, Royal North Shore Hospital |
| Dr Margaret Ginger | Director of Prevocational Education and Training, Wentwest Limited |
| Ms Heather Gray | Chief Executive, Health Education and Training Institute |
| Dr Justine Harris | Director of Medical Services, Sutherland Hospital |

| Name | Position |
|---|---|
| Ms Lyn Hemmings | Postgraduate Medical Council Tasmania |
| Professor Cliff Hughes | Chief Executive Officer, Clinical Excellence Commission, NSW |
| Dr Sam Hwang | Resident Medical Officer, Sydney Children's Hospital |
| Ms Alison Jones | South Australia IMET |
| Dr Kate Kearney | Intern, Blacktown Hospital |
| Professor Greg Keogh | Chief, Medical Education, HETI |
| Dr Amanda Krstevski | Resident Medical Officer, President of RMOA, Hunter Network |
| Dr Johann Leuffer | Prevocational Trainee Hunter Network |
| Dr Emily Lewis | Intern, Wagga Wagga Base Hospital |
| Dr Anthony Llewellyn | Medical Director, Health Education and Training Institute |
| Dr Nigel Lyons | Chief Executive, Agency for Clinical Innovation, NSW |
| Dr Colin MacArthur | Senior Clinician, Liverpool Hospital |
| Dr Martin Mackertich | Director Clinical Services, St George Hospital |
| Dr Linda MacPherson | Medical Advisor, Workforce Planning and Development, Ministry of Health |
| Ms Michelle McWhirter | JMO Manager, Royal Prince Alfred Hospital |
| Ms Jean Mah Collins | JMO Manager, Concord Hospital |
| Dr Kate Moriarty | Prevocational trainee Hunter Network |
| Ms Judy Muller | JMO Manager, Hornsby Hospital |
| Ms Korina Nand | Program Support Officer, Prevocational Medical Training Unit, Health Education and Training Institute |
| Dr Adam Nelson | Fellow, Paediatric Haematology, Sydney Children's Hospital |
| Ms Jackie O'Callaghan | Senior Program Coordinator, Prevocational Medical Training Unit, Medical Portfolio, HETI |
| Ms Debbie Paltridge | National Project Coordinator, ACF Project, CPMEC |

| Name | Position |
|---|---|
| Dr Annette Pantle | Group General Manager Clinical Governance, Chief Medical Officer, St Vincent's Health Australia |
| Mr Kieren Purnell | Education Program Coordinator, Prevocational Medical Training Unit, Health Education and Training Unit |
| Associate Professor Ian Rewell | Director of Medical Services, South East Sydney and Illawarra LHD |
| Ms Maggie Robinson | JMO Manager, Wagga Wagga Base Hospital |
| Ms Preeti Saraswati | Medical Network Support Officer, Prevocational Medical Training Unit, Health Education and Training Institute |
| Dr Denis Smith | Medical Advisor, Medical Workforce Programs, Western Sydney Local Health District. |
| Mr Matt Smith | Network Coordinator, Prevocational Medical Training Unit, Health Education and Training Institute |
| Dr Renee Shepherd | Junior doctor |
| Ms Jenny Sleighman | JMO Manager, Auburn Hospital |
| Ms Elizabeth Stone | Program Coordinator, Prevocational Medical Training Unit, Health Education and Training Institute |
| Dr Michael Tong | Prevocational Trainee Hunter Network |
| Dr Satya Varanasi | Resident Medical Officer, Blacktown Hospital |
| Ms Chrissy Wamel | Medical Education Coordinator, Tamworth Base Hospital |
| Dr Zara Watson | Resident Medical Officer, Orange Base Hospital |
| Dr Bruce Way | Senior Staff Specialist, Prince of Wales Hospital |
| Ms Dawn Webb | Program Coordinator, Prevocational Medical Training Unit, Health Education and Training Institute |
| Dr Simon Willcock | Professor and Head, Discipline of General Practice, Sydney Medical Program |
| Ms Karen Wolf | Chief Executive Officer PMCQ |
| Ms Jan Worsley | Junior Medical Workforce Planning and Operations Manager, Resident Support Unit, Westmead and Auburn Hospitals |

# Appendix C – List of source documents

**1. Health Education and Training Institute (HETI) documents**

1.1. HETI Standards of Education, Training and Supervision for Prevocational Trainees and Post AMC Supervised Training Version 4.4

1.2. General Practice Education and Training Standards – version 3

1.3. A Framework for Accrediting Training and Supervision in General Practice Settings

1.4. Prevocational Accreditation Committee Terms of Reference

1.5. PGPPP Interim Evaluation Report 2011

1.6. Network Principles for Prevocational Medical Training 2012

1.7. Insert additional

**2. Australian Medical Council (AMC) documents**

2.1. Quality Framework for Intern Training Accreditation (draft)

2.2. Internship in the national registration and accreditation scheme

2.3. Intern Global Outcome Statements (draft)

2.4. Guidelines for intern rotations (draft)

2.5. Assessment of interns (draft)

**3. Confederation of Postgraduate Medical Councils (CPMEC)**

3.1. Prevocational Medical Accreditation Framework for the Education and Training of Prevocational Doctors (PMAF) 2009

3.2. Australian Curriculum Framework for Junior Doctors

**4. Other postgraduate medical councils (or equivalent) accreditation standards**

4.1. Postgraduate Medical Council of Queensland (PMCQ) Accreditation Standards

4.2. Postgraduate Medical Council of Victoria (PMCV) Accreditation Survey Instrument Parts 1-2 (March 2013)

4.3. South Australian Institute of Medical Education and Training (SA IMET) Accreditation Standards Version 1.0 June 2010

4.4. Postgraduate Medical Council of Western Australia (PMCWA) Guide to Accreditation Standards

4.5. Northern Territory Postgraduate Medical Council (NTPMC) Accreditation Standards for Intern Training Program 2009

4.6. Postgraduate Medical Council of Tasmania (PMCT) Accreditation Guidelines July 2013

4.7. Medical Council of New Zealand Education and supervision for Interns 2006 (reprinted 2011)

**5. Medical Board of Australia**

5.1. Registration standard for granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training

**6. United Kingdom**

6.1. Temple J, *Time for Training: A Review of the Impact of the European Working Time Directive on the Quality of Training*, 2010

6.2. Tooke J (Chair), Aspiring to Excellence: Findings and Final Recommendations of the Independent Inquiry into Modernising Medical Careers, 2008

6.3. Collins, J Foundation for Excellence An Evaluation of the Foundation Programme Medical Education England, NHS 2010

6.4. *The Quality Improvement Framework*, General Medical Council UK 2011

6.5. The Trainee Doctor Foundation and specialty, including GP training, General Medical Council. UK 2011

6.6. UK Foundation Program Curriculum, UK FPO, 2010

**7. *Canada***

7.1. *The Future of Medical Education in Canada 2012 (FMEC): A Collective Vision for Postgraduate Medical Education in Canada* available at www.afmc.ca/future-of-medical-education-in-canada/postgraduate-project

**8. United States**

8.1. ACGME Program Requirements for Graduate Medical Education in the Transitional Year 2007 available at www.acgme.org

8.2. Accreditation Council for Graduate Medical Education *Policies and Procedures* 2013 available at www.acgme.org

**9. New Zealand**

9.1. A Review of Prevocational Training Requirements for Doctors in New Zealand: Stage 2 *A second consultation paper on the proposed changes to prevocational training.* Medical Council of New Zealand, February 2013

9.2. Report on the feedback and decisions following the consultation of: *A review of prevocational training requirements for doctors in New Zealand: Stage 2.* Medical Council of New Zealand, August 2013

# Appendix D – Summary of selected articles from literature review

| | Authors | Title | Journal | Summary/key findings |
|---|---|---|---|---|
| 1 | Mitka M. | Residencies roll out new training system | Journal of American Medical Association, 2013; 309:2085-2086 | Comment on the Next Accreditation System commencing July 1 2013 that further moves the accreditation system to an outcomes-based approach. |
| 2 | Shaw CD. Braithwaite J. Moldovan M. Nicklin W. Grgic I. Fortune T. Whittaker S. | Profiling health-care accreditation organizations: an international survey | International Journal for Quality in Health Care, 2013; 25: 222-231 | Study (web-based questionnaire) designed to describe global patterns among health-care accreditation organizations and to identify determinants of sustainability and opportunities for improvement. Successful organizations tend to complement mechanisms of regulation. |
| 3 | Weiss KB. Bagian JP. Nasca TJ. | The clinical learning environment: the foundation of graduate medical education | Journal of American Medical Association 2013; 309: 1687-1688 | Authors describe the Clinical Learning Environment Review (CLER), a component of the Next Accreditation System (NAS) which identifies teaching hospitals' efforts to engage residents in 6 areas of focus: patient safety; health care quality, including reduction in health care disparities; transitions in care; supervision; duty hours and fatigue management and mitigation; and professionalism. |
| 4 | Scott J. | ACGME Competencies should be required of our residencies, not just our residents | Academic Medicine, 2012; 87: 1480 | Letter in which the author describes the move away from process-driven accreditation schemes to outcomes based schemes but also argues that the 6 competencies should equally apply to the residencies, hospitals and health systems. |
| 5 | Browne J. | Setting standards: quality in accreditation | Medical Education, 2012; 46: 1017 | Letter in which the author argues that accrediting both medical schools and individual medical teachers is a crucial step towards ensuring continued improvement in clinical care for patients. |
| 6 | Beatty K. Strasser R. Graves L. Ellaway R. | Accreditation Collaborative: a systems approach to institutional accountability | Medical Education, 2012; 46: 1123-1124 | The authors describe an accreditation collaborative established within the Northern Ontario School of Medicine to provide support to each program as it negotiates its accreditation cycle. They conclude that despite some challenges, the collaborative has allowed the school to manage its responses to accreditation requirements across a number of programs more efficiently and |

| | Authors | Title | Journal | Summary/key findings |
|---|---|---|---|---|
| | | | | consistently. |
| 7 | van Zantan M. McKinley D. Montiel ID, Pijano C V. | Medical education accreditation in Mexico and the Philippines: impact on student outcomes | Medical Education, 2012, 46: 586-592 | The authors investigate the examination performance of Mexican and Philippine citizens who attending medical schools in their home countries by medical school accreditation status and demonstrate an association between accreditation and student outcomes. |
| 8 | Nauta RJ. | Residency training oversight(s) in surgery: the history and legacy of the Accreditation Council for Graduate Medical Education reforms | Surgical Clinics of North America, 2012: 92: 117-123 | Provides a view regarding the historical context and impact of the ACGME reforms. The author examines the changes to accreditation standards in the areas of clinical handover and work hours. He concludes that despite the ACGME rules in place, there is further opportunity for work, particularly in the provision of an evidence base. |
| 9 | Alwan IA. | Is accreditation a true reflection of quality? | Medical Education, 2012; 46: 542-544 | Letter in which the author argues that as the purpose of accreditation is to improve the quality of health care, the objective of accreditation is to adapt medical education to changing conditions in health care delivery and to prepare doctors to meet the needs and expectations of society. He supports the development of the global standards of the WFME. |
| 10 | Dauphinee WD. | Educators must consider patient outcomes when assessing the impact of clinical training | Medical Education, 2012; 46: 13-20 | The author uses peer-reviewed evidence and an outcomes framework to explore the implications of current realities for the makers of education policy in the health professions and for the staff who train health professionals. |
| 11 | Linegar A. Whittaker S, van Zyl G. | Academic hospital accreditation strengthens postgraduate training programmes: Case study from Universitas Academic Hospital | South African Medical Journal, 2012; 102: 146-148 | Case study illustrating the positive influence of the accreditation process (Council for Health Services Accreditation South Africa COHSASA) on the quality of clinical service delivery and, in consequence, on postgraduate training standards. |
| 12 | Hunt D. Migdal M. Eaglan R. Barzansky B. Sabalis R. | The unintended consequences of clarity: reviewing the actions of the Liaison Committee on Medical | Academic Medicine, 2012; 87: 560-566 | The purpose of the study was to determine the frequency of severe action decisions made by the Liaison Committee on Medical Education (LCME) before and after the reformatting of the standards. The authors conclude that the reformatting |

| | Authors | Title | Journal | Summary/key findings |
|---|---|---|---|---|
| | | Education before and after the reformatting of accreditation standards | | allowed the LCME to more easily identify areas of chronic noncompliance and to improve survey team training, thus improving the LCME's ability to monitor medical education programs. |
| 13 | Farnan JM. Petty LA. Georgitis E. Martin S. Chui E. Prochaska M. Arora VM. | A Systemic Review: The Effect of Clinical Supervision on Patient and Residency Education Outcomes | Academic Medicine, 2012; 87: 428-442 | Literature review – to explore the effect of clinical supervision on patient and educational outcomes. Authors conclude that enhanced clinical supervision of trainees has been associated with improved patient- and education-related outcomes in published studies. |
| 14 | DeRienzo CM. Frush K. Barfield ME. et al | Handoffs in the era of duty hours reform: a focused review and strategy to address changes in the Accreditation Council for Graduate Medical Education common program requirements | Academic Medicine, 2012; 87: 403-410 | The authors describe the response of their institution to changes to accreditation requirements with regards to clinical handover, including a focused review, comprehensive education and evaluation for residents. (Provides an example of how standards might be used as a lever for reform in patient care.) |
| 15 | Huggan PJ. Samarasekara DD. Archuleta S. Khoo SM. Joo Sim JH. Ping Sin CS. Suat Ooi SB. | The successful, rapid transition to a new model of graduate medical education in Singapore | Academic Medicine, 2012; 87: 1268- 1273 | The authors outline the historic development of GME in Singapore and describe the reforms leading to ACGME-I accreditation. They argue that external accreditation can be a powerful driver of educational reform. |
| 16 | Donato AA. George DL. | A blueprint for implementation of a structured portfolio in an internal medicine residency | Academic Medicine, 2012; 87: 185-191 | The ACGME recommends the structured portfolio as a preferred assessment tool for assessing the core competencies. The authors review the components necessary to successfully build and maintain a robust portfolio learning environment in a graduate medical education setting. |
| 17 | Tzarnas CD. | Are smaller plastic surgery residency programs at an Accreditation Council for Graduate Medical Education accreditation disadvantage? | Plastic and Reconstructive Surgery, 2012; 129: 892e-893e | Letter in which author questions whether smaller sites may be at a disadvantage with regards to the accreditation process and conducted a survey of program directors. He concludes that the smaller programs are not statistically significantly disadvantaged compared with larger programs. |

| | Authors | Title | Journal | Summary/key findings |
|---|---|---|---|---|
| 18 | Miles S. Swift L. Leinster SJ. | The Dundee Ready Education Environment Measure (DREEM): a review of its adoption and use | Medical Teacher, 2012; 34: e620 –e634 | Study aimed to review the settings and purposes to which the DREEM has been applied and concluded that the instrument has been used international for different purposes and is regarded as a useful tool by users but methods of reporting and analysis of DREEM data are inconsistent. The authors conclude that greater clarity and uniformity of approach in data reporting and analysis would enable meaningful comparisons across institutions. List of studies are included. |
| 19 | Van Zanten M. Boulet JR. Greaves I. | The importance of medical education accreditation standards | Medical Teacher, 2012; 34: 136-145 | Authors surveyed 22 undergraduate medical education accreditation experts using 150-item survey that consisted of WFME standards. While there is some global variation in experts' opinions of accreditation standards, certain standards are considered essential. |
| 20 | Nasca TJ. Philibert I. Brigham T. Flynn TC. | The next GME accreditation system – rationale and benefits | New England Journal of Medicine, 2012; 366: 1051-1056 | Describes the new accreditation system including identifying some of the benefits (creation of a national framework for assessment, reduction in the burden associated with process-based accreditation system, opportunity for residents to learn in innovative programs, and enhanced resident education in quality, patient safety and the new competencies. The authors argue that over time the focus will be less on identification of problems and more on success of programs. Detailed example of selected milestones in the NAS provided. |
| 21 | Burch VC. | Medical education in the 21st century: what would Flexner ask? | Medical Education, 2011; 45: 22-24 | Discusses some of the main drivers for medical education reform, including global distribution of workforce, within country distribution of workforce, increasing demand and community expectations of health care. |
| 22 | Houben KW. Van den Hombergh CLM. Stalmeijer RE. Scherpbier AJ. Marcus MAE. | New training strategies for anaesthesia residents | Current Opinion in Anesthesiology, 2011; 24: 682-686 | Authors provide an overview of developments in anaesthesia residency training and conclude that portfolio, simulation and quality assurance are among the most prominent developments aimed at creating successful residency programs. |
| 23 | Holmboe E. Ginsburg S. Bernaeo E. | The rotational approach to medical education: time to | Medical Education, 2011; 45:69-80 | Authors examine the issue of rotational transitions from the three perspectives of sociology, learning theory and the |

| | Authors | Title | Journal | Summary/key findings |
|---|---|---|---|---|
| | | confront our assumptions? | | improvement of quality and safety and argue that further research is required in this area. |
| 24 | Holt KD. Miller RS. Philibert I. Heard JK. Nasca TJ. | Residents' perspectives on the learning environment: data from the Accreditation Council for Graduate Medical Education Resident Survey | Academic Medicine, 2010; 85: 512-518 | The authors examine the reliability and validity of a resident/fellow survey and explored the relationship between reported duty hours noncompliance and residents' perceptions of other aspects of their learning environments. They conclude that the survey is a reliable, valid and useful tool for evaluating residency programs. |
| 25 | Gough J. Bullen M. Donath S. | PHEEM 'Downunder' | Medical Teacher, 2010; 32: 161-163 | The authors administered the PHEEM in nine Victorian hospitals and conclude that is it valuable for systematically collecting information about the educational environment of hospitals. They argue that it brought particular attention to problems associated with protected training time for first year trainees, inappropriate paging and lack of feedback. |
| 26 | Nair M. Webster P. | Education for health professionals in emerging market economies: a literature review | Medical Education, 2010; 44: 856-863 | Paper provides a review of the literature in relation to recent updates on medical and nursing education in EMEs. It concludes that reforms in the health system need to be complemented by educational reforms and also argues that there is a need for a standardized accreditation system for quality assurance. |
| 27 | Amin Z. Burdick WP. Supe A. Singh T. | Relevance of the Flexner Report to contemporary medical education in South Asia | Academic Medicine, 2010; 85: 333-339 | Authors report on issues with regards to university medical education and argue that strengthening accreditation standards, amongst other suggestions, will ensure better quality of medical schools. |
| 28 | Fahy BN.Todd SR. Paukert JL. Johnson ML. Bass BL. | How accurate is the Accreditation Council for Graduate Medical Education (ACGME) resident survey? Comparison between ACGME and in-house GME survey | Journal of Surgical Education, 2010; 67: 387-392 | The purpose of the study was to compare the responses obtained in the ACGME survey with an in-house GME survey. The authors conclude that the results suggest that responses obtained on the ACGME survey may inaccurately reflect the magnitude of noncompliance found in certain areas and suggest that this discrepancy may be the result of the limited range of response available on the ACGME survey. |

| | Authors | Title | Journal | Summary/key findings |
|---|---|---|---|---|
| 29 | Maniate JM. | Redesigning a Resident Program Evaluation to strengthen the Canadian Residency Education Accreditation System | Academic Medicine, 2010; 85: 1196-1202 | The author provides a brief description of the current state of the Canadian postgraduate medical education system, examining how it connects to the existing accreditation system and then describes the development and implementation of a new set of resident program evaluation (RPE) The new RPE is one component of a new accreditation survey package. |
| 30 | Boelen C. Woollard B. | Social accountability and accreditation: a new frontier for educational institutions | Medical Education, 2009; 43: 887-894 | The authors argue that as globalization is reassessed for its social impact, societies will seek to justify their investments with more solid evidence of their impact on the public good and medical schools should be prepared to be judged accordingly. There is an urgent need to foster the adaptation of accreditation standards and norms that reflect social accountability. The authors conclude that only then can educational institutions be measured and rewarded for their real capacity to meet the pressing health care needs of society. |
| 31 | Lune S. Mooney C. Lyness J. | Measurement of the General Competencies of the Accreditation Council for Graduate Medical Education: A Systematic Review | Academic Medicine, 2009; 84:301-309 | Systematic review – to evaluate whether the ACGME's 6 general competencies can be measured in a valid and reliable way. Peer reviewed literature provides no evidence that current measurement tools can assess competencies independently of one another. Authors recommend using competencies to guide and coordinate specific evaluation efforts. |
| 32 | Greenfield D. Braithwaite J. | Developing an evidence base for accreditation of healthcare organisations: a call for transparency and innovation | Quality and Safety in Health Care, 2009; 18: 162-3 | Editorial. The authors argue that despite the fact that accreditation of healthcare organisations has become standard practice, research in this area is underdeveloped. They argue that some research is now been undertaken by accreditation bodies in some countries, including Australia. The authors conclude by arguing that there should be transparency in the publication of results. |
| 33 | Nagler A. Andolsek K. Padmore JS. | The Unintended Consequences of Portfolios in Graduate Medical Education | Academic Medicine, 2009; 84: 1522-1526 | Examines some of the legal issues relating to the use of collection of clinical data in resident's portfolios and provides some practical suggestions and policy implications. |
| 34 | Maniate JM. Karimuddin A. | A Set of Principles, Developed | Academic Medicine, 2009; 84: | The authors present a set of principles they developed based on |

| | Authors | Title | Journal | Summary/key findings |
|---|---|---|---|---|
| | | by Residents to Guide Canadian Residency Education | 1527-1532 | resident's perspectives of what was important in creating the "ideal" postgraduate medical education system. The principles are presented in Appendix 1. |
| 35 | Denz-Penhey H. Murdoch JC. | A comparison between findings from the DREEM questionnaire and that from qualitative interviews | Medical Teacher, 2009; 31: e449-e453 | Study from WA that aimed to identify if the DREEM data could be used qualitatively and descriptively to determine specific problems from the data alone despite the small numbers at some sites. The authors concluded that DREEM questionnaire identified student perception of site issues as accurately as did the individual interviews and at considerable cost and time saving. |
| 36 | Chaudhry SI. Caccamese SM. Beasley BW. | What Predicts Residency Accreditation Cycle Length? Results of a National Survey | Academic Medicine, 2009; 84: 356-361 | The purpose of this study was to determine whether residency program baseline characteristics, program director characteristics and the date of the most recent ACGME site visit would affect program accreditation cycle length. The authors concluded that the strongest predictor was the time of site visit in relation to ACGME rule changes, but included other program and director characteristics, which may be markers of program quality. |
| 37 | Curry RH. Burgener AJ. Dooley SL. Christopher RP | Collaborative Governance of Multiinstitutional Graduate Medical Education: Lessons from the McGraw Medical Center of Northwestern University | Academic Medicine, 2008; 83: 568-573 | The authors explore the rationale for pursuing a new model of graduate medical education governance and identify "critical success factors". |
| 38 | Collins J. | New Standards and Criteria for accreditation of hospitals and posts for surgical training | ANZ Journal of Surgery, 2008; 78: 277-281 | Author describes the refinement by RACS of their accreditation methodology, including the standards, following accreditation by the AMC. |
| 39 | Greenfield D. Braithwaite J | Health sector accreditation research: a systemic review | International Journal of Quality in Health Care, 2008; 20 (1): 72-83 | The purpose of this study was to identify and analyze research into accreditation and accreditation processes. The authors conclude that the health care accreditation industry appears to be purposely moving towards constructing the evidence to ground our understanding of accreditation. |

| | Authors | Title | Journal | Summary/key findings |
|---|---|---|---|---|
| 40 | Swanick T. | See one, do one, then what? Faculty development in postgraduate medical education | Postgraduate Medical Journal, 2008; 84: 339-343 | The author argues that medical education is changing and calls for faculty development. He concludes that widespread cultural change is required and this in turn will require effective and sympathetic leadership from postgraduate training institutions, hospitals and health authorities. |
| 41 | Bashmore TM. Wang A. | Have Accreditation Council for Graduate Medical Education initiatives improved the education of cardiology fellows? | Circulation, 2008; 118: 532-537 | Provides succinct history of the establishment of the ACGME and offers views on issues related to the process of accreditation. |
| 42 | Bancroft G. Basu B. Leong M. Hollier LH. Stal S. | Outcome-Based Residency Education: Teaching and Evaluating the Core Competencies in Plastic Surgery | Plastic and Reconstructive Surgery, 2008; 121: 441e-448e | Outlines the implications of the Outcomes Project (ACGME) for plastic surgical training, with respect to curriculum and outcomes assessment methodology. |
| 43 | van Zanten M. Norcini JJ. Boulet JR. Simon F. | Overview of accreditation of undergraduate medical education programs worldwide | Medical Education, 2008; 42: 930-937 | This paper investigates the oversight of undergraduate medical education programs from an international perspective. The authors conclude that there is significant variation in both the nature of the accrediting bodies and levels of enforcement. |
| 44 | Phitayakorn R. Levitan N. Shuck JM. | Program report cards: evaluation across multiple residency programs at one institution | Academic Medicine, 2007; 82: 608 - 615 | The paper describes the development and implementation of a standardized, dimensional program report card for more than 60 residency and fellowship programs at their institution across four dimensions: quality of candidates recruited; resident educational program; graduate success; and overall house officer satisfaction. |
| 45 | Teo, A. | The current state of medical education in Japan: a system under reform | Medical Education, 2007; 41: 302-308 | This paper describes undergraduate and postgraduate medical training in Japan and the reforms that were implemented in response to concerns regarding the quality of training. The major reforms include the introduction of a two year structured internship and an intern matching system. The absence of accountability and objective assessment of training programs (the equivalent of the LCME and ACGME) in Japan is noted. |

| | Authors | Title | Journal | Summary/key findings |
|---|---|---|---|---|
| 46 | Boor K. Scheele F. van der Vleuten CPM. Scherpbier AJJA. Teunissen PW. Sijtsma K. | Psychometric properties of an instrument to measure the clinical learning environment | Medical Education, 2007; 41:92-99 | The authors investigate the psychometric properties of the Postgraduate Hospital Educational Environmental Measure (PHEEM). The statistical analysis did not support the 3-dimensional structure but suggested a one-dimensional scale. |
| 47 | Thrush CR. Hicks EK. Tariq SG. Johnson AM. Clardy JA. O'Sullivan PS. Williams DK. | Optimal Learning Environments from the Perspective of Resident Physicians and Associations with Accreditation Length | Academic Medicine, 2007; 82: s121-125 | Responses to questions about program strengths and areas in need for improvement were collected from 392 residents. A qualitative analysis was undertaken and correlated data was used to examine associations between resident perceptions and accreditation length. The authors conclude that resident feedback can provide beneficial information about dimensions of program quality and the learning environment. |
| 48 | Bannon M. | What's happening in postgraduate medical education? | Archive of Diseases in Childhood, 2006; 91: 68-70 | Author describes current challenges and system drivers in postgraduate medical education. Summary of some of these issues as they pertain to paediatrics training. |
| 49 | Karle H. | Global standards and accreditation in medical education: A view from the WFME | Academic Medicine, 2006; 81: s43-s48 | Author argues that the promotion of national accreditation systems will pivotally influence future international appraisal of medical education. Information about accreditation status will be essential to future databases of medical schools and will be a foundation for international "meta-recognition" of institutions and programs ("accrediting the accreditors'). |
| 50 | Irvine D. (Sir) | A short history of the General Medical Council | Medical Education, 2006; 40: 202-211 | Provides a history of the evolution of the GMC across a range of roles including registration of doctors, setting of professional standards, regulating basic medical education and managing doctor's fitness to practice. |
| 51 | Silber C. Novielli K. Paskin D. Brigham T. Kairys J. Kane G. Veloski J. | Use of critical incidents to develop a rating form for resident evaluation of faculty teaching | Medical Education, 2006; 40: 1201-1208 | Authors used a critical incident technique to develop a 23-item rating form. They conclude that residents consider commitment of time to teaching and clinical effectiveness to be the most important dimensions of faculty teaching. Other important dimensions include written and verbal communication, cost-effectiveness and concern for resident's professional development. |

| | Authors | Title | Journal | Summary/key findings |
|---|---|---|---|---|
| 52 | Musick DW. | A Conceptual Model for Program Evaluation in Graduate Medical Education | Academic Medicine, 2006; 81: 759-765 | In response to the ACGME shift from a process-oriented to an outcomes oriented system of education, the author provides a five-step process to assist program directors and educations in developing effective ways to use program evaluation data to improve graduate medical education training programs. The article includes a list of potential outcome measures in GME. |
| 53 | Roff S. | Education environment: a bibliography | Medical Teacher, 2005; 27: 353-357 | Bibliography lists over 100 articles relevant to the educational environment in which doctors are educated and trained as an important aspect of medical education. Includes specific section on postgraduate medical educational environment and other health professions. |
| 54 | Roff S. McAleer S. Skinner A. | Development and validation of an instrument to measure the postgraduate clinical learning and teaching educational environment for hospital-based junior doctors in the UK | Medical Teacher, 2005; 27: 326-331 | The paper describes the development and validation of a 40-item inventory, the Postgraduate Hospital Educational Environment Measure (PHEEM) using a combination of grounded theory and Delphi process. The authors conclude that the PHEEM may be a useful instrument in the quality assurance of medical education. The instrument is provided at Appendix 1. |
| 55 | Roff S. | New resources for measuring educational environment | Medical Teacher, 2005; 27: 291-293 | Commentary on the article above in addition to information about other instruments used to measure the education environment. Extensive reference list. |
| 56 | Goroll AH. Sirio C. Duffy D. LeBlond RF. et al | A new model for accreditation of residency programs in internal medicine | Annals of Internal Medicine, 2004; 140: 902-909 | The paper proposes a new outcomes-based accreditation strategy for residency training programs in internal medicine. The authors argue that it shifts residency program accreditation from external audit of educational process to continuous assessment and improvement of trainee clinical competence. |
| 57 | Hoff TP. Pohl H. Bartfield MD. | Creating a Learning Environment to Produce Competent Residents: The Roles of Culture and Context | Academic Medicine, 2004; 79: 532-540 | Authors argue that development of a learning-orientated culture should be a high priority and formal accountability for this should rest with programs (facilities). Authors identify specific attitudes, behaviours and interactions that should be assessed as part of identifying a learning orientated environment. |

| | Authors | Title | Journal | Summary/key findings |
|---|---|---|---|---|
| 58 | Leach D. | A model for GME: shifting from process to outcomes. A progress report from the Accreditation Council for Graduate Medical Education | Medical Education, 2004; 38: 12-14 | Leach, the Executive Director of ACGME, provides an update on progress towards the use of educational outcome measures as an accreditation tool. |
| 59 | Leung WC. | Competency based medical training: review | British Medical Journal, 2002; 325: 693-696 | The author explores the origins and development of the competency approach and evaluates its current role in medical training, highlighting its strengths and weaknesses. He argues that compared with the traditional approach, the competency based approach potentially leads to individualized flexible training, transparent standards and increased public accountability. However he also cautions that higher order competencies need to be defined before universal adoption of this approach. |
| 60 | Batalden P. Leach D. Swing S. Dreyfus H. Dreyfus S. | General competencies and accreditation in graduate medical education | Health Affairs, 2002; 21: 103-111 | This article describes work undertaken by the ACGME with regards to the development of six general competencies of graduate medical education and argues that the collaborative process offers a model of the role accrediting agencies can play in fostering workforce developmental change. |
| 61 | Anderson GF. Greenberg GD. Wynn BO. | Graduate medical education: the policy debate | Annual Review of Public Health | Authors argue that the cost of providing graduate medical education to the approximately 100,000 medical residents in the US is approximately $18billion (2001). They provide an overview of funding of graduate medical education and identify specific policy objectives that academic medical centers should be held accountable for achieving in return for receiving public funds. These include: encouraging more primary care training; encouraging more training outside the hospital; and encouraging more training in underserved areas. |
| 62 | Cooke L. Hurlock S. | Education and training in the senior house officer grade: results from a cohort study of United Kingdom medical graduates | Medical Education, 1999; 33: 418-423 | Paper shows the findings of a survey of 439 SHOs as a way of assessing the quality of SHO training. It concluded that there was wide variability in the quality of training and argues that there is a need for a more systematic approach to maintaining standards in SHO training with greater incentives for under- |

| | Authors | Title | Journal | Summary/key findings |
|---|---|---|---|---|
| | | | | performing trusts. |
| 63 | Cassie JM. Armbruster JS. Bowmer MI. Leach DC. | Accreditation of postgraduate medical education in the United States and Canada: a comparison of two systems | Medical Education, 1999; 33: 493-498 | Authors compare the two systems, arguing that although they are similar in purpose (importance of educational programs structured to provide graded professional responsibility with appropriate guidance and supervision to residents) and process (periodic on site visits, faculty and resident interviews) there are differences in the operation of the two systems. |
| 64 | Cooke L. Hurlock S. | Education and training in the senior house officer grade: results from a cohort study of United Kingdom medical graduates | Medical Education, 1999; 33: 418-423 | Paper shows the findings of a survey of 439 SHOs as a way of assessing the quality of SHO training. It concluded that there was wide variability in the quality of training and argues that there is a need for a more systematic approach to maintaining standards in SHO training with greater incentives for under-performing trusts. |
| 65 | Rolfe, Gordon, Atherton, Pearson, Kay, Fardell | A system for maintaining the educational and training standards of junior doctors | Medical Education, 1998; 32: 426-431 | Paper describes the methods by which the Postgraduate Medical Council of NSW addresses the needs of junior doctors in the state in order to improve the quality of their education. |
| 66 | Maudsley, RF | Service and education in postgraduate medical education: striking a proper balance | Canadian Medical Association Journal, 1986; 135: 449-453 | Provides historical perspective on issues facing Canadian medical workforce and education system with suggestions for future directions. |

# Appendix E – Table 2: Overview of NSW Accreditation Framework mapped against the Draft AMC Quality Framework for Review of Intern Training Accreditation Bodies

**Table 2: Overview of NSW Accreditation Framework mapped against the Draft AMC Quality Framework for Review of Intern Training Accreditation Bodies**

| DOMAIN | | OVERVIEW | DOCUMENTS | COMMENT |
|---|---|---|---|---|
| **DOMAIN 1: GOVERNANCE**<br>**The intern training accreditation body effectively governs itself and demonstrates competence and professionalism in the performance of its accreditation role.** | | | | |
| 1.1 | The intern training accreditation body is a legally constituted body and registered as a business entity. | The Health Education and Training Institute (HETI) is the intern training accreditation body established under Health Services Act 1997.<br>PAC not a separate entity | Evidence of PHO /legal entity<br>Organisational Chart<br>Accreditation program structure | Clarification of relationship between HETI and accreditation program. (See also 2.1)<br>Need to determine which is the 'governing body' for the purposes of the AMC review. |
| 1.2 | The intern training accreditation body's governance and management structures give appropriate priority to the accreditation of intern training programs relative to other activities. | A primary function of the medical portfolio is accreditation of intern training programs and this is given appropriate priority. | Organisation chart with FTE for accreditation program staff | |
| 1.3 | The intern training accreditation body is able to demonstrate business stability, including financial viability. | Funded through MoH, with proportion coming from MBA | Financial statements | Confirmation of budget for accreditation activities. |
| 1.4 | The intern training accreditation body's accounts meet relevant Australian accounting and financial reporting standards. | Financial accounts of HETI comply with relevant standards. Annual reports provided to Minister and made publicly available. | See 1.3 | See 1.1 |

| DOMAIN | | OVERVIEW | DOCUMENTS | COMMENT |
|---|---|---|---|---|
| 1.5 | There is a transparent process for selection of the governing body. | PvTC and PAC – indicate process by which appointed | Information on appointment processes | See 1.1 |
| 1.6 | The intern training accreditation body's governance arrangements provide for input from stakeholders including input from the health services, intern supervisors and junior doctors. | PAC is currently based on representative model with stakeholders from these groups. | TOR and membership for PAC | |
| **DOMAIN 2: INDEPENDENCE**<br>**The intern training accreditation body carries out independently the accreditation of intern training programs** | | | | |
| 2.1 | Decision making about accreditation of programs is independent and there is no evidence that any area of the community, including government, health services, professional associations has undue influence. | PAC has broad representation and independent Chairs | See 1.6 | This could be strengthened in light of relationship between accreditation program and HETI (compared with many other PMCs which are at arm's length from Health Department) |
| 2.2 | There are clear procedures for identifying and managing conflicts of interest | HETI has clear procedures for managing conflict of interest at both Committee and survey visits. Process of accreditation decisions through 2 layers (team, PAC) | Conflict of interest Policy | Latest revision 2009 – requires updating |
| **DOMAIN 3: OPERATIONAL MANAGEMENT**<br>**The intern training accreditation body effectively manages its resources to perform functions associated with accreditation of intern programs** | | | | |
| 3.1 | The intern training accreditation body manages human and financial resources to achieve objectives in relation to accreditation of intern training programs. | Established accreditation program with staff and budget | | See 1.3 |
| 3.2 | There are effective systems for monitoring and improving the intern training accreditation processes, and identification and management of risk. | Independent review 2013<br>Evaluation of accreditation process | Report on accreditation activities | This could be strengthened. PAC has not engaged in strategic planning for some |

| DOMAIN | | OVERVIEW | DOCUMENTS | COMMENT |
|---|---|---|---|---|
| | | following visit (not currently occurring) | | time. |
| 3.3 | There are robust systems for managing information and contemporaneous records, including ensuring confidentiality. | Confidentiality agreement for all involved in program (including surveyors)<br><br>Records management as per Policy however requires communication to those involved in program | Process and Records Management PD2009-057 | This will be strengthened by online system.<br><br>Confidentiality agreement requires updating |
| **DOMAIN 4: PROCESS FOR ACCREDITATION OF INTERN TRAINING PROGRAMS**<br><br>**The intern training accreditation body applies the approved national standards for intern training in assessing whether programs will enable interns to progress to general registration in the medical profession. It has rigorous, fair and consistent processes for accrediting intern programs.** | | | | |
| 4.1 | The intern training accreditation body ensures documentation on the accreditation requirements and procedures is publicly available. | Standards and associated documentation should be available on HETI website | List of documents available on website | Currently on website under Courses/Accreditation (potentially confusing to stakeholders). Information (including policies) difficult to access or not available – requires updating |
| 4.2 | The intern training accreditation body has policies on the selection, appointment, training and performance review of survey team members. Its policies provide for the use of competent persons who are qualified by their skills, knowledge and experience to assess intern training programs against the accreditation standards. | This should include clear position descriptions and information regarding the selection of surveyors. Whilst there is currently some information available on the website it only provides a brief overview.<br><br>Surveyor training held every two years in addition to online training | Position descriptions<br><br>Policy on surveyors | Policy requires updating<br><br>Review of current training of surveyors |
| 4.3 | There are procedures for identifying, managing and recording conflicts of interest in the work of survey teams and working committees. | Clear information on conflict of interest in policy, surveyor guide and included in training | Conflict of interest policy<br><br>Guide for hospitals<br><br>Guidelines for | |

| DOMAIN | | OVERVIEW | DOCUMENTS | COMMENT |
|---|---|---|---|---|
| | | | surveyors | |
| 4.4 | The accreditation process includes self-evaluation, assessment against the standards; site visits where appropriate, and a report assessing the program against the standards. | Process includes all these elements. | Templates for report<br>Templates for term accreditation<br>Evidence of site visits<br>Other documents | |
| 4.5 | The accreditation process facilitates continuing quality improvement in the delivery of intern training. | Implicit in standards<br>Process based on peer review and support.<br>Provision of recommendations | | |
| 4.6 | There is a cyclical accreditation process, in line with national guidelines and standards, which provides for regular monitoring and assessment of intern programs to ensure continuing compliance with standards. | Current accreditation cycle is 3 years but transitioning to 4 years | Change of circumstances policy<br>Departure from standards notification<br>Data on accreditation of facilities and status | This will be strengthened by requirement for submission of progress reports by facilities moving to 4-year accreditation cycles. |
| 4.7 | The intern training accreditation body applies national guidelines in determining if changes to posts, programs and institutions will affect the accreditation status. It has clear guidelines on how the institution reports on these changes and how these changes are assessed. | There is a change of circumstances policy that outlines this process. | Change of circumstances policy<br>Accreditation of terms mid cycle | |
| 4.8 | The intern training accreditation body follows documented processes for decision-making and reporting that enable decisions to be made free from undue influence by any interested party. | The PAC decision making process is outlined in survey tool<br>PAC membership includes broad range of representation | | The documentation supporting decision making requires review. |

| DOMAIN | | OVERVIEW | DOCUMENTS | COMMENT |
|---|---|---|---|---|
| 4.9 | The intern training accreditation body communicates the accreditation status of programs to employers, prospective interns and other stakeholders. It communicates accreditation outcomes to the relevant health services facility and other stakeholders. | Accreditation status is communicated to all key stakeholders. Report is sent to CE of LHD, facility and there is a requirement to circulate to GCTC.<br><br>A list of accredited facilities is maintained on the website | | |
| 4.10 | There are published complaints, review and appeals processes, which are rigorous, fair and responsive. | There is an appeals policy however the processes for complaints and review is less clear | Appeals Policy<br><br>Complaints Policy/process | The Appeals policy should be on website and readily accessible<br><br>Complaints process requires review |
| **DOMAIN 5: STAKEHOLDER COLLABORATION**<br><br>**The intern training accreditation body works to build stakeholder support and collaboration with other intern training accreditation bodies and medical education standards bodies.** | | | | |
| 5.1 | There are processes for engaging with stakeholders, including health departments, health services, junior doctors, doctors who supervise and assess junior doctors, the national board, professional organisations, and consumers/community. | Describe engagement with key stakeholders – including key committees, PVT forum, JMO forum and links with Health Department and Medical Board | | Consideration of including consumer representative on PAC to strengthen this (see recommendation 8.6) |
| 5.2 | There is a communications strategy, including a website providing information about the intern training accreditation body's roles, functions and procedures. | This information would generally be available on website. | | Website requires work to ensure that accreditation processes, policies and other documents are clear and accessible. |
| 5.3 | The intern training accreditation body collaborates with other relevant accreditation organisations. | Medical Director sits on CPMEC<br><br>Representation on CPMEC Prevocational Medical Accreditation Network | Membership on National Boards, Committees and Working Parties | May require further information regarding relationship with College accreditation programs |

| DOMAIN | | OVERVIEW | DOCUMENTS | COMMENT |
|---|---|---|---|---|
| | | accreditation programs | | |
| 5.4 | The intern training accreditation body works within overarching national and international structures of quality assurance/accreditation. | Work with CPMEC (PMAF) and AMC (National guidelines) | | Independent review mapped current standards against AMC guidelines |

# Appendix F – Table 3: Mapping of NSW Accreditation Standards for Prevocational Training against the AMC Draft National Standards for Intern Training

**Table 3: Mapping of NSW Accreditation Standards for Prevocational Training against the AMC Draft National Standards for Intern Training**

| NUMBER | AMC STANDARD | HETI STANDARD | COMMENT |
|---|---|---|---|
| 1 THE CONTEXT IN WHICH TRAINING IS DELIVERED | | | |
| **1.1 Governance** | | | |
| 1.1.1 | The governance of the intern training program, and assessment roles are defined. | Not explicitly specified | This requires strengthening within the HETI standards |
| 1.1.2 | In the health services that contribute to intern training there is a system of clinical governance or quality assurance that includes clear lines of responsibility and accountability for the overall quality of medical practice. | Not explicitly specified though clearly implied in the HETI standards | Requires inclusion |
| 1.1.3 | The health services give appropriate priority to medical education and training relative to other responsibilities. | Not explicitly specified | Requires inclusion |
| 1.1.4 | The intern training program complies with relevant national, state or territory laws and regulations pertaining to prevocational training | Implicit | Requires inclusion |
| **1.2 Program Management** | | | |
| 1.2.1 | The intern training program has a mechanism or structures with the responsibility, authority, capacity and appropriate resources to direct the planning, implementation and review of the intern | Promoting prevocational trainee interests (3.4) | Aligned but could be made more explicit with inclusion of detail on governance.<br>Role of GCTC and Network |

| NUMBER | AMC STANDARD | HETI STANDARD | COMMENT |
|---|---|---|---|
| | training program(s) and to set relevant policy and procedures. | | Role of DPET |
| 1.2.2 | The intern training program documents and reports to the intern accreditation body on changes in the program, units or rotations which may affect the delivery of the program at the level consistent with the national standards. | Not explicitly specified | Aligned - Covered by change of circumstances policy |
| 1.2.3 | The health services have effective organisational and operations structures to manage interns. | Prevocational trainee management (3.1) | Aligned |
| **1.3 Educational Expertise** | | | |
| 1.3.1 | The intern training program is underpinned by sound medical education principles | Not explicitly specified | Not aligned – this requires strengthening |
| **1.4 Relationships To Support Medical Education** | | | |
| 1.4.1 | The intern training program supports the delivery of intern training by constructive working relationships with other relevant agencies and facilities. | Implicit – Network arrangements | Aligned |
| 1.4.2 | Health services coordinate the local delivery of the intern training program. Health services that are part of a network or dispersed program contribute to the coordination and management of the program across diverse sites. | Prevocational trainee management (3.1)<br>Formal education program (2.3)<br>Training and service requirements (2.2)<br>Promoting prevocational trainee interests (3.4) | Aligned<br>Supported by Network Principles document and arrangements of Networks / Network Committees |
| 2 ORGANISATIONAL PURPOSE | | | |
| 2.1 | The purpose of the health service which employ and train interns includes setting and promoting high standards of medical practice and junior doctor training. | Not explicitly specified in Standards | Specified in HETI mission statement<br>LHD statements may be variable – requires review |

| NUMBER | AMC STANDARD | HETI STANDARD | COMMENT |
|---|---|---|---|
| 3 THE INTERN TRAINING PROGRAM | | | |
| **3.1 Program structure and composition** | | | |
| 3.1.1 | The intern training program overall, and each rotation is structured to reflect the requirements of the Registration standard. | Term orientation (1.2)<br>Training and service requirements (2.2) | Aligned |
| 3.1.2 | For each rotation, the health service has identified the relevant global outcome statements and the skills and procedures that can be achieved in that rotation, and the nature and range of clinical experience available to meet these objectives. | Term orientation (1.2)<br>Training and service requirements (2.2) | Global outcome statements could be strengthened but otherwise aligned |
| 3.1.3 | Interns participate in formal orientation programs, which are designed and evaluated to ensure relevant learning occurs. | Hospital orientation (1.1)<br>Term orientation (1.2) | Aligned |
| **3.2 Flexible training** | | | |
| 3.2.1 | The intern training provider guides and supports supervisors and interns in the implementation and review of flexible training arrangements. Available arrangements are consistent with the registration standard. | Not explicitly specified | This requires inclusion |
| 4 THE TRAINING PROGRAM – TEACHING AND LEARNING | | | |
| 4.1.1 | Interns have access to formal clinical teaching and structured clinical and non-clinical learning activities in addition to informal work-based teaching and learning. | Training and service requirements (2.2)<br>Education and information resources (2.6)<br>Clinicians as teachers | Aligned |
| 4.1.2 | The intern training program provides for interns to | Formal education program (2.3) | Aligned |

| NUMBER | AMC STANDARD | HETI STANDARD | COMMENT |
|---|---|---|---|
| | attend formal educational sessions, and ensures that they are supported by senior medical staff to do so. | | |
| 4.1.3 | The health service specifies the dedicated time for teaching and training for interns, and reviews the opportunities for work-based teaching and training. | Training and service requirements (2.2) | Aligned - supported by policy |
| 5 ASSESSMENT OF LEARNING | | | |
| **5.1 Assessment approach** | | | |
| 5.1.1 | The intern training program implements assessment consistent with the registration standard. | Assessment and feedback (2.5) | Aligned |
| 5.1.2 | Assessment of interns is based on the achievement of outcomes with the national standards. | Not specified | Requires alignment once national standards finalised |
| 5.1.3 | The assessment program is understood by supervisors and interns. | Assessment and feedback (2.5)<br>Hospital Orientation (1.2)<br>Supervision (1.3) | Aligned |
| 5.1.4 | Intern assessment data is used to improve the intern training program. | Not specified | Not aligned |
| **5.2 Feedback and performance review** | | | |
| 5.2.1 | The intern training program provides regular, formal and documented feedback to interns on their performance within each rotation. | Assessment and feedback (2.5) | Aligned |
| 5.2.2 | The intern training program documents the assessment of the intern's performance consistent | Assessment and feedback (2.5) | Aligned |

| NUMBER | AMC STANDARD | HETI STANDARD | COMMENT |
|---|---|---|---|
| | with the Registration standard for granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training. | | Supported by policy |
| 5.2.3 | Interns receive timely, progressive and informal feedback from clinical supervisors during every rotation. | Assessment and feedback (2.5) | Aligned |
| 5.2.4 | Interns are encouraged to take responsibility for their own performance, and to seek feedback from their supervisors in relation to their performance. | Assessment and feedback (2.5) | Aligned |
| 5.2.5 | The intern training program has clear procedures to address immediately any concerns about patient safety related to the performance of intern or interns. | This is covered in health department policy but not explicitly stated in Standards | Partial alignment -requires specification<br>Supported by trainee in difficulty guide (explicitly) |
| 5.2.6 | The intern training program identifies early junior doctors who are not performing to the expected level and provides remediation for them. | Prevocational trainees with special needs (3.2) | Aligned |
| 5.2.7 | The intern training program establishes review groups as required to assist with more complex decisions on remediation of interns who do not achieve satisfactory supervisor assessments. | Not specified | Requires inclusion<br>Supported by policy document and TID guide |
| **5.3 Assessors training** | | | |
| 5.3.1 | The intern training program has processes for ensuring those assessing interns have relevant capabilities and understanding of the processes required. | Assessment and feedback (2.5)<br>Clinicians as teachers (2.4) | Partial alignment |

| NUMBER | AMC STANDARD | HETI STANDARD | COMMENT |
|---|---|---|---|
| 6 MONITORING AND EVALUATION | | | |
| 6.1 | The intern training provider regularly evaluates and reviews its intern training program and posts to ensure that standards are being maintained. Its processes check program content, quality of teaching and supervision, assessment and trainee's progress. | Evaluation criterion (at each standard) | Aligned<br>Evaluation of trainee progress could be emphasized |
| 6.2 | Supervisors contribute to monitoring and to program development. Their feedback is sought, analysed and used as part of the monitoring process. | Clinicians as teachers (2.4)<br>Promoting prevocational trainee interests (3.4) | Aligned<br>Role of the GCTC |
| 6.3 | Interns have mechanisms for providing confidential feedback about their training and education experiences in the program overall and in individual posts and rotations. | Evaluation criterion | Aligned but could be strengthened |
| 6.4 | The intern training program acts on feedback and modifies the program as necessary to improve the intern experience for interns, supervisors and hospital administrators. | Evaluation criterion | Aligned |
| 7 IMPLEMENTING THE EDUCATION AND TRAINING FRAMEWORK – JUNIOR DOCTORS | | | |
| **7.1 Appointment to program and allocation to rotation** | | | |
| 7.1.1 | The processes for appointment of interns:<br>Are based on the published criteria and the principles of the program concerned;<br>Are transparent, rigorous and fair. | Not specified in HETI standards but clear responsibility of HETI in prevocational workforce | Aligned (in collaboration with MoH) |

| NUMBER | AMC STANDARD | HETI STANDARD | COMMENT |
|---|---|---|---|
| **7.2 Welfare and support** | | | |
| 7.2.1 | The duties, rostering, working hours and supervision of interns are consistent with the delivery of high-quality, safe patient care. | Prevocational trainee management<br>Training and service requirements<br>Safe practice | Aligned |
| 7.2.2 | Interns have access to personal counseling and career advice. The personal and career counseling services are publicized to interns, their supervisors, and other team members. | Professional development | Aligned |
| 7.2.3 | The procedure for accessing appropriate professional development leave is published, fair and practical. | Not specified | Industrial instrument does not have provision for professional development leave for PGY1 – education program provided at facility level. |
| **7.3 Junior doctor participation in governance of their training** | | | |
| 7.3.1 | Interns are involved in the governance of their training. | Promoting prevocational trainee interests (3.4) | Compliant |
| **7.4 Communication with junior doctors** | | | |
| 7.4.1 | The intern training program informs junior doctors about the activities of committees that deal with intern training. | Promoting prevocational trainee interests (3.4) | Compliant |
| 7.4.2 | The intern training program provides clear and easily accessible information about the training program. | Implicit though not specified | Requires inclusion |

| NUMBER | AMC STANDARD | HETI STANDARD | COMMENT |
|---|---|---|---|
| **7.5 Resolution of training problems and disputes** | | | |
| 7.5.1 | The intern training program has processes with appropriate confidentiality to support interns to address problems with training supervision and requirements. | Prevocational trainee management (3.1) | Requires strengthening |
| 7.5.2 | The intern training program has clear impartial pathways for timely resolution of training-related disputes between interns and supervisors, or interns and the health service. | Prevocational trainee management (3.1) | Aligned though grievance policies tend to be focused on intern as employee as opposed to trainee. This likely requires strengthening. |
| 8 IMPLEMENTING THE TRAINING FRAMEWORK – DELIVERY OF EDUCATIONAL RESOURCES | | | |
| **8.1 Supervisors** | | | |
| 8.1.1 | Interns are supervised at all times at a level appropriate to their experience and responsibilities. | Supervision (1.3) | Aligned |
| 8.1.2 | Supervision is provided by qualified medical staff with appropriate competencies, skills, knowledge, authority, time and resources to participate in training and/or orientation programs. | Supervision (1.3)<br>Clinicians as teachers (2.4) | Aligned |
| 8.1.3 | Intern supervisors understand their roles and responsibilities in assisting interns to meet learning objectives, and demonstrate a commitment to intern training. | Supervision (1.3)<br>Assessment and feedback (2.5) | Aligned |
| 8.1.4 | The intern training program regularly evaluates the adequacy and effectiveness of supervision of interns. | Evaluation criteria | Partial alignment |
| 8.1.5 | Staff involved in intern training have access to professional development activities to support improvement in the quality of the intern training | Clinicians as teachers (2.4) | Aligned |

| NUMBER | AMC STANDARD | HETI STANDARD | COMMENT |
|---|---|---|---|
| | program. | | |
| **8.2 Clinical experience** | | | |
| 8.2.1 | The intern training program provides clinical experience consistent with the Registration standard for granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training. The intern training program conforms to the guidelines on opportunities to develop knowledge and skills relevant to the domains of clinical management, communication and professionalism in medicine, surgery and emergency medical care. | Training and service requirements (2.2) | Requires explicit link to the Registration standard |
| 8.2.2 | In identifying rotations for training, the intern training program considers the following:<br>Complexity and volume of the unit's workload<br>The intern's workload<br>The experience interns can expect to gain<br>How the intern will be supervised and by whom. | Term orientation (1.2)<br>Training and service requirements (2.2) | Aligned<br>Supported by term description and process underpinning accreditation of terms |
| **8.3 Facilities** | | | |
| 8.3.1 | The intern training program provides the educational facilities and infrastructure support to deliver intern training such as access to the internet, library, journals and other learning facilities, and continuing medical education sessions accessible to the junior doctor. | Formal education program (2.3)<br>Education and information resources (2.6) | Aligned |
| 8.3.2 | The intern training program provides a safe physical environment and amenities that support the intern. | Physical amenities (3.6)<br>Safe practice (3.3) | Aligned |

# Appendix G – Table 4: Comparison of Accreditation Process, Standards and Policies within Australia and New Zealand

**Table 4: Comparison of Accreditation Process, Standards and Policies within Australia and New Zealand**

| | NSW | VIC | QLD | SA | WA | NT | TAS | NZ |
|---|---|---|---|---|---|---|---|---|
| **Overview** | | | | | | | | |
| Governance body | HETI | PMCV | PMCQ | SA IMET | PMCWA | NTPMC | PMCT | Medical Council of NZ |
| Number of hospital facilities accredited | 65 | 32 | 34 | 9+ | 29 * | 2 | 3 | 23+ |
| Number of PGPPP practices accredited | 84^ | 40 | 8 | 25+ | 22+ | | - | 0 |
| Accredited at facility or individual post level (FAC/POST) | Post | Program | Post | Post | Post | Post | Post | Facility |
| PGY 1 posts | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| PGY 2 posts | ✓ | ✓ | ✓ | ✓ | ✓ | ? | ✓ | X |
| IMG posts | X | X | X | X | X | ? | X | ✓ |
| Other | X | X | X | Vocational (Limited) | X | X | PGY3 | X |
| Maximum survey cycle (# year) | 3 | 3 | 4 | 4 | 3 | 4 | 3 | 3 |
| Surveyor training | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | - | |

| | NSW | VIC | QLD | SA | WA | NT | TAS | NZ |
|---|---|---|---|---|---|---|---|---|
| **Accreditation process** | | | | | | | | |
| Pre-survey assessment by facility | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Pre-survey junior medical staff survey (on-line) | X | ✓ | X | X | X | X | X | X |
| Pre-survey junior medical staff survey (hard copy) | X | X | X | X | X | X | X | ✓ |
| Submission of additional evidence | ✓ | ✓ | ✓ | ✓ | ? | ✓ | ✓ | |
| On-line capacity for pre-survey assessment | X | ✓ | ✓ | ? | X | | X | X |
| Site visit | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Site visit duration (hospital) | 1-2 | 1-3 | 1-3 | 0.5-1 | 1-2 | 1-2 | 1-2 | <1 |
| Site visit duration (PGPPP) | < 0.5 | - | - | - | - | - | N/A | N/A |
| Hospital report | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Review of draft report by facility prior to decision | X | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ |
| Accreditation Committee | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Public reporting of accreditation outcome | X | X | X | ? | ✓ | ✓ | X | ✓ |
| Peer review | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |
| Periodic review | X | X | ✓ | X | X | ✓ | X | X |
| **Documents** | | | | | | | | |
| Standards for prevocational training | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

| | NSW | VIC | QLD | SA | WA | NT | TAS | NZ |
|---|---|---|---|---|---|---|---|---|
| Most recent revision | Sept 2011 | Mar 2013 | Nov 2012 | Oct 2010 | 2012 | April 2009 | July 2013 | 2011 |
| Standards for PGPPP (as separate document) | ✓ | ✓ | ✓ | | | | | N/A |
| **Supporting policies/documents** | | | | | | | | |
| Appeals policy | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Supervision policy | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Change in circumstances policy | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Accreditation of terms mid-survey cycle | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Accreditation guide for surveyors | ✓ | ✓ | - | - | - | - | - | ✓ |
| Accreditation guide for health services | ✓ | ✓ | - | - | - | - | - | - |
| Accreditation guide for general practices | ✓ | ✓ | - | - | - | - | - | - |
| Accreditation guide (general) | N/A | N/A | ✓ | ✓ | ✓ | ✓ | ✓ | - |
| Position description for team leader | ✓ | ✓ | ✓ | ✓ | - | ✓ | ✓ | - |
| Position description for surveyors | ✓ | ✓ | ✓ | ✓ | - | ✓ | ✓ | - |
| Accreditation Committee Terms of Reference | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Cross-border accreditation | ✓ | ✓ | # | # | N/A | # | N/A | N/A |
| Guidelines for orientation for junior doctors | X | ✓ | X | X | X | X | X | X |
| Communication of accreditation recommendations to third | X | ✓ | X | X | X | X | X | ✓ |

| | NSW | VIC | QLD | SA | WA | NT | TAS | NZ |
|---|---|---|---|---|---|---|---|---|
| parties | | | | | | | | |
| Credentialing of surveyors | X | X | X | X | ✓ | X | X | X |
| Confidentiality and conflict of interest | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | - |
| Consent policy | X | X | X | X | ✓ | X | X | X |
| Night cover for interns | X | X | X | X | X | X | X | ✓ |
| Relief as first run [rotation] | X | X | X | X | X | X | X | ✓ |

* Includes a number of smaller facilities and private hospitals
^ This denotes total number of PGPPP terms accredited, not all have prevocational trainees allocated to them at any one time.

# Appendix H – Table 5: Comparison of Accreditation Standards and Criterion for Prevocational Training within Australia and New Zealand

**Table 5: Comparison of Accreditation Standards and Criterion for Prevocational Training within Australia and New Zealand**

| Standards/Criterion[5] | NSW | VIC | QLD | SA | WA | NT | TAS | NZ | College* |
|---|---|---|---|---|---|---|---|---|---|
| **General information** | | | | | | | | | |
| Overview of facility | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Clinical services | ✓ | ? | X | X | ✓ | ? | | X | ✓ |
| Medical workforce | ✓ | ✓ | ✓ | ✓ | - | ? | ✓ | # | ✓ |
| Details of key individuals | ✓ | ✓ | ✓ | ✓ | - | ✓ | ✓ | ✓ | ✓ |
| Specific considerations about hospital | ✓ | ✓ | X | X | - | X | ✓ | X | X |
| Actions since previous survey | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| *Organisation accreditation and status (for example ACHS)* | X | ✓ | X | X | X | X | ✓ | X | ✓ |
| *Specialist college accreditation programs* | X | ✓ | X | X | X | X | ✓ | X | ✓ |
| *IMGS – specific considerations* | X | ✓ | X | X | X | X | ✓ | X | N/A |
| *Governance (specified)* | X | X | ✓ | ✓ | ✓ | ✓ | X | X | ✓ |
| *Strategic planning* | X | X | ✓ | ✓ | ✓ | ✓ | X | ✓ | X |
| *Dedicated budget* | ✓ | X | ✓ | ✓ | ✓ | ✓ | X | X | X |

[5] Italics denotes criterion drawn from other than the NSW standards.

| Standards/Criterion[5] | NSW | VIC | QLD | SA | WA | NT | TAS | NZ | College* |
|---|---|---|---|---|---|---|---|---|---|
| *Appropriately qualified staff to manage PVT training* | X | X | ✓ | ✓ | ✓ | ✓ | X | X | N/A |
| *Policies and processes facilitating training (specific)* | X | X | ✓ | ✓ | X | ✓ | X | X | X |
| **Hospital orientation** | | | | | | | | | |
| Provision of hospital orientation (specific components) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ? | X |
| Clinical information and skills required to commence | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ? | X |
| Evaluation of hospital orientation | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | X | X |
| **Term orientation** | | | | | | | | | |
| Provision of written term description | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| *Orientation is provided to PVT at unit level* | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| Term supervisor provides term orientation | ✓ | X | X | X | X | X | X | X | X |
| Hospital ensures PVT has appropriate knowledge and skills | ✓ | X | X | X | X | X | X | ✓ | N/A |
| Effective clinical handover | ✓ | X | ✓ | ✓ | X | ✓ | X | ✓ | X |
| Evaluation of term orientation | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | X |
| *Development of learning plan at commencement of term* | X | X | ✓ | ✓ | X | ✓ | X | ✓ | X |
| *Scope of practice documented – skills needing observation* | X | X | ✓ | X | X | ✓ | X | X | X |

* For the purposes of this comparison, the Royal Australasian College of Surgeons and The Specialist Surgical Associations and Societies of Australia and New Zealand Accreditation of Hospitals and Posts for Surgical Education and Training – Process and Criteria for Accreditation 2008 was used.

| Standards/Criterion | NSW | VIC | QLD | SA | WA | NT | TAS | NZ | College |
|---|---|---|---|---|---|---|---|---|---|
| **Supervision** | | | | | | | | | |
| Adequate numbers of appropriately qualified medical staff | ✓ | X | X | X | X | X | X | X | ✓ |
| Effective clinical supervision during normal hours | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Effective clinical supervision outside normal hours | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| All clinical supervisors educated and supported in role | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | X | ✓ |
| Hospital educates PVTs in identifying limitations/seeking help | ✓ | X | X | X | ✓ | X | X | X | N/A |
| Evaluation of adequacy and effectiveness of supervision | ✓ | # | ✓ | ✓ | ✓ | ✓ | # | X | X |
| *Awareness of and commitment to supervision policy* | X | ✓ | ✓ | ✓ | X | ✓ | ✓ | X | X |
| *Support and supervision of effective clinical handover (shifts)* | X | ✓ | X | X | X | X | ✓ | X | X |
| **Professional development** | | | | | | | | | |
| Assessment of professional development needs of PVTs | ✓ | ✓ | ✓ | ✓ | X | ✓ | ✓ | X | ✓ |
| Identifies and provides resources to fulfill needs | ✓ | X | ✓ | ✓ | ✓ | ✓ | X | X | ✓ |
| Access to career guidance and opportunities | ✓ | ✓ | X | X | ✓ | X | ✓ | ✓ | ✓ |
| **Training and service requirements** | | | | | | | | | |
| Quarantined education and training time | ✓ | # | ✓ | X | ✓ | X | ✓ | X | ✓ |
| Balance and mix of terms | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Monitoring and evaluation of training and workload | ✓ | ✓ | ✓ | ✓ | X | ✓ | ✓ | ✓ | ✓ |

| Standards/Criterion | NSW | VIC | QLD | SA | WA | NT | TAS | NZ | College |
|---|---|---|---|---|---|---|---|---|---|
| *Clear definition of training experience when seconded* | X | X | X | ✓ | ✓ | X | X | X | X |
| *Active promotion of expanded settings* | X | X | X | ✓ | X | X | X | X | N/A |
| *Mapping of education training program (ETP) to ACF* | X | X | ✓ | ✓ | X | ✓ | ✓ | X | N/A |
| **Formal education program** | | | | | | | | | |
| Provision of a formal structured education program | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | X | ✓ |
| Evaluation of adequacy and effectiveness | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | X | X |
| *Attendance supported by senior medical and nursing staff* | X | ✓ | X | X | X | X | ✓ | X | ✓ |
| *Attendance at formal education program in paid time* | X | X | ✓ | ✓ | X | ✓ | X | X | N/A |
| *Mapping of formal education program to ACF* | X | X | ✓ | X | X | ✓ | X | X | N/A |
| **Clinicians as teachers** | | | | | | | | | |
| Hospital ensures clinicians are aware of responsibilities | ✓ | X | ✓ | ✓ | X | ✓ | X | ✓ | ✓ |
| Hospital has processes to develop teaching skills | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Hospital provides effective clinical practice-based teaching | ✓ | X | ✓ | ✓ | ✓ | ✓ | X | ✓ | ✓ |
| Evaluation of effectiveness | ✓ | X | ✓ | ✓ | X | ✓ | X | X | X |
| Performance appraisal those involved in teaching (DPET) | ✓ | X | ✓ | ✓ | X | ✓ | X | X | X |
| *Performance appraisal of term supervisors* | X | X | ✓ | ✓ | X | ✓ | X | X | X |
| *Evaluation mechanisms – information from term supervisors* | X | X | X | X | ✓ | X | X | X | X |

| Standards/Criterion | NSW | VIC | QLD | SA | WA | NT | TAS | NZ | College |
|---|---|---|---|---|---|---|---|---|---|
| **Assessment and feedback** | | | | | | | | | |
| Hospital explains criteria, process and timing of assessment | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | X | N/A |
| Provision of regular informal feedback about performance | ✓ | ✓ | X | ✓ | ✓ | X | ✓ | X | ✓ |
| Term supervisor undertakes formal assessment [MTA and ETA] | ✓ | ✓ | ✓ | ✓ | # | ✓ | ✓ | ✓ | ✓ |
| Encouragement for PVTs to seek feedback | ✓ | X | X | X | X | X | X | X | ✓ |
| Monitoring of performance across hospital and network | ✓ | ✓ | X | X | X | X | ✓ | X | N/A |
| Evaluation of systems for assessment and feedback | ✓ | ✓ | ✓ | ✓ | X | ✓ | ✓ | X | X |
| Opportunities for feedback from DPET | X | ✓ | X | X | X | X | ✓ | X | N/A |
| *PVTs participate in observed assessments by a TS or delegate* | X | X | ✓ | ✓ | X | ✓ | X | X | ✓ |
| *Where A/H work in term, inclusion of A/H supervisor feedback* | X | X | ✓ | ✓ | X | ✓ | X | X | N/A |
| *Confidentiality of assessment forms* | X | X | ✓ | ✓ | X | ✓ | X | X | N/A |
| *Handover of information between term supervisors* | X | X | X | ✓ | X | X | X | X | N/A |
| *Direct observation of clinical skills recorded* | X | X | ✓ | X | X | ✓ | X | X | N/A |
| **Education and information systems** | | | | | | | | | |
| Access to range of education and information resources | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| PVTs provided with information and training in use of resources | ✓ | ✓ | X | X | ✓ | X | ✓ | ✓ | ✓ |
| Evaluation of access to information resources | ✓ | X | X | X | X | X | X | X | ✓ |

| Standards/Criterion | NSW | VIC | QLD | SA | WA | NT | TAS | NZ | College |
|---|---|---|---|---|---|---|---|---|---|
| *Specified internet access* | X | X | ✓ | ✓ | ✓ | ✓ | X | ✓ | ✓ |
| *Designated skills/training facilities* | X | X | ✓ | ✓ | X | ✓ | X | ✓ | ✓ |
| *Access to a printer and photocopier at all times* | X | X | X | ✓ | X | # | X | X | X |
| **Prevocational trainee management** | | | | | | | | | |
| Hospital provides effective organisational structures | ✓ | ✓ | X | X | X | X | ✓ | ✓ | ✓ |
| Hospital manages PVT grievances effectively | ✓ | X | X | X | ✓ | X | X | X | ✓ |
| Effective processes for rostering PVT staff | ✓ | X | X | X | X | X | X | X | ✓ |
| Active participation in management of the network | ✓ | ✓ | X | X | X | X | ✓ | X | N/A |
| Evaluation of PVT management | ✓ | X | X | X | X | X | X | X | N/A |
| **Prevocational trainees with special needs** | | | | | | | | | |
| Effective early identification of PVTs with special needs | ✓ | ✓ | X | X | ✓ | X | ✓ | X | X |
| Structured support coordinated at term, hospital, network level | ✓ | X | X | X | X | X | X | X | X |
| Monitoring/evaluation of support of PVTs with special needs | ✓ | X | # | # | ✓ | # | X | X | X |
| Implementation of action plan for trainees in difficulty | X | | ✓ | ✓ | ✓ | ✓ | | X | ✓ |
| **Safe practice** | | | | | | | | | |
| Duty rosters balance service needs with safe working hours | ✓ | ✓ | X | X | ✓ | X | ✓ | X | ✓ |
| Complies with occupational health and safety obligations | ✓ | X | X | X | ✓ | X | X | X | ✓ |

| Standards/Criterion | NSW | VIC | QLD | SA | WA | NT | TAS | NZ | College |
|---|---|---|---|---|---|---|---|---|---|
| Evaluation of safety of working conditions | ✓ | X | X | X | X | X | X | X | X |
| **Promoting prevocational trainee interests** | | | | | | | | | |
| Engages PVTs and their advocates in decision making | ✓ | X | ? | ? | X | ? | X | X | ✓ |
| GCTC is established, delegated authority and meets regularly | ✓ | X | ✓ | ✓ | ✓ | ✓ | X | ✓ | N/A |
| DPET supports and advocates effectively for PVTs | ✓ | ✓ | X | X | ✓ | X | ✓ | X | N/A |
| Hospital provides adequate support for DPET | ✓ | X | ✓ | ✓ | ✓ | ✓ | X | X | N/A |
| *Active engagement of PVT - development of training program* | X | ✓ | X | X | X | X | ✓ | X | ✓ |
| *Office space for the PVT training staff (+ counseling space)* | X | X | X | ✓ | ✓ | X | X | X | ✓ |
| **Supporting prevocational trainees** | | | | | | | | | |
| Supports PVTs in taking responsibility for health and well-being | ✓ | X | X | X | ✓ | X | X | ✓ | ✓ |
| Evaluation of effectiveness of self-care programs | ✓ | X | X | X | X | X | X | X | X |
| **Physical amenities** | | | | | | | | | |
| Provision of overnight accommodation (on-call rooms) | ✓ | X | X | X | ✓ | X | X | ✓ | X |
| Provision of extended stay accommodation | ✓ | X | X | X | X | X | X | X | X |
| Provision of recreational area with range of amenities | ✓ | ✓ | X | ✓ | ✓ | X | ✓ | ✓ | X |
| *Provision of an appropriate ward environment for PVTs* | X | ✓ | X | X | ✓ | X | ✓ | X | X |
| **Program evaluation** | | | | | | | | | |

| Standards/Criterion | NSW | VIC | QLD | SA | WA | NT | TAS | NZ | College |
|---|---|---|---|---|---|---|---|---|---|
| *Formal processes in place to receive feedback on program* | ✓ | ✓ | ✓ | ✓ | X | ✓ | ✓ | X | X |
| *Hospital ensures all involved staff receive evaluation analysis* | X | ✓ | X | X | X | X | ✓ | X | X |
| **Other** | | | | | | | | | |
| *Coordination with partner facilities (network)* | # | X | ✓ | X | ✓ | ✓ | X | X | - |
| *Capability to deliver all required core and non-core terms* | X | X | X | X | ✓ | X | X | X | - |
| *Compliance with medical education calculator* | X | X | ? | ✓ | ✓ | ? | X | X | - |
| *Provision of medical education officer* | X | X | X | X | ✓ | X | X | X | - |
| *Communication facilities (page, pigeon holes, email)* | X | X | X | X | ✓ | X | X | X | - |
| *Access to nutrition 24/7* | X | X | X | X | ✓ | X | X | X | - |
| *Safe and flexible work practices (including flexible hours)* | X | X | X | X | ✓ | X | X | X | - |
| *Systems to accommodate job share arrangements* | X | X | X | X | ✓ | X | X | X | - |
| *Accommodating leave requests where possible* | X | X | X | X | ✓ | X | X | X | - |
| *Terms and conditions in accordance with the Award* | X | X | X | X | ✓ | X | X | X | - |
| *Obtaining informed consent by PVTs* | X | X | X | X | ✓ | X | X | ✓ | - |
| *Supervision in the emergency department* | X | X | X | X | X | X | X | ✓ | - |
| *Advanced cardiac life support training (Level 7 NZRC)* | X | X | X | X | X | X | X | ✓ | - |
| *Training in cultural competence* | X | X | X | X | X | X | X | ✓ | - |

| Standards/Criterion | NSW | VIC | QLD | SA | WA | NT | TAS | NZ | College |
|---|---|---|---|---|---|---|---|---|---|
| *Quality assurance activities for interns (incident reports, audit)* | X | X | X | X | X | X | X | ✓ | - |
| *Intern experience of continuity of care (rosters, handover)* | X | X | X | X | X | X | X | ✓ | - |
| *Coping mechanisms for dealing with time pressures + demands* | X | X | X | X | X | X | X | ✓ | - |
| *Processes whereby leave is applied for, given or declined* | X | X | X | X | X | X | X | ✓ | - |
| *Networks for professional support and dispute resolution* | X | X | X | X | X | X | X | ✓ | - |
| *Innovative structures – encourage a + learning environment* | X | X | X | X | X | X | X | ✓ | - |
| *Recruitment and retention policies for interns* | X | X | X | X | X | X | X | ✓ | - |

# Appendix I – List of abbreviations

| LIST OF ABBREVIATIONS | |
|---|---|
| **ACF** | Australian Curriculum Framework |
| **AMC** | Australian Medical Council |
| **CPMEC** | Confederation of Postgraduate Medical Councils |
| **MBA** | Medical Board of Australia |
| **PAC** | Prevocational Accreditation Committee (HETI) |
| **PMAF** | Prevocational Medical Accreditation Framework (CPMEC) |
| **Prevocational trainee** | Doctor in the first two years of medical practice following university. |
| **PvTC** | Prevocational Training Council (HETI) |
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JB