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ABOUT THIS DOCUMENT

This guide is for Directors of Prevocational Education and Training (DPETs) and others responsible for delivering prevocational training programs across diverse sites.

It describes what a network needs for the delivery of a successful prevocational medical education and training program in New South Wales. It also describes the structures governing the network system from the state level to the training sites.

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

The Health Education and Training Institute (HETI) provides and promotes the support of high quality education and training to sustain excellence in health care delivery across the NSW Health system.

**HETI’S VISION**
Where innovation drives excellence in education and training for improved health outcomes.

**HETI’S PURPOSE**
Working with health partners to develop contemporary and responsive health education and training to enable a world class workforce.

HETI promotes education and training that:
- Supports safe, high quality, multi-disciplinary, team-based, patient-centred care.
- Meets service delivery needs and operational requirements.
- Enhances workforce skills, flexibility and productivity.

**HETI’S MAIN FUNCTIONS ARE TO:**
- Design, commission, conduct, coordinate and evaluate education and training for patient care, administrative and support services.
- Establish governance for whole of health education and training programs for the NSW Health system.
- Take the lead role in NSW Health for the design, commissioning, conduct, coordination and evaluation of leadership and management development.
- Support reform to improve workforce capacity and the quality of clinical and non-clinical training.
- Develop, coordinate, oversee and evaluate education and training networks, ensuring they support service delivery needs and meet operational requirements.
The Director of Prevocational Education and Training (DPET) directs the training of prevocational medical trainees at each training site and has a more continuous involvement with trainees than their supervisors, who change from term to term.

The DPET:

- Promotes, develops and coordinates the clinical training of prevocational trainees in association with prevocational trainee staff management, the General Clinical Training Committee (GCTC) and the Network Committee for Prevocational Training (NCPT).
- Develops a formal intern education program which is directed by The Intern Guide\(^1\).
- Advocates for trainee welfare within the health system.
- Supports term supervisors and prevocational trainees and helps solve problems that can arise during training (e.g. underperformance, mismatch of expectations, trainee distress, communication issues between trainee and team).
- Coordinates the assessment of trainees, co-signing all end-term assessments along with the term supervisor. At home hospitals, the DPET or the Director of Medical Services (DMS) certifies prevocational trainees as eligible for general registration upon the satisfactory completion of the requirements for internship.
- Evaluates training terms using the term evaluations completed by trainees and other information, and provides feedback to term supervisors. The DPET oversees the annual review of term descriptions by term supervisors, helps create new training terms and improves the quality of existing terms.
- Participates in the education of prevocational trainees and promotes professional responsibility and ethics among prevocational trainees.
- Takes the lead in meeting the NSW Prevocational Accreditation Standards for the training program.

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

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

For more information about the role of the DPET please refer to the HETI DPET Guide\(^2\) available for download on the HETI website\(^3\).

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**THE ROLE OF JMO MANAGEMENT UNITS**

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

The JMO unit supports and monitors trainees, manages their rosters, rotations and leave requests, advocates for quality training terms and good supervision, and supports the training program in meeting the requirements for their accreditation.

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\(^3\) https://www.heti.nsw.gov.au/
Network Committee for Prevocational Training (NCPT)

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

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

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

Each network meeting should invite a HETI representative to provide an update and advise on any accreditation matters that arise. The HETI staff should be advised at the commencement of each clinical year, of the proposed dates for the year’s meetings and be formally invited to attend. Please ensure they are given access to agenda papers and minutes.

The template terms of reference (see appendices) is a good summary of the NCPTs responsibilities.

Trainee Representation

Interns are actively involved in the governance of their training. All network and hospital committees for prevocational training must include trainee representation. This is to encourage trainee representation, engage trainees in the work of the committee and to value the continuation of the trainee representatives by giving them tasks and expecting their input to meetings. It may be helpful to have an active trainee subcommittee that meets separately. For more information please see the revised standard 7.3 on the communication with trainees as per the AMC Standards for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development.

“All network and hospital committees for prevocational training must include trainee representation.”

4 https://www.amc.org.au/files/b637b4920ce-666e8687cd8a4a396e7d5bf5fcff1_original.pdf
GENERAL CLINICAL TRAINING COMMITTEE (GCTC)

Each prevocational training hospital must have a General Clinical Training Committee (GCTC) to advise on education and information resources needed to support the education program and to advise on other matters relating to the delivery of the medical education and training as required. The GCTC can be part of another committee as long as it is site-based as per the Accreditation Standards.

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

GCTC Responsibilities:

- The Committee will conduct its activities in accord with the rules of the hospital and its terms of reference.
- Develop, implement, monitor and evaluate all orientation, training and educational programs for prevocational doctors.
- Ensure that each term, including secondments, is consistent with HETI guidelines.
- Regularly review and evaluate training, education, experience and working conditions of each prevocational trainee.
- Review prevocational training program according to the HETI Accreditation Standards.
- Review and evaluate the performance of Term Supervisors and the Director of Prevocational Education and Training.

The HETI template for the GCTC Terms of Reference is provided as an appendix to this document.
NSW PREVOCATIONAL NETWORK FUNCTIONS

No single health care facility can provide all the training and experience required to prepare new doctors for the diversity of medical practice, so facilities are organised into networks that cooperate to deliver training to a group of prevocational trainees. From an educational perspective, the key requirement of a network is that it should be capable of delivering all the elements of the learning model. In practical terms, several sets of factors need to be considered when running a successful training network.

1 TRAINING COMPONENTS

It is the responsibility of the training network to ensure that every trainee has access to an effective program of education in an appropriate training environment, across each site within the network. The following is required:

- Each site should have access to the resources required to deliver clearly documented learning outcomes. This requires:
  - Directors of training, supervisors and trainees who are familiar with the learning outcomes and training curriculum of the site.
  - Term descriptions that outline how the trainee will be exposed to learning opportunities specific to the term and in alignment with the curriculum of the training site.
- A network lecture series and term-specific teaching program that addresses the proposed learning outcomes.
- The required amount of training positions sufficient to allocate all trainees to their required core terms in medicine, emergency medicine and surgery. (An outline of these required terms is provided in the appendices of this document.)
- An appropriate mix of specialty terms, including availability for most trainees to:
  - Pediatrics
  - Psychiatry
  - Obstetrics and gynaecology
  - Geriatrics or rehabilitation
• Access to an appropriate mix of training settings (large and small hospitals, rural and metro and a range of patient types and acuities).

• Relief terms: a maximum of 2 of 10 terms for each trainee. This includes clinical duties providing bedside care after hours. These terms are a valuable practical learning experience for trainees.

• The accreditation of all terms, which requires that:
  - The term description sets clear and achievable training outcomes and outlines monitoring and assessment procedures.
  - Clinical supervision is sufficient for both clinical effectiveness and the education and training of trainees. Responsibility for direct oversight of all patient care is explicit, senior supervision is active and ensures patient safety at all times with trainees having immediate access to senior experienced clinicians.
  - The workload is appropriate to maximise both patient care and trainee development.
  - Processes for assessing trainees and evaluating each term are effective. Use of workplace-based assessment tools (including miniCEX and multi-source feedback) are strongly encouraged. Formal assessment according to the prescribed form is essential at the end of each term.
  - The DPET be aware of any changes to existing terms or the potential for new terms.
  - Any amendments or changes relating to new or existing terms must first be approved by the Prevocational Accreditation Committee (PAC).

• An education series for trainees coordinated at a network level and made available between sites where access to educators or specialists may not be available. (E.G. via video conferencing)

• Protected time for formal prevocational teaching (minimum one hour weekly).

• Specific teaching in each term. Lectures, demonstrations, journal clubs, morbidity and mortality meetings and quality assurance processes consolidate the trainee’s work experience. Teaching activities should be routinely evaluated by the GCTC using trainee feedback, and trainee attendance and participation should be used as part of the term assessment of the trainee. Specific, assessable assignments as part of term-specific teaching are recommended (e.g. case presentation to peers, teaching medical students).

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

• Access to after-hours shifts for all trainees.

• A workplace culture supportive of training and education with training and support for all levels of the workforce and a commitment to continuous professional development.

Good prevocational training cannot occur in a vacuum: the understanding and support of all staff from the Chief Executive down is required. This requires a significant commitment of resources, including for the Director of Prevocational Education and Training in each facility to fulfil the responsibilities of the position description and support term supervisors and trainees.
Due to the rotation of trainees within training networks it is essential for each network to endorse the use of a single education series, particularly for the intern protected teaching time (minimum 1 hour per week). An agreed series of learning will allow trainees to access, across the network, the same topics of learning at each of the network sites. It is expected that this be monitored by the NCPT so that trainees do not experience gaps or repeated training sessions where possible. This can be achieved by implementing some of the following suggestions:

- Provide access to video or teleconferencing facilities at remote sites.
- Access to recorded lectures which are also made available for reviewing at a later time.
- Each site provides their own education session, based on the agreed timetable of lecture topics, with network oversite to ensure trainees receive essential sessions regardless of their rotation.

The Prevocational Training Council (PvTC) of NSW endorses the Unified Education Series⁵ as a concept, and recommends it to DPETs as an aid to coordinating JMO education across each training network. This document can be downloaded from the HETI website⁶.

The essential features of a network lecture series are:

- Access to the lectures for all trainees, including those who are rostered to after hours or night shifts. Usually, this is because the lectures are held at the local facility, but it can be because trainees are able to travel to another facility for lectures or because trainees at a small facility are able to attend lectures elsewhere by videoconference.
- Lectures are held in protected teaching time. This means that trainees are released from clinical duty to attend, and are not interrupted by pagers.
- Lectures are organised locally by DPETs but there is coordination at a network level to avoid trainees missing topics or repeating topics when they go on rotation. This may not be completely avoidable, but networks should be developing options to overcome the problem, such as recording lectures or providing online tutorials for trainees who cannot come to the live event.
- Trainee evaluations of the lectures are routinely collected and used to improve the series.
- Trainee attendance at the lectures is recorded and reported.

“Due to the rotation of trainees within training networks it is essential for each network to endorse the use of a single education series...”

RATE OF TRAINEE PARTICIPATION REQUIRED FOR INTERN TEACHING

Some training sites report difficulties getting prevocational trainees to attend lectures. The Prevocational Training Council recommends that it is appropriate to require attendance at:

- All core training activities, which include DETECT (approach to the deteriorating patient), basic and advanced life support courses, communication workshops (including breaking bad news) and any other session deemed core training by the Network Committee for Prevocational Training (NCPT).
- All of intern orientation week and all term orientation activities.
- A percentage (to be determined by the NCPT) of all other educational sessions.

Inadequate attendance can be deemed a failure to pass the training term. Providers with low attendance that show no evidence of attempts to address the issue may jeopardise their accreditation.

Enforcing attendance is only acceptable if the network and the training facility meets organisational requirements:

- The educational program must be regularly scheduled and publicised.
- Educational presenters should be appropriately qualified and prepared.
- Term supervisors and other clinical team members must understand that releasing prevocational trainees for their scheduled education sessions is required in all but exceptional circumstances and the pagers of prevocational trainees should be held for them by an appropriate party so that educational time is protected.

TERM-SPECIFIC TEACHING

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

RESIDENT TRAINING PROGRAMS

The Prevocational Training Council (PvTC) advocates for each training network to offer a training program specifically targeting the second year of prevocational training. It is acknowledged that the training program aimed at the interns may not be appropriate to the level of learning required by a resident so it is necessary for an alternative program be implemented. The PvTC recommends that a PGY2 training program include:

- Communication skills.
- Managing teams.
- Dealing with difficult patients.
- Case presentations.
- Career and vocational training pathway requirements.

It is necessary for all PGY2 trainees to continue to receive mid and end of term assessments so it may be suitable to align a training program with the outcome statements discussed within these documents.
INFRASTRUCTURE

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

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

- Networks must have appropriate infrastructure and staffing to:
  - Manage their trainees’ employment and welfare.
  - Supervise the trainees.
  - Provide regular feedback to trainees.
  - Assess the trainees.
  - Evaluate the program.
  - Keep adequate and secure records.
- Each training site should have appropriate physical amenities for the welfare of trainees.
- Trainees need access to:
  - Lecture theatres and learning centres.
  - The internet — both on wards and in study areas.
  - Medical and mental health care for themselves.
- Video-conferencing should be available within the network to connect smaller sites with larger sites for the purposes of educational sessions and network meetings.
- Trainees that are rotated to rural sites a significant distance from their home hospital must be provided with suitable accommodation. For rural trainees moving to metropolitan training sites, HETI facilitates the Metropolitan Access Scholarships (MAS) program providing financial support to eligible NSW rural vocational and prevocational medical trainees undertaking metropolitan training. The scholarships aim to assist rural trainees, with a strong commitment to rural practice in NSW, to relocate to a metropolitan centre for further training.

- Libraries — these may be digital libraries accessible from quiet study areas.
- Simulation training facilities — not every site will provide high-fidelity simulation facilities but trainees should have access within the network to high-fidelity simulation facilities for training in advanced life support, and low fidelity simulation training for training in teamwork, engaging with people from different cultural backgrounds and practising conflict resolution.
**3 GEOGRAPHY**

HETI strongly supports prevocational trainees rotating through the prevocational training network (including to metropolitan, private or rural providers). These rotations provide prevocational trainees with exposure to different health geographies and demographics as well as an opportunity to experience the ways in which the provision of medical services can differ.

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

**BENEFITS OF A RURAL TERM TO METROPOLITAN TRAINEES**

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<th>Different patient mix</th>
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<tr>
<td>Smaller teams, closer relationship with senior clinicians</td>
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<td>More opportunities to be hands-on</td>
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**BENEFITS OF A METROPOLITAN TERM TO RURAL TRAINEES**

<table>
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<tr>
<th>Different patient mix</th>
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</thead>
<tbody>
<tr>
<td>Larger teams, more specialised wards and techniques</td>
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<tr>
<td>More chances to see subspecialists at work</td>
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Most rural trainees should receive at least one training term at a metropolitan tertiary referral centre out of their 10 training terms (not a relief term), and networks should try hard to ensure that this term advances the trainee along his/her intended vocational pathway.

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

In networks where a private training facility is present, the network should include their accredited terms, where appropriate, in the allocation to the entire cohort of JMOs. This will provide beneficial access to a broader range of clinical settings.
4 NETWORK MEMBERSHIP

All prevocational networks are made up of a diverse range of training providers in both metro and rural areas, both private and public and large and small.

New providers need to be accredited by meeting the NSW Prevocational Accreditation Standards whilst complying with the same requirements of existing providers. This includes involvement with an existing NSW prevocational training network. HETI encourages the expansion of networks to accommodate new training sites and for existing providers to understand the inherent value in additional training services and educational opportunities for their trainees.

A new provider may come from an existing Local Health District (LHD) and thus join a network already associated with the LHD. Another type of new provider is a private sector facility. Typically these sites are not part of an LHD and they are not allocated interns via the HETI allocation process.

The Commonwealth Medical Internship fund is commonly used to fund positions for providers outside an LHD who seek to train prevocational trainees. For more information about the fund please go to their website.  

5 RELATION TO THE SYSTEM

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

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

Network governance is the vital element in ensuring that prevocational training is effective and continuously improving.

**ESSENTIAL ELEMENTS OF EFFECTIVE GOVERNANCE**

A prevocational training network is a peer-to-peer network, not a hub-and-spoke network, irrespective of relative size.

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

- **Small sites may have gaps in local expertise required for education and training, and the network should work to overcome these difficulties.** There are several possibilities:
  - Videoconferencing.
  - Online learning.
  - Travelling to a central location for lectures.
  - Using small sites for specialised training, and ensuring that all trainees receive core training at large sites.
  - Education and training resources need to be shared within the network in whatever manner maximises their effectiveness for trainees.

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

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

- **An effective network committee.** The network committee for prevocational training must:
  - Meet regularly, with an appropriate agenda, minutes, chair and secretary.
  - Have committed representation from all training sites within the network.
  - Actively involve trainees in the governance of their training as per the AMC Standards for Professional Development 7.3.1.

- **Effective lines of reporting — both to HETI and to the health service administration of each local health district in the network.** Without clear lines of reporting, problems identified within the network can remain unresolved.

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

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

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

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

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

“Network governance is the vital element in ensuring that prevocational training is effective and continuously improving.”
The Prevocational Training Council (PvTC) oversees the functions of the NSW prevocational training networks.

To promote healthy networks the sections entitled, ‘Managing Leave’, ‘Leave and Registration Requirements’ and ‘Workforce Distribution Principles’ have been included at the Council’s request to give an example of the appropriate distribution of junior medical workforce staff. This will highlight how staff can best be utilised to manage workplace workload surges and support the needs of smaller training sites within the network.

As an ongoing auditing mechanism, the PvTC will expect each prevocational training provider to have access to and provide to the Council a copy of the signed Memorandum of Understanding for their training network specific to the distribution of the prevocational medical workforce. This will be required by each site as part of their annual report submission.

**MEMORANDUM OF UNDERSTANDING**

HETI strongly recommends that all training sites within a network should agree to and sign off on a memorandum of understanding for the allocation of trainees, taking into account any rural and regional recruits, before all recruitment is finalised for the year. It is expected that where a network features a single T5 home hospital, that they take the lead in supporting the smaller network sites to ensure access to training opportunities, appropriate terms required for a diverse educational experience and support for workforce shortages. As it states in the *AMC national standard 7.1.1*, “The processes for intern appointments are based on the published criteria and the principles of the program concerned and are transparent rigorous and fair.”

The memorandum of understanding must outline the roles of all network sites and, in the case of more than one T5 home hospital within the network, should delineate the responsibilities to the network for those areas mentioned.

**MANAGING LEAVE**

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

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

- Unplanned leave under two weeks should be the responsibility of the local facility from which the trainee is absent, while unplanned leave beyond two weeks becomes a network responsibility.

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• The cover for planned leave should be the responsibility of the facility which approved the leave.

• Generally, planned leave will be approved by the home hospital of the trainee, and should take place in a term at the home hospital. Leave within a training term must be approved by the training site hosting the term. If a home hospital approves leave for a trainee on rotation, it is the responsibility of the home hospital to cover that leave.

• Hospitals with rural preferential recruits should aim to employ sufficient numbers to cover relief, or should seek the prior agreement of the network that the network can cover relief.

• Management of leave may include planned transfer of funds between rural and metropolitan hospitals.

• Network agreements, either employing additional leave relief, or “purchasing” positions from other hospitals in the network, should be in place before the recruitment period ends to provide adequate baseline numbers.

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

WORKFORCE DISTRIBUTION PRINCIPLES

• All prevocational training terms must be accredited by HETI for all PGY1 and PGY2 positions. Workforce must be distributed in accordance with the accredited positions only. Any changes to the positions must be approved by the PAC before prevocational trainees are allocated. Please note that the process of approval of new and revised terms can take up to three months. Please email HETI-Accreditation@health.nsw.gov.au for more information regarding this process.

• The availability of terms, quality of supervision and the provision of education and training must be taken into account when distributing the workforce.

• The network shall consider the totality of the individual trainee’s experience when making decisions about term allocation.

• In networks with more than one home hospital, the allocation of trainees to home hospitals must be done using a fair and transparent process. Trainees must do at least three terms at their home hospital in PGY1 and two in PGY2. New trainees must be inform of their home hospital by November before the start of the clinical year.

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

• If there is a workforce shortage this should be shared equitably within the network, having regard to the proportional impact of a shortage and giving priority to the smaller or rural network sites.
TERM ALLOCATION

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

Not all trainees can be allocated their first choices, but networks should have a range of terms and educational opportunities which support the career aspirations and outcomes for the prevocational trainees and the system.

Neither rural, regional, nor metropolitan trainees should have special preference in relation to desirable terms: all trainees should have equal opportunity to receive their term preferences.

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

TERM TO TERM TRANSITIONS

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

The Ministry of Health’s JMO Wellbeing and Support plan stipulates that:

• Employees are not to be rostered for shift periods totalling more than 14 consecutive hours (inclusive of meal breaks and handover).
• Rosters must be arranged so that there is a break after rostered shift periods of at least 10 hours. It is up to the respective workforce teams at both sites to ensure their rosters allow for a safe transition for the trainee.

SWAPS ACROSS NETWORKS

PGY1 trainees are unable to move between networks. During the PGY2 year, JMOs can request training at other network sites if there is an opportunity to complete a term at another facility that will enhance career progression.

Trainee swaps can be arranged between networks on a case-by-case basis and are supported by HETI to provide opportunities for trainees to support further career paths. JMO Managers can use their professional network to help facilitate trainee swaps.

Swaps require the mutual agreement of the trainees, JMO management and DPET in both networks. Information on trainees should be shared to JMO Managers and DPET to ensure that the trainees are supported within their rotation term.

WORKFORCE SHORTAGES

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

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

The network memorandum of understanding, implemented prior to recruitment should outline the requirements of the network when managing workforce changes.
NATIONAL STRUCTURES

The Commonwealth Government provides funding, policy guidance and support for a range of clinical education and training activities.

The Australian Medical Council (AMC)\textsuperscript{10} is an independent national standards body for medical education and training. Its purpose is to ensure standards of education, training and assessment of the medical profession to promote and protect the health of the Australian people. It does not provide clinical education and training, but does assess overseas-qualified medical practitioners seeking registration to practice medicine in Australia.

The Australian Health Practitioner Regulation Agency (AHPRA)\textsuperscript{11}, which includes the Medical Board of Australia (MBA), manages the registration of medical practitioners. The MBA sets national standards for internship that have to be met by all state jurisdictions. AHPRA and the MBA have no direct role in providing education and training. The Health Education and Training Institute (HETI) is accredited by the Australian Medical Council and approved by the Medical Board of Australia as the intern training accreditation authority for New South Wales.

The HETI Prevocational Accreditation Program implements and monitors standards for the training and welfare of prevocational trainees in their first two postgraduate years (PGY1 and PGY2).

HETI is responsible for ensuring the health services it accredits are compliant with the NSW Prevocational Education and Training Standards for prevocational training providers. Its functions include setting standards for education and training and accreditation of institutions for prevocational education and supervision.

\textsuperscript{10} \url{http://www.amc.org.au/}
\textsuperscript{11} \url{http://www.ahpra.gov.au/}
THE ROLE OF LOCAL HEALTH DISTRICTS (LHD)

Education and training of staff is one of the essential functions of health services at the local level.

Prevocational trainees offered a position by HETI are allocated a prevocational training network that assigns the trainee to a home hospital. Prevocational trainees are employees of the LHD of their home hospital and are managed in accordance with the relevant employment award and NSW Ministry of Health policies. Applicants who accept positions from HETI acknowledge that they will rotate to any facility in the network if required. There is an expectation that prevocational trainees may need to complete at least one term in the two year period outside the home hospital.

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

NSW has several privately funded training providers who offer programs for prevocational medical trainees. Most of these sites seek alternative funding sources for their prevocational trainees but are expected to meet the NSW Prevocational Accreditation Standards for the provision of training. They must also comply with requirements for general registration.

It is the responsibility of the network to manage the smooth transition for all trainees between sites and to support the workforce requirements of smaller sites to ensure patient-centred care whilst providing trainees with adequate exposure to learning opportunities.

“NSW has several privately funded training providers who offer programs for prevocational medical trainees.”
NSW PREVOCATIONAL ACCREDITATION

HETI is accredited by the Medical Board of Australia as the intern training accreditation authority for New South Wales to ensure high standards of training, education and welfare for all prevocational trainees. This authority extends across all prevocational training providers inclusive of positions that provide training opportunities for prevocational medical trainees employed by NSW Health and private hospitals.

HETI has the responsibility to revise the NSW Prevocational Accreditation Standards, framework and survey tools to align with national accreditation processes.

Medical intern positions are located in clinical terms. Each year trainees rotate through five positions located in various terms to enable them experience in a range of clinical situations and service environments. Rotation between terms means that each accredited fulltime equivalent position can be used to train five trainees.

Post graduate year one (PGY1) trainees are required to rotate through an emergency medicine, surgery and medicine term. The positions must be accredited in accordance with guidelines developed by HETI and must ensure adequate case-mix, service, teaching, supervision and assessment. All core terms must meet the requirements set out in the AMC Intern training – Guidelines for terms.

HETI’s annual prevocational accreditation work plan includes monitoring to ensure there are sufficient terms accredited such that all trainees can gain general medical registration at the end of their first postgraduate year.

In addition to maintaining their compliance to the Standards, providers have a responsibility to maintain all criteria pertaining to their classification throughout their accreditation cycle. HETI assesses a Provider’s capacity to deliver a balanced mix of clinical experiences and a variety of training opportunities, and award a classification accordingly.

The Prevocational Accreditation Committee (PAC) assesses all term descriptions submitted for their potential to provide quality prevocational education and training including appropriate supervision. All terms must ensure the safety of both patients and prevocational trainees by providing appropriate levels of supervision, workload, hours and clinical practice suitable to the skills of the prevocational trainees performing them. These requirements are explained later in this document.

Accreditation Surveys are undertaken to assess compliance with the NSW Prevocational Accreditation Standards. Following an accreditation survey, a report is compiled and reviewed by the Prevocational Accreditation Committee (PAC). The PAC then makes a decision regarding the accreditation status to be awarded to the facility. Before a Provider in NSW can commence employing prevocational trainees they must have formal accreditation from HETI.
SUMMARY OF THE ACCREDITATION CYCLE

Provider seeking accreditation

Pre Survey documentation completed

Accreditation Survey Conducted by Survey Team

PAC reviews survey report and makes an Accreditation Decision

Accreditation length of more than one year

Provider responds to any conditions. Provider has a focus visit if requested

PAC confirms Accreditation

Provider submits annual reports each year

PAC confirms Accreditation

Accreditation length of one year or less

Provider responds to any conditions. Provider has a focus visit if requested

PAC requests more information about the Condition or imposes a new condition or focus visit

PAC confirms Accreditation

Commencement of next accreditation cycle
**ACCREDITATION STANDARDS**

The HETI Prevocational Accreditation Committee (PAC) develops NSW Standards and oversees all accreditation activities. The PAC makes decisions about the accreditation of Prevocational Training Providers and individual terms including the Conditions placed upon Prevocational Training Providers. The Prevocational Training Provider will be assessed against each of the thirteen Standards.

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ACCREDITATION SURVEYS

The NSW prevocational accreditation program is cyclical and involves accreditation of individual clinical terms, and the Prevocational Training Provider. Accreditation surveys are a peer to peer system and a JMO must be on an accreditation team.

The accreditation process consists of:

- Prevocational Training Provider’s self-assessment;
- Accreditation survey,
- Prevocational Accreditation Committee decision; and
- Ongoing monitoring of the Provider to ensure Standards continue to be met via:
  - Annual reports submitted by Providers
  - JMO feedback
  - Self-reporting of changes which may affect the Providers ability to meet the Standards
  - Focus visits and site visits.

“The NSW prevocational accreditation program is cyclical and involves accreditation of individual clinical terms, and the Prevocational Training Provider.”
THE PREVOCATIONAL ACCREDITATION COMMITTEE (PAC)

The Prevocational Accreditation Committee (PAC) oversees the HETI accreditation program. The PAC makes decisions about accreditation of providers, accreditation of terms and the conditions placed on a provider’s accreditation.

The Prevocational Accreditation Committee (PAC) can award a provider accreditation for a minimum period of six months up to a maximum period of four years. When there are specific issues that require attention, the PAC may award accreditation contingent on the provider addressing conditions within a given period of time. The PAC may also decide that a focus visit is required to ensure conditions have been addressed.

The PAC also reviews summaries of the providers’ annual reports on accreditation. The annual reports are due on the anniversary of a provider’s accreditation (excluding years when they are scheduled for an accreditation survey). If the PAC considers it necessary to conduct an investigation into what is reported, HETI will notify the general manager of the provider and conduct investigations as requested by the PAC.
THE PREVOCATIONAL TRAINING COUNCIL (PVTC)

The role of the Prevocational Training Council (PVTC) is to ensure state-wide coordination of the prevocational training networks and develop resources which will improve prevocational training in NSW. The PVTC promotes and supports high quality training for prevocational trainees in NSW.

The functions of the PVTC:
- Oversee and support medical education and training for prevocational trainees in NSW.
- Support prevocational training networks in relation to development and delivery of education and training across the NSW health system.
- Review and determine DPET funding to hospitals in accordance with NSW Health policies.
- Review and approve applications from Providers who wish to appoint a new DPET.
- Support the professional development of DPETs and term supervisors.
- Facilitate innovation and appropriate workplace teaching, learning and assessment for prevocational doctors.
- Provide advice and expertise to HETI executive on issues related to prevocational training.

“The role of the Prevocational Training Council (PVTC) is to ensure state-wide coordination of the prevocational training networks and develop resources which will improve prevocational training in NSW.”
ANNUAL REPORTS

The Australian Medical Council requires the Health Education and Training Institute (HETI) to monitor Providers annually (between surveys). This is to ensure they continue to meet the Prevocational Education and Training Accreditation Standards and are continuously improving the quality of their prevocational education and training program. To meet this requirement, HETI requires Providers to submit an annual report on the anniversary of their accreditation date.

Sites with accreditation as T5 home Hospitals, T3 and Rotation sites are required to submit annual reports on the anniversary of their accreditation survey each year. Those with offsite terms are required to include information specific to their offsite terms as part of the report.

“The Australian Medical Council requires the Health Education and Training Institute (HETI) to monitor Providers annually (between surveys).”

PURPOSE OF ANNUAL REPORTS

HETI’s Prevocational Accreditation Committee (PAC) will review the provider’s responses to outstanding conditions and recommendations stemming from their last accreditation survey whilst identifying any issues that may impact the accreditation status of the Provider.

The Prevocational Training Council (PvTC) will identify issues of trainee welfare, education and/or supervision specific to the learning outcomes of the training program. The PvTC reviews the annual reports for innovative initiatives and review the spending of the DPET funds in accordance with the DPET Funding Guidelines.

Each report is reviewed by PAC and PvTC with a joint letter issued to indicate that the report has been accepted.

The annual report also serves to assist with the preparations for an accreditation survey, providing a summary of the training program for each year of the current accreditation cycle. Providers are encouraged to view their annual reports in this manner so that they support the cycle of accreditation whilst providing insight into the current programs issues and initiatives.
The Health Education and Training Institute (HETI) have delegated authority from the NSW Ministry of Health to allocate trainees to prevocational training networks in NSW on behalf of the Local Health Districts.

In NSW, prevocational trainee positions are located with the 15 prevocational training networks who work cooperatively to provide the training and experiences required to prepare prevocational doctors for a diverse range of medical practice.

Prevocational training positions offered by HETI are a two-year position and enable the completion of the first and second postgraduate years (PGY) in a single network. All the terms and facilities in the network are accredited for this training.

The network will assign the trainee to a home hospital. The trainee’s employer is the LHD that governs the home hospital.

There are four recruitment pathways to obtain a prevocational training position in NSW. The pathways offer positions sequentially in the following order:

1. Aboriginal Medical Workforce
2. Rural Preferential Recruitment
3. Direct Regional Allocation
4. Optimised Allocation

**ABORIGINAL MEDICAL WORKFORCE**

This pathway provides Aboriginal and/or Torres Strait Islander medical graduates with the opportunity to be allocated to a prevocational training network or rural preferential hospital that can support their transition to prevocational training by providing access to established support networks.

**RURAL PREFERENTIAL RECRUITMENT**

Rural preferential recruitment is a merit-based recruitment program for doctors who want to complete prevocational training in a rural setting. It helps build a sustainable rural workforce by giving priority to filling rural positions.
REGIONAL PREFERENTIAL ALLOCATION

This pathway provides applicants interested in undertaking prevocational training in a regional or outer metropolitan Sydney area with an opportunity to be directly recruited to a regional and/or outer metropolitan network, when they nominate one of these networks as their first preference.

OPTIMISED ALLOCATION

This is the main recruitment pathway in NSW. Applicants’ rank each of the 15 prevocational training networks and allocation to positions is completed via recruitment rounds. The preferences of all applicants in the round are taken into consideration when the allocation is undertaken. The purpose is to ensure that the whole cohort of applicants in the round is considered for each of the positions that are available and the best outcome is sought via the algorithm.

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

“The purpose of these pathways are to facilitate recruitment to the facility, within the networks, and not to give preference for specific terms within the network...”
APPENDICES

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NETWORK COMMITTEE FOR PREVOCATIONAL TRAINING (NCPT)

SUGGESTED TERMS OF REFERENCE

PURPOSE

• Each prevocational training network will establish a Network Committee for Prevocational Training to support the efficient running of training in a fair and transparent manner. The purpose of the committee is to develop safe, high quality training of prevocational trainees through good governance and management of the training program based in the network.

ROLE

• Govern the training network in an equitable and open manner, on the basis that all training sites are partners in the network.
• Allow all stakeholders (including trainees, supervisors, departmental directors and health service administrators) to participate actively in network governance.
• Distribute prevocational trainees across the network in ways that share workforce equitably among sites and that share training opportunities equitably among trainees.
• Ensure that core orientation activities essential to a safe start at work are provided to all trainees in the network.
• Promote best practice methods as standards within the network.
• Ensure that all trainees within the network have access to high quality education and training.

• Coordinate and monitor formal education programs across the network to ensure that trainees do not have gaps or unnecessary repetition as they rotate through training sites.
• Monitor the quality of clinical supervision provided to trainees and take actions to improve supervision when required.
• Monitor the quality of training terms and education programs using trainee feedback.
• Monitor the progress of trainees as they move from term to term and site to site to ensure that difficulties are detected early. Referral to the Hospital or network Assessment Review Committee if required.
• Develop ideas and strategies to improve training within the network and to remedy identified deficiencies.
• Support the Directors of Prevocational Education and Training at each training site in the network
• Promote sharing of resources between training sites within the network to achieve efficiencies and maximise learning opportunities available to trainees.

In networks with rural preferential recruitment sites or regional preferential allocation sites, the network committee must arrange a formal agreement between sites covering:
• separate orientation at the rural or regional site for locally-based trainees in addition to any network orientation,
• accommodation arrangements for both rural and metropolitan placements,
• leave arrangements, and
• term allocations.

PRINCIPLES
The NCPT shall uphold the following principles:

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

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

Chair
• The Chair of the NCPT will be elected annually at a meeting of the Committee.
• The Chair may be shared between co-Chairs with the agreement of the Committee.
• The Chair may appoint a Secretary, or put the Secretary position to a vote of the Committee.

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

Committee representatives
• All training sites must be represented on the committee.
• At least four trainee representatives from both PGY1 and PGY2 and from more than one site.
• All the Directors of Prevocational Education and Training from training sites within the network.
• Senior representatives of JMO management
• Senior representatives of Directors of Medical Services.

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

The Chair will determine the official membership of the committee, which shall be minuted.
A HETI representative shall be invited to attend the NCPT as a non-voting observer and advisor.

DISTRIBUTION OF AGENDAS AND MINUTES
Agendas and minutes of NCPT meetings will be distributed to:
• trainee representatives from both PGY1 and PGY2.
• all the Directors of Prevocational Education and Training from training sites within the network,
• senior representatives of JMO management,
• senior representatives of Directors of Medical Services, and
• HETI.

QUORUM FOR MEETINGS
A quorum requires:
• That 80% of training sites are represented by at least one official member, and
• that JMOs, medical administration, JMO management and DPETs are represented, except that:

For the purposes of a quorum, small rural sites (ie, rotation sites, not rural home hospitals) should be allowed to delegate representation, provided that the delegate is briefed with a report from the rural site.

EXCLUSIONS FROM MEETING AND MINUTES
The NCPT can regularly include an agenda item to discuss the management of individual trainees in difficulty, with the JMO and HETI representatives on the committee absenting themselves from the meeting for this item.

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

FREQUENCY OF MEETINGS
The NCPT will meet at least once per training term (minimum five meetings per year).

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

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

FORMAL REPORTING
The NCPT shall report to:

- the Chief Executive of each Local Health District involved in the prevocational training network, or his/her nominated delegate, and
- the Chair of the Prevocational Training Council at HETI.

Formal reporting shall include:

- an annual written report of NCPT activities and achievements,
- specific data about: the number of prevocational trainees in the network, their distribution by training site and term, vacancies, and progression, and
- the minutes of the NCPT.

ENDORSEMENT
These terms of reference endorsed by:

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

Copies of the endorsed terms of reference should be provided to all NCPT members, the Chief Executive of each Local Health Network involved in the prevocational training network and the Chair of the Prevocational Training Council at HETI.
GENERAL CLINICAL TRAINING COMMITTEE TERMS OF REFERENCE

SUGGESTED TERMS OF REFERENCE

PURPOSE:
To support the mission of the Health Education and Training Institute (HETI), by ensuring that prevocational trainees are competent for safe practice and provide quality patient care.

ROLE
• Advise on resources needed to support prevocational education and training.
• Provide appropriate advice on other matters relating to the delivery of medical education and training, as required by the hospital.

RESPONSIBILITIES
• The Committee will conduct its activities in accord with the rules of the hospital and its terms of reference.
• Develop, implement, monitor and evaluate all orientation, training and educational programs for prevocational doctors.
• Ensure that each term, including secondments, is consistent with HETI guidelines.
• Regularly review and evaluate training, education, experience and working conditions of each prevocational trainee.
• Review prevocational training program according to the HETI Accreditation Standards.
• Review and evaluate the performance of Term Supervisors and the Director of Prevocational Education and Training.
MEMBERSHIP

The Committee should include members with a broad range of backgrounds and expertise. The Committee should ensure that all relevant departments of the hospital develop a sense of responsibility for the education, training and development of trainees.

Chair

To be nominated. This role cannot be held by the Director of Prevocational Education and Training

Responsibilities

The Chair provides leadership to the GCTC and promotes a cohesive and effective environment. Key roles and responsibilities of the Chair include:

• Evaluate the performance of Term Supervisors and the Director of Prevocational Education and Training on a regular basis.
• Ensure rotations, including secondments, are consistent with HETI guidelines.
• Provide recommendations and advice to HETI in respect to medical education, training standards, accreditation and workforce.
• Disclose conflicts of interest which may impinge upon the exercise of his or her duties as Chair of the Committee.

Committee support officer

To be nominated.

Responsibilities

• This person is held accountable for the preparation of agendas, minutes, the distribution of minutes and committee papers and follow-up on matters raised.
• Minutes of meetings should be documented and circulated to members of the Committee and the senior management of each hospital in the network after every meeting.

Committee representatives

The Committee must include representatives of:

• Hospital management,
• PGY1 and PGY2,
• JMO Workforce administrative team,
• Vocational training programs,
• Term Supervisors, and
• Director of Prevocational Education and Training.

Ex Officio and Co-opted non-voting members

The Committee may co-opt members to the Committee and/or establish working parties as may be necessary

QUORUM

The quorum is determined by the Committee

VOTING

As necessary

FREQUENCY

The Committee will meet at least quarterly

FORMAL REPORTING

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

ENDORSEMENT

These terms of reference endorsed by:

[List should include the General Manager or equivalent, the Chair of the Committee and the DPET for the training site.]

Copies of the endorsed terms of reference should be provided to all GCTC members.
ASSESSMENT REVIEW COMMITTEE

SUGGESTED TERMS OF REFERENCE

PURPOSE:

• The Assessment Review Committee’s (ARC) purpose is to assist with complex decisions on remediation for interns who do not achieve satisfactory supervisor assessments.

• The ARC may choose to assist with other or all prevocational training assessment decisions.

• Assessment review groups should have clear and transparent procedures for deciding on any course of action and for resolving disputes and appeals.

• HETI recommends that the ARC review all JMO assessment decisions, especially for decisions relating to general medical registration, to create a consistent and defensible assessment process for JMOs.

• The ARC can be based within a Hospital or at a Network level, particularly where hospitals have one major hospital and a series of smaller hospitals.
ROLE:
The Australian Medical Council’s *Intern training – National standards for programs* clause 5.2.7 requires “The intern training program establishes assessment review groups, as required, to assist with more complex remediation decisions for interns who do not achieve satisfactory supervisor assessments.”

When decisions about the performance of individual interns need review, the document *Intern training – Assessing and certifying completion* outlines processes to be followed.

For NSW training sites, the Assessment Review Committee (ARC) is accountable to the hospital general manager or equivalent.

MEMBERSHIP

- A senior clinician with experience in prevocational education and training.
- Director of Prevocational Education and Training.
- Representative from the JMO workforce administrative team.
- Representative from vocational training programs as appropriate.
- JMOs may nominate their own representative to be a part of the ARC.

FREQUENCY OF MEETINGS

The Assessment Review Committee should be available to review assessment decisions at the end of each term.

APPEALS PROCESS

- Junior Medical Officers have access to and knowledge of the method of appealing decisions made by the Assessment Review Committee.
- Appeals must be submitted formally to the Hospital’s General Manager (or equivalent) and reviewed independently.
- Junior Medical Officers can appeal any decision made by the ARC, including those regarding assessment, registration or other decisions included within the remit of the ARC as decided by the training site.

ENDORSEMENT

These terms of reference endorsed by:

[List should include Chair of the Committee, Hospital general manager or equivalent and DPET.]

*Copies of the endorsed terms of reference should be provided to all NCPT members, the Chief Executive of each Local Health Network involved in the prevocational training network and the Chair of the Prevocational Training Council at HETI.*
**POSITION DESCRIPTION: **

**DIRECTOR OF PREVOCATIONAL EDUCATION AND TRAINING (DPET)**

**NAME OF HOSPITAL**
To be completed by employing hospital

**RESPONSIBLE TO**
Hospital executive through the General Clinical Training Committee (GCTC)
Version: July 2018

**MISSION OF THE HOSPITAL**
(2–3 sentences to be completed by employing hospital)

**ROLE OF DPET IN ACHIEVING THE MISSION OF THE HOSPITAL**
(2–3 sentences to be completed by employing hospital)

**KEY ACCOUNTABILITIES**
The Role of the DPET is to ensure a high quality, sustainable prevocational training program in the facility. The program must meet the Australian Medical Council’s National Standards for prevocational training\(^\text{12}\).

The DPET is responsible for the planning, delivery and evaluation of the prevocational training program at the facility by delivering the following outcomes:

- Develop, coordinate and promote a structured, high quality prevocational training program with Staff Management and the General Clinical Training Committee (GCTC) in the facility.
- Support a formal orientation program which is designed and evaluated to ensure the intern is ready to commence safe, supervised practice.
- Ensure and support constructive prevocational training program review, assessment and feedback processes to inform program improvement and innovation.
- Oversee the policies, procedures and allocation of appropriate resources that contribute to the prevocational training program.

**KEY RELATIONSHIPS**
- Liaise regularly with Prevocational Trainees and Term Supervisors
- Liaise with the General Manager, Attending Medical Officers, and administrative staff as required.

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Network Principles for prevocational medical training

• Liaise and attend meetings with relevant groups and individuals to promote and enhance the training and education of prevocational trainees, including:
  - Term Supervisors
  - Network Committee for Prevocational Training (NCPT)
  - General Clinical Training Council (GCTC)
  - Directors of Medical Services
  - Visiting Medical Officers
  - JMO Managers and administrative staff
  - Hospital Executive
  - Other DPETs within the Network
  - HETI

• Advocate for the professional development of prevocational trainees.

• Ensure that adequate supervision and support is provided for prevocational trainees.

• Assist in the provision of fair and transparent term allocations and workload.

• Supervise the personal and professional welfare of prevocational trainees, particularly those experiencing difficulties.

SELECTION CRITERIA – SKILLS, KNOWLEDGE AND EXPERIENCE

1. Medical graduate with clinical postgraduate qualifications.
2. A clinical appointment to practice at the hospital.
3. Qualifications, appointment and experience at a level sufficient for communicating on authoritative terms with senior consultants acting as term supervisors.
4. A genuine interest and/or relevant experience in postgraduate medical education, a willingness to develop expertise in this area and a demonstrated understanding of the importance of the continuum of medical education as a lifelong professional commitment.
5. A commitment to and confidence in improving the quality of education and training offered by the hospital.
6. An understanding of the principles of adult education and professional development.
7. A commitment to the mission of HETI and the ability to present and explain HETI’s goals.
8. A Term Supervisor may be appointed to the role of DPET only in exceptional circumstances. The facility must ensure policies and procedures are in place to avoid a potential conflict of interest.

APPOINTMENT PROCESS

1. The hospital will send correspondence to the Chair of the Prevocational Training Council (PvTC) informing them when the DPET position will be advertised and when interviews will be conducted. A member of the hospital’s GCTC should be involved in the selection process.
2. The hospital will conduct interviews and select the preferred candidate for the DPET role.
3. The Director of Medical Services (DMS) or equivalent will send formal correspondence to the Program Coordinator or Program Support Officer (Allocation) recommending the preferred candidate to the DPET role for submission to the PvTC for approval. The correspondence must include:
   a. An outline of why the preferred candidate has been recommended for the DPET position.
   b. The Full Time Equivalent (FTE) hours the DPET will be allocated to perform the role and the FTE hours spent in the clinical role at the hospital.
   c. The correspondence must be accompanied by a current curriculum vitae of the preferred candidate which clearly addresses the selection criteria outlined in the position description.

The PvTC will review the DPET application at the scheduled meeting. The PvTC will approve the application for the preferred candidate to be appointed as the DPET at the hospital.
POSITION DESCRIPTION:

TERM SUPERVISOR

NAME OF HOSPITAL
To be completed by employing hospital

REPORTS TO
Director of Medical Services (DMS)

MISSION OF THE HOSPITAL
(2–3 sentences to be completed by employing hospital)

ROLE OF TERM SUPERVISOR IN ACHIEVING THE HOSPITAL MISSION
(2–3 sentences to be completed by employing hospital)

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

KEY RELATIONSHIPS

• Prevocational trainees
• Medical staff in the department
• Director of Prevocational Education and Training
• JMO Managers
• Chair of the General Clinical Training Committee.

KEY ROLES AND RESPONSIBILITIES

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

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

- Prepares and reviews the term description in consultation with other attending medical officers in the team, the Director of Prevocational Education and Training, Junior Medical Officer Management and prevocational trainees. The term description describes the responsibilities and accountabilities of the prevocational trainee, specifies the skills required by the prevocational trainee to function safely and defines the specific knowledge and skills to be gained or enhanced during the term.

- Discusses training goals and expectations with the trainee at the beginning of term and ensures that a clinical orientation to the term is provided.

- Develops the educational program available to trainees during the term, supports attendance by prevocational trainees at educational events and provides effective practice-based teaching.

- Monitors the progress of prevocational trainees and provides continuous constructive feedback to guide their professional development.

- Encourages attending medical officers to provide continuous teaching, supervision and constructive feedback to prevocational trainees.

- Provides formal documented assessment at mid-term and the end of term. These two formal assessments begin with the trainee’s self-assessment and are developed in consultation with attending medical officers, registrars, nurses and other professional staff. Assessment includes planning and documenting actions to improve trainee performance.

- Intervenes when necessary to correct gaps or weaknesses in the knowledge or skills of prevocational trainees.

- Informs the Director of Prevocational Training if a prevocational trainee appears to be experiencing difficulty with work or the training program.

SKILLS, KNOWLEDGE, EXPERIENCE 
COMPETENCIES AND BEHAVIOURS

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

Term Supervisors must have:

- an understanding of the concepts of adult education, performance monitoring and quality improvement, and

- excellent interpersonal skills.

PERFORMANCE EVALUATION

The performance of the Term Supervisor will be evaluated annually by the General Clinical Training Committee (GCTC).

VERIFICATION

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

Position Holder
Signature
Date

Manager
Signature
Date
GLOSSARY OF TERMS

PGY1 TRAINEE

A PGY1 may be called:
• PGY1 – Post Graduate Year 1
• Intern
• Trainee (Generic to both years)
• Prevocational trainee (Generic to both years)
• Junior doctor (Generic to both years)
• PT – Prevocational trainee (Generic to both years)
• PVT – Prevocational trainee (Generic to both years)
• JMO – Junior medical officer (Generic to both years)

PGY2 TRAINEE

A PGY2 may be called:
• PGY2 – Post Graduate Year 2
• RMO – Resident Medical Officer
• Resident
• Trainee (Generic to both years)
• Prevocational trainee (Generic to both years)
• Junior doctor (Generic to both years)
• PT – Prevocational trainee (Generic to both years)
• PVT – Prevocational trainee (Generic to both years)
• JMO – Junior medical officer (Generic to both years)

JMO MANAGER

The JMO Manager role can range from managing a small cohort of junior doctors in a rural hospital, (often in addition to a number of other responsibilities), through to having responsibility for the entire junior medical workforce across a large prevocational Network.

DPET

Directors of Prevocational Education and Training (DPET) are responsible for providing medical leadership and oversight of the prevocational training period in the facility in which they work. In fulfilling this role, the DPET is responsible for the education, training, supervision and welfare of junior doctors during the first two years of medical practice.