



FIRST EDITION | HETI RESOURCE

The JMO Manager's Guide

to managing and supporting
prevocational trainees

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prevocational trainees

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Foreword

HETI's mission is to provide a central source of leadership and coordination in the area of clinical education and training to ensure all health professionals have the necessary skills and knowledge to deliver high quality and safe patient care to the people of NSW. This mission is a pretty good description of the work done by JMO Managers.

The role of a JMO Manager is to be a central source of leadership and coordination of the education and training of JMOs, and to work to ensure that JMOs have the necessary skills and knowledge to deliver high quality and safe patient care.

I trust this guide will provide JMO Managers with the information and resources needed to guide the development of JMOs as they hone their skills and knowledge.

The NSW Health "Health Professionals Workforce Plan 2012 – 2022" states that meeting the challenges of providing health services will require the managers and leaders of health professionals to be skilled and competent in the management of services, people and resources. The JMO Manager's Guide provides a resource to empower the development of the next generation of health professionals.

It gives me great pleasure to introduce this guide that supports the JMO Managers who play such a crucial role in supporting junior doctors. Every decision and every person in the NSW Health system must be focused on patients and ways to improve their access to quality health care. To do this requires a culture and working environment in the health system where health professionals are respected, supported and can spend more time caring for patients. This guide provides JMO Managers with the principles to create this culture and working environment.

I understand that JMO Managers often have greater responsibilities than just prevocational trainees. To that extent, I see this guide as a living document that will be added to and updated from time to time.

I hope the JMO Manager's Guide will make the very important work of managing JMOs imminently achievable.

Heather Gray
HETI Chief Executive

As Chair of the NSW Statewide JMO Manager's Forum, I am very pleased to introduce this guide. I welcome the support that HETI and HWA have made towards the development of a resource to support the crucial role that JMO Managers play in the NSW Health system.

The guide will be a great resource for JMO Managers whether they have just taken on the role, or have been supporting junior doctors for many years.

I know that JMO Managers take great pride in their work, and get a great deal of satisfaction from seeing medical graduates hesitantly entering their internship transform into confident and professional clinicians during their two years of prevocational training.

An effective JMO Manager can have a significant impact on the ability of a hospital to attract and retain junior doctors. This guide should help all JMO Managers make this vital contribution to their hospital.

Jan Worsley
Chair, Statewide JMO Managers Forum

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PART 1

JMO management

“Approachable, flexible and genuinely interested in the welfare of her flock of JMOs, she has always been willing to try to accommodate leave requests, term preferences and offer advice on other work life problems. Seemingly unflappable, extremely well connected and immensely efficient, she also always had time for a chat and has generally been a fantastic support for all of us trying to survive the early years of employment.”

Adapted from a nomination for JMO Manager of the Year 2012

The JMO Manager role at a glance

Ask any experienced JMO Manager what they do and they will generally reply “everything”. This response reflects both the diversity of the role and responsibilities and the context and location of the facility or Network within which JMO Managers work.

It also reflects that many JMO Managers bring to the role a deep commitment to making a difference to the working lives of junior doctors. “Everything” in this context might sometimes be translated as “whatever it takes”. Junior doctors recognise and value this commitment and express it in a myriad of ways.

JMO Managers with this approach are an integral part of and asset to the healthcare team – they are after all, looking after the doctors who look after the patients.

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 metropolitan Network.

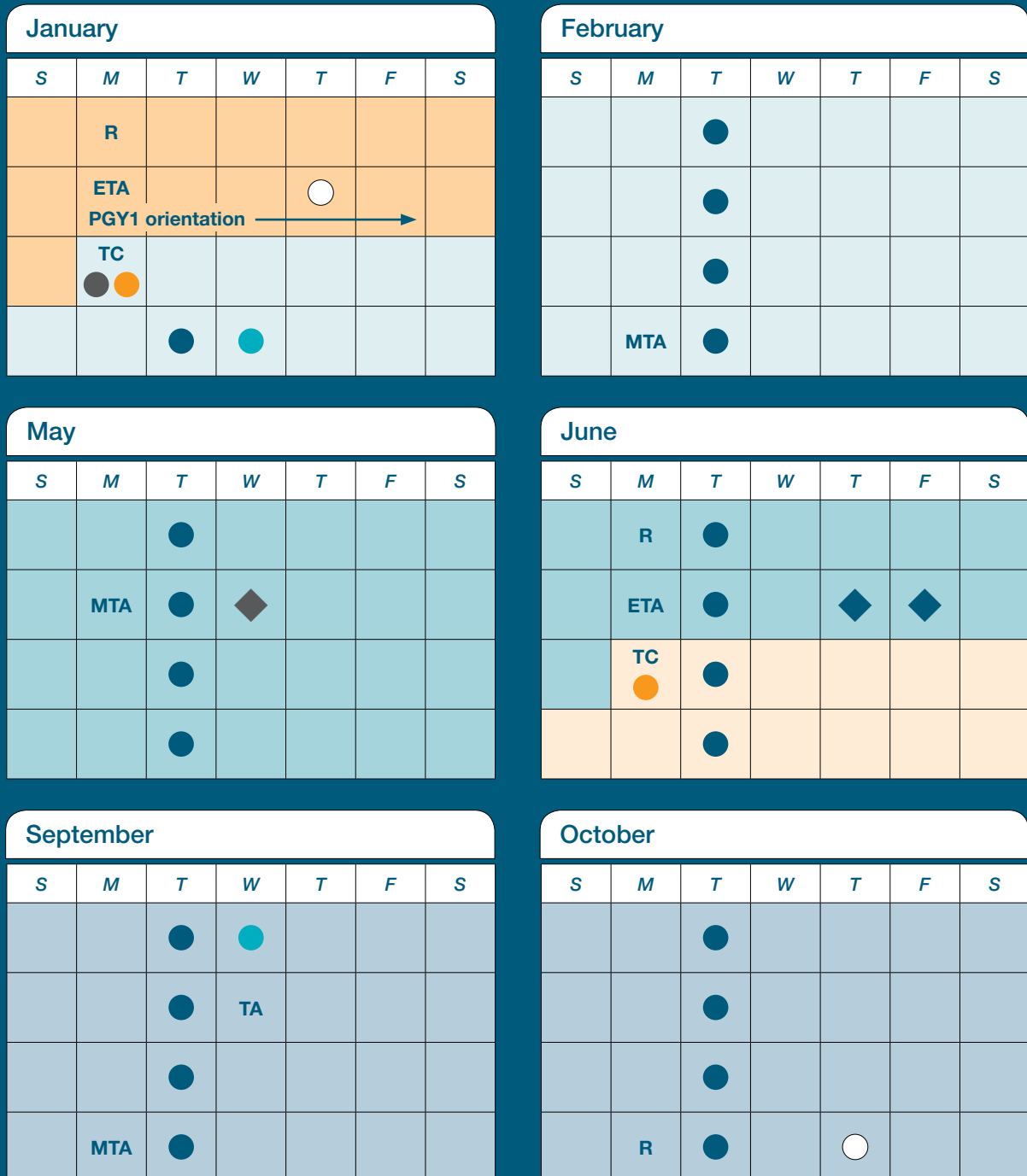
Whilst this guide has a focus on prevocational trainees, it also acknowledges that most JMO Managers are responsible for a much broader cohort of junior doctors – many of the principles and resources contained within it are also applicable to these other medical staff.

The variation in roles and responsibilities may also depend on the other support structures and staffing arrangements within the facility or network. So although not all JMO Managers will be responsible for *all* of the following, roles and responsibilities may include:

- Oversight of junior medical workforce in a hospital, facility or network
- Recruitment of junior medical staff
- Orientation – commencement of year, mid year and change of rotations
- Term allocations
- Rostering
- Leave management
- Human resource functions related to payroll (liaison with HealthShare)
- Performance management, including support of trainees in difficulty
- Organisation of the prevocational trainee education program
- Preparation and support of accreditation processes (HETI and College)
- Managing grievances and complaints involving junior doctors
- Liaison with external organisations in relation to junior medical staff, on behalf of the facility (HETI, Colleges, Medical Board of Australia).



The JMO Manager year at a glance (example only)

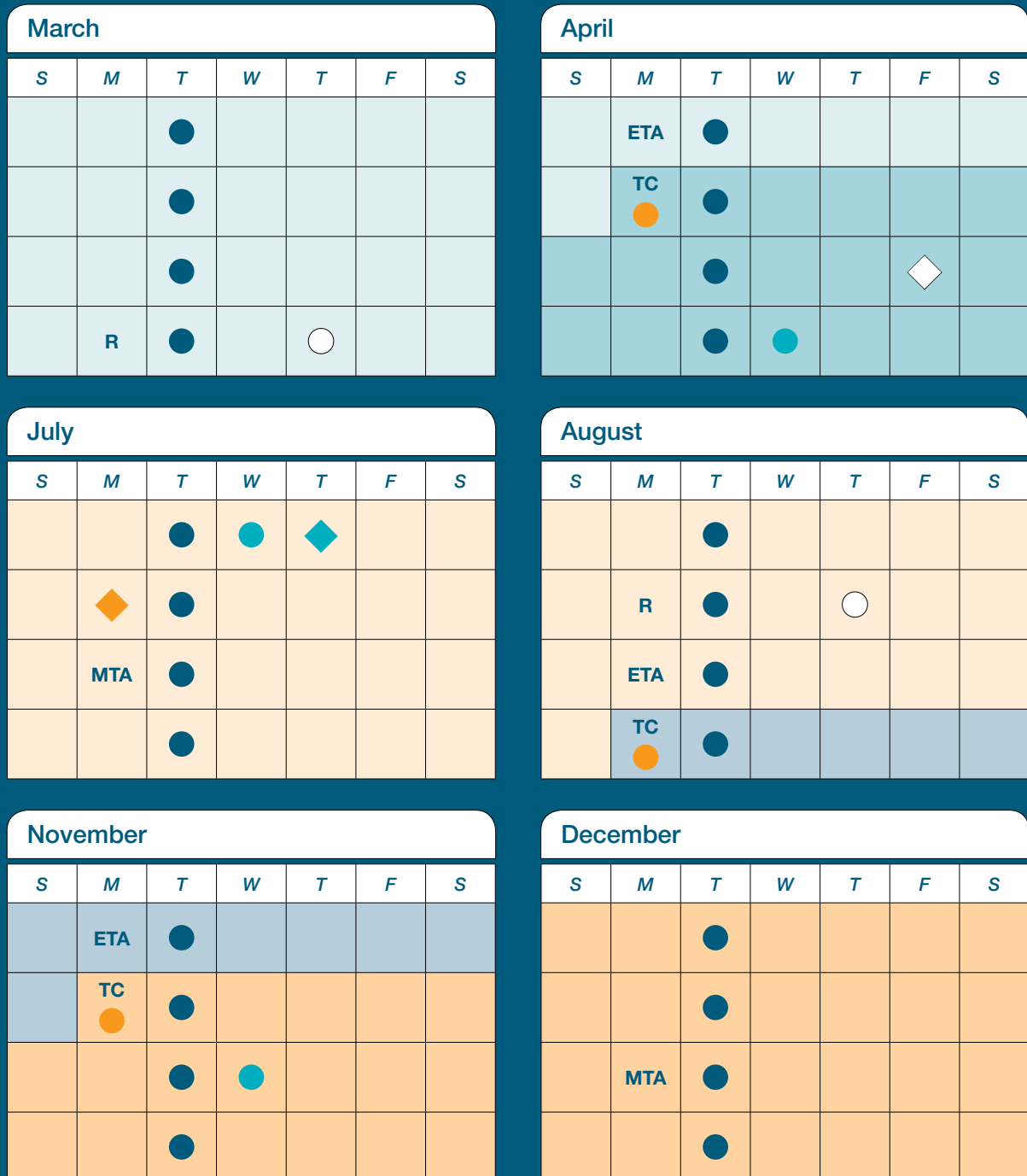


KEY

	Term 1
	Term 2
	Term 3
	Term 4
	Term 5

TC	Term changeover (see also supporting effective clinical handover) (page 35)
MTA	Mid term appraisal due (page 15)
ETA	End of term assessment due (page 15)
R	Rosters sent out for following term (page 32)
TA	Term allocations for following year (page 30)
PGY1	Postgraduate year one orientation (page 17)

This diagram provides an example of the JMO Manager's year, highlighting topics which are covered in the Guide. The dates and features are indicative only and are based on a five term prevocational training year.



- Commencement of the clinical year
- PGY2+ Orientation (page 17)
- General Clinical Training Committee (GCTC) meeting (page 46)
- Formal Education Program (page 19)
- Network Committee for Prevocational Training (NCPT) meeting (page 46)
- ◆ Annual recruitment cycle commences (page 37)
- ◆ Prevocational trainee forum (HETI) (page 47)
- ◇ Pre-survey evidence due (page 42)
- ◆ HETI accreditation survey visit (periodic) (page 44)
- ◆ Medical graduate recruitment (page 39)

Prevocational training

To the new JMO Manager unfamiliar with the medical training continuum, the structures, requirements and associated terminology can appear very complex and at times, confusing. This section focuses on the prevocational training period. A later section provides some information on deciphering all the acronyms.

Prevocational training refers to the two-year period immediately following medical school undertaken prior to a doctor entering specialist (vocational) training. During the first year, postgraduate year one (PGY1) doctors (also known as interns) are provisionally registered with the Medical Board of Australia (MBA) and are only permitted to work in accredited training facilities, during which they complete a number of rotations or terms.

At the end of the successful completion of 12 months of training, or internship, the year one prevocational trainee is recommended to the Medical Board of Australia for general registration.

Prevocational trainees in their second postgraduate year are also required to work in clinical training terms accredited by HETI for prevocational training. The completion of a two-year generalist prevocational training program, guided by the Australian Curriculum Framework for Junior Doctors (ACF), provides each medical graduate the appropriate clinical experience during which knowledge, skills and professional behaviours fundamental to safe medical practice are consolidated.

Whilst many PGY2 doctors enter vocational training programs at the commencement of the PGY3 year, others may complete further generalist years, undertake academic studies or research prior to entering a vocational training program.

The essential elements of the prevocational training program are:

- **Patient safety** – the program creates a supervised environment in which prevocational trainees are able to make the transition from medical student to medical practice in ways that are safe for patients.
- **Learning by doing** – the majority of learning during the prevocational training period is by doing – the apprenticeship model is central to this and supplemented by a range of formal educational activities.
- **Trainee welfare** – the program ensures through appropriate structures that prevocational trainees are safe and supported in their work. JMO Managers have a central role with regards to this.
- **Learning culture** – the program promotes the values of self-directed lifelong learning by all of its participants – both supervisors and trainees – thereby promoting and contributing to the learning culture of the health care system.

PART TWO

Medical education and training

Governance arrangements

The governance arrangements involved in medical education and training within Australia can seem quite complex, with multiple organisations and structures involved. This section provides a brief overview, with a focus on the prevocational training period.

Training for medical practice is a lengthy process, commencing with a university based degree of between four and six years. Many medical degree programs are now undertaken on a postgraduate basis, with applicants having completed a basic degree prior to entering a medical program.

Most graduates from Australian medical schools graduate with a Bachelor of Medicine Bachelor of Surgery (MBBS), although there is variation (BMed for example). Despite the variation in the name of the actual degree awarded, all medical school programs within Australia must comply with the standards set by the Australian Medical Council (AMC), who are responsible for accrediting medical schools.

The purpose of the AMC accreditation is to ensure that medical courses produce graduates competent to practice safely and effectively under supervision as interns in Australia and New Zealand, with an appropriate foundation for lifelong learning and for further training in any branch of medicine.¹

Upon completion of the university-based program, medical graduates are eligible for provisional registration with the Medical Board of Australia (MBA). During the year of provisional registration (internship), PGY1 doctors are only permitted to work in terms and facilities accredited through their state based postgraduate medical council. Following the successful completion of the first postgraduate year, prevocational trainees obtain general registration with the MBA and complete



¹ Australian Medical Council. Basic Medical Education Goals and Objectives. Available at: www.amc.org.au Accessed April 2013.

a further prevocational training year. In NSW, HETI has responsibility for setting the standards and accrediting facilities and posts for both years of the prevocational training period.

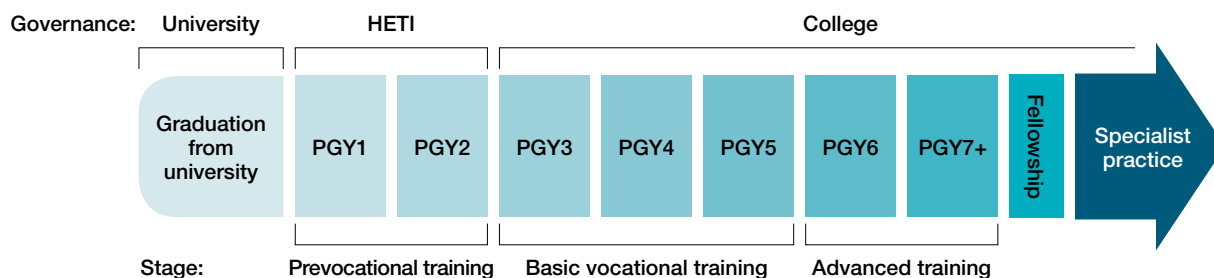
Although all prevocational trainees are employed within the public sector (state or territory health departments), and predominantly work within the public hospital system, they may also complete rotations in accredited terms in other settings, including community health, general practice and more recently, private hospitals. Whilst undertaking a term outside the public hospital setting, the prevocational trainee remains an employee of the feeder hospital or network.

Most junior doctors complete between two and three years in general rotations before entering a vocational training program. Vocational or specialty training generally takes between three and six years.

Medical Colleges are responsible for specialty training, both setting the curriculum, training program and examination requirements for candidates, in addition to oversight of continuing professional development of College fellows.

In addition to accrediting university based medical schools, the AMC also has responsibility for accreditation of providers of specialist medical training and their specialty training programs that lead to qualifications for practice in recognised medical specialties. The AMC has also recently been asked by the MBA to drive a national framework for intern training accreditation and it is very likely that the AMC will accredit postgraduate medical councils from 2014. In NSW, in addition to many other responsibilities, HETI performs the functions of a postgraduate medical council as it relates to the prevocational training. Further information on the AMC can be found at the AMC website listed at the end of this section.

Training pathways at a glance



Medical Training Continuum – Overview of training pathways. This is indicative only – training pathways can vary from specialty to specialty. For information about specific training programs, refer to the relevant College website.

How junior doctors learn

JMO Managers with previous experience of other public sector professional or employment groups will notice some important differences with respect to prevocational trainees, some of which have implications for the way in which junior doctors work and are employed.

In the first instance, prevocational trainees are just that – trainees. Although there have been some significant changes to the medical training paradigm in recent years, medical training during the prevocational period is still largely predicated on the apprenticeship model.

Junior doctors learn by doing. So whilst some of their training will be supplemented by formal educational activities (see later section on the formal education program) much of what a junior doctor learns will be on the basis of the clinical exposure they get whilst caring for patients, during their rotations, under the supervision of consultant medical staff and other doctors. Junior doctors in their first year of training must complete core terms as required by the MBA. Further information about core term requirements is included in a later section.



Prevocational year one trainees are provisionally registered with the MBA and having graduated from medical school, have the basic knowledge and skills to work as junior doctors. However there is a clear expectation that during the course of the prevocational training period they will develop and consolidate the knowledge, skills and behaviours required of medical practitioners, gradually moving toward more independent medical practice.

This has important implications for the way in which junior doctors work and are assessed. Implicit in this is the expectation that prevocational trainees at the completion of the PGY1 year will be quite different in terms of knowledge and skills acquisition compared to interns at the commencement of the year. The buffer for this variation in practice across the year is an appropriate level of supervision.

Terms are accredited on the basis of the skill mix of the medical workforce and levels of supervision available to support junior doctors throughout this period. As the year progresses, the prevocational trainee will gain clinical experience and require progressively less direct supervision. It is also understood that it will be many years of medical practice before a doctor is ready to practice completely independently.

It should also be noted that junior doctors are engaged by the public hospital system on the basis of temporary contracts whilst they complete their prevocational and vocational training. This has implications not just for recruitment (covered in a later section) but also means that the junior doctor workforce as a whole can be quite mobile, with large cohorts changing hospitals and locations as they access the various terms required of their chosen vocational training program.

Sometimes the interface between trainee education and employee service commitments can become a point of tension. Experienced JMO managers will work with junior doctors to create a positive training environment, but one that places the delivery of safe patient care at the centre.

A learning model for prevocational medical education and training

Supervised clinical work

- Clinician-led patient interactions
- Opportunistic learning
- Situational learning
- Experiential learning
- Observation and feedback

Curriculum

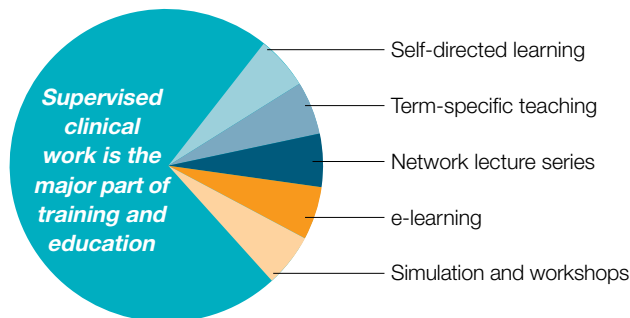
- Framework: ACFJD
- Term objectives described in term description
- Individual trainee objectives (trainee journal or learning plan)

Trainee assessment

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

Program evaluation

- Trainee term evaluation forms
- Monitoring of trainee outcomes



e-learning

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

Curriculum

- Framework: ACFJD
- See also JMO Forum recommendations

Trainee assessment

- Online record of participation and results

Program evaluation

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

Term-specific teaching

- Lectures, journal club, M&M etc.
- Trainee presentations

Curriculum

- Framework: ACFJD
- Term objectives described in term description

Trainee assessment

- Participation records
- Assessment of trainee presentations by supervisors and peers

Program evaluation

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

Simulation and workshops

- Network-coordinated
- ALS, DETECT and core skills

Curriculum

- Framework: ACFJD

Trainee assessment

- Trainee observation by educators
- Self-assessment

Program evaluation

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

Network lecture series

- Network-coordinated, facility-based lectures

Curriculum

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

Trainee assessment

- Participation records

Program evaluation

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

Self-directed learning

- Individual responsibility in a supportive environment

Curriculum

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

Trainee assessment

- Self-assessment
- Observation by DPET

Program evaluation

- Observation by DPET
- Evidence of self-directed learning: e.g. journal

Core term requirements

The Medical Board of Australia requires that interns undertake a twelve month period of general clinical experience providing opportunities for the newly qualified medical graduate to apply, consolidate and expand clinical knowledge and skills while taking increasing responsibility for safe high quality patient care.

The general clinical experience is achieved by completing a series of supervised rotations. Under the terms of the provisional registration with the MBA, prevocational trainees are required to undertake the following terms during the intern period:

- At least 10 weeks in a term that provides experience in medicine
- At least 10 weeks in a term that provides experience in surgery
- At least 8 weeks in a term that provides experience in emergency medical care
- Other rotations that provide opportunities for wide clinical experience in hospital, general practice and community settings.

All Networks must have adequate numbers of emergency, surgical and medical terms accredited for PGY1 trainees to cover the actual number of PGY1 trainees allocated to the Network.

The specific requirements for core terms are reflected in the accreditation standards and associated policies. Follow the link listed under resources at the end of the section on accreditation for more information.

Assessment processes

During the first two years, term supervisors assess prevocational trainees with regards to performance under three domains of the Australian Curriculum Framework for Junior Doctors² – clinical management, communication and professionalism. JMO Managers are frequently involved in setting up the administrative processes underpinning assessment of prevocational trainees, in addition to monitoring the performance and progression of trainees.

This section provides an overview of prevocational trainee assessment processes to assist in fulfilling these responsibilities.

The purposes of assessment are as follows:

- Assessment should provide trainees with feedback about their performance that will help their development as doctors. This is the **formative assessment** purpose and with respect to the mid-term assessment is referred to as appraisal. Appraisal should help trainees identify their strengths and weaknesses, and give them ideas about how to improve.
- Assessment should provide evidence that trainees are achieving the competencies required for their future responsibilities as doctors. This is a **summative assessment** process and provides evidence for certification and registration. A good assessment system should assure the community that doctors are meeting certain standards of practice and competence before advancing to higher levels of responsibility.
- Assessment should **identify underperforming trainees** so that appropriate remedial action can be taken early. In some cases this may involve the provision of additional supervision or support activities. In more serious cases of underperformance, the trainee is prevented from advancing to the next stage of training before remediation. This is the safety purpose, protecting both patients and trainees.

In the case of PGY1 trainees, the satisfactory completion of rotations during internship is the basis on which the hospital, (usually through the DPET and DMS) provide a recommendation to the MBA for progression from provisional to general registration. The progress review forms therefore provide documentation of this.

² Australian Curriculum Framework for Junior Doctors available at <http://curriculum.cpmech.org.au>.



Term supervisors should meet with prevocational trainees at the commencement of the rotation to provide an orientation to the term in addition to discussing the appraisal and assessment processes. Term supervisors should meet with trainees in about week 5 to discuss the mid-term appraisal and then at the end of term, to complete the end of term assessment. Further information regarding the nature of the assessment process can be found in the Superguide and the DPET guide.

JMO Managers who are responsible for the administrative processes supporting the assessment of prevocational trainees will likely have systems in place that ensure that trainees are provided with the forms in a timely manner in addition to being able to collate and monitor forms as they are returned.

Tips from JMO Managers on supporting assessment processes

- Group email to prevocational trainees to remind them re requirements for MTA and ETA
- Group email to term supervisors to remind them re requirements for MTA and ETA (sent by DPET)
- Remind PGY1s that they need signed forms to be submitted for recommendation for general registration with MBA
- Encourage PGY2s to get forms signed as useful for future College requirements and recognition for prior learning (RPL)
- Encourage prevocational trainees to make an appointment with TS well beforehand to discuss MTA and ETA
- Encourage PVTs to keep their own copy of signed assessment form.

Orientation program

Just as with other employees, all prevocational trainees should receive an appropriate orientation: (1) to the facility or network within which they work at the commencement of employment, and (2) to the specific unit or rotation at the commencement of each term.

These requirements are reinforced through the provisions of the accreditation standards. JMO Managers are likely to be very involved in both organising and participating in the orientation program for junior doctors at the commencement of the clinical year. This also extends to managing rosters and term changeover to optimise attendance.

The prevocational year one orientation program, held just prior to the formal commencement of the clinical year, is a major undertaking for any facility or network. The orientation program covers a range of topics that are aimed at assisting the prevocational trainees transition to working as a junior doctor. Most programs cover the following four themes³:

- **General information** about the hospital/facility/Network/LHD as it relates to all employees. This includes mandatory training, important general policies and procedures, human resource matters, IT systems, and usually a tour of the hospital.
- **Specific information related to role as a junior doctor.** This might include roles and responsibilities of junior doctors, important clinical policies and procedures, multidisciplinary care, diagnostic test ordering, education and training as a junior doctor, assessment procedures, medicolegal matters and so on.
- **Clinical and procedural skills training and verification.** All orientation programs incorporate some practical training sessions, sometimes with additional skills verification activities, covering topics such as basic and advanced life support, venipuncture, cannulation, scrubbing and safe prescribing.
- **Ward attachment with outgoing junior doctor.** Incoming prevocational trainees are attached to the outgoing junior doctor on the term that they are rotated to for term 1. This provides an opportunity for an effective clinical handover in addition to a more extended term orientation.

The orientation period will provide you with the opportunity to meet prevocational trainees attached to your Network. Those JMO Managers from smaller facilities relying on the larger facility to host the program should attend relevant sessions of the orientation week.

Half-day facility orientation program

In addition to the main orientation program held at the commencement of the clinical year, most facilities (particularly the outer metropolitan and rural sites which do not host the extended orientation program) hold a half-day orientation at the commencement of each term. This orientation program should supplement the main orientation provided to year one prevocational trainees and delivers information specific to the facility, highlighting local policies and procedures, access to IT systems, diagnostics (particularly after hours) and clinical services. It should also include a tour of the hospital.

Many JMO Managers will also be involved in organising the orientation program attended by postgraduate year twos and beyond new to the hospital. This program usually supplements the general staff orientation program and provides information required by junior doctors at all grades to fulfill their responsibilities.

3 Burnand, J (Ed). *Becoming a Doctor: surviving and thriving in the early postgraduate years*. Sydney, Elsevier 2007.

Term orientation

Term orientation is an important component of the prevocational training program. It is the responsibility of the term supervisor to provide an orientation to the term for prevocational trainees. Whilst junior doctors appreciate the participation of senior doctors, and particularly the term supervisor in term orientation, registrars, nursing staff and allied health staff, might deliver some aspects of the orientation. This also provides an opportunity for the prevocational trainee to get to know and be inducted by members of the team that they will closely work with for the duration of the rotation.

JMO Managers, working with the DPET and others, may be involved in implementing systems and processes that support effective term orientation. These include:

- Ensuring that there is a term description for every prevocational term with current information reviewed by the term supervisor on a regular basis and made available to the prevocational trainee prior to the commencement of term.
- Having systems in place that remind term supervisors and other clinical staff of term changeover dates and the requirement for term orientation.
- Reviewing rosters covering the term changeover period in order to optimise term orientation and effective clinical handover (refer to later section for further information).

Resources

ROVER Form (JMO Rolling Term Handover Form)

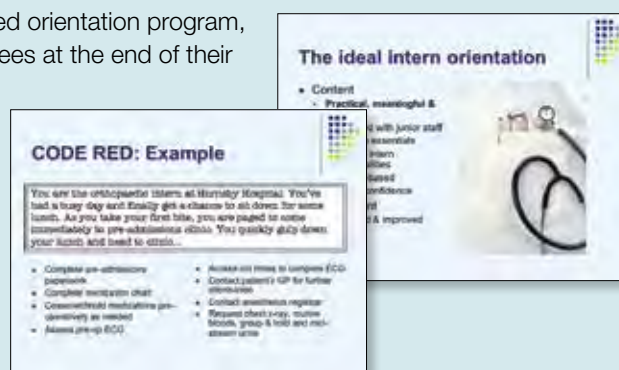
- A few years ago, some prevocational trainees developed a resource to assist their colleagues with term orientation.
- The ROVER Form is a template for collecting information about the specific practical day-to-day responsibilities involved in a particular rotation.
- It is designed to supplement information provided in the term description and the orientation by the term supervisor.

See templates at the back of this Guide.

Some JMO Managers and DPETs have led very innovative approaches to orientation, in addition to other prevocational training activities.

For example, one hospital developed a peer led orientation program, called Code Red, whereby prevocational trainees at the end of their first year provide much of the orientation to incoming trainees.

Each year, the prevocational training forum, hosted by HETI, provides those working with prevocational trainees opportunities to showcase innovative approaches.



Formal education program

Whilst the focus of prevocational training is *learning by doing*, the formal education program supplements unit based activities and ensures that all prevocational trainees have an opportunity to cover important clinical topics, pitched at their level. The unified lecture series was developed a couple of years ago by the JMO forum based upon the ACF and provides a schedule of teaching sessions that ensure topics will not be missed by JMOs as they rotate through the Network.

The development of the formal education program is one of the flagships of a prevocational training site. Whilst the DPET will ultimately be responsible for the formal education program, as the JMO Manager you will undoubtedly have a role in providing support to its development and implementation. The topics, underpinned by the ACF, are ordered in such a way as to ensure that common clinical problems are dealt with during the first part of the year.

As the JMO Manager, you will also have a critical role in encouraging and supporting attendance.

Expecting and encouraging prevocational trainees to attend formal education sessions provides an important lesson in exposing them to the discipline of setting aside time in the context of clinical demands for their own professional development and learning – this is a lesson in life long learning.

Of course, rostering practices will underpin this.

In addition to the obvious educational benefits, the formal education program also offers an opportunity for prevocational trainees to come together as a group away from the clinical environment. This can foster an esprit des corp amongst the group.

As well it will provide you with an opportunity to informally catch up with them on a regular basis, even if you are only able to attend for a few minutes at the beginning of the session or during the break.

As the JMO Manager you can use this as an opportunity to make important announcements, provide reminders of significant events and so on. It should be noted though, that this is quarantined time for *medical education* activities and therefore the time should not be used for non-clinical topics.

Unified lecture series topics

TERM 1	<ul style="list-style-type: none"> • ACLS • Chest pain and acute coronary syndrome • Assessing shortness of breath • Assessing syncope and loss of consciousness • Management of diabetes • Fluid and electrolyte management • Assessing abdominal pain • Assessing and managing delirium • The deteriorating patient • Management of blood pressure.
TERM 2	<ul style="list-style-type: none"> • Analgesia and pain management • Interpreting chest and abdominal x-rays • Gastrointestinal bleeding • ECG interpretation and management of arrhythmias • Perioperative assessment and management • Antibiotics and their use • Pathology tests: ordering and interpretation • The hard stuff: death certification, breaking bad news, communicating with difficult patients and families.
TERM 3	<ul style="list-style-type: none"> • Pleural and ascetic taps and drains: the when, why and how • Geriatric medicine • Recognition of a sick child • Introduction to trauma • Anticoagulants and their use • Looking after the JMO • Psychiatry 101: depression, anxiety and Mental Health Act • Medicolegal issues: privacy, confidentiality, informed consent and open disclosure.
TERM 4	<ul style="list-style-type: none"> • Introduction to ENT medicine • Fundamental orthopaedics • Intracerebral events • Psychiatry 102: the psychotic patient, drug overdose and withdrawal syndromes • Basic anaesthesiology • O & G emergencies • Introduction to ophthalmology • Wounds, dressings and suturing.
TERM 5	<ul style="list-style-type: none"> • Vascular surgery • Urology • Introduction to oxygen delivery systems and intensive care medicine • Oncology and palliative care • Advance lines • Radiology essentials • Neonatal and paediatric resuscitation.

You may also be involved in setting up systems to evaluate the formal education program, often with the assistance of the DPET. This is usually achieved through the distribution of evaluation forms at the conclusion of each formal education session asking prevocational trainees to evaluate that session in terms of relevance of content and delivery. The information contained in these forms is then collated and provided to the GCTC. An example of an evaluation form for the education sessions may be found in the DPET Guide.

Australian Curriculum Framework for Junior Doctors (ACF)

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

The ACF is built around three learning areas: clinical management, communication and professionalism. These areas are subdivided into categories, each of which is further subdivided into learning topics. Within each learning topic, the ACF describes the workplace performance outcomes that prevocational trainees are expected to acquire.

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





It includes a list of specific skills and procedures that prevocational trainees should learn over the two years of training in addition to a list of common problems and conditions they should learn to manage and assess.

The ACF is not just about knowledge acquisition, it is also about the application of knowledge, skills and behaviours within the workplace. This is about learning for performance (as opposed to simply demonstrating competence) and then demonstrating that performance consistently within the workplace.

The ACF can be used in a number of ways, including the following:

- To provide a guide to appropriate goals for each training term
- To review learning opportunities offered by existing training terms and to identify gaps in training
- To plan development of new training terms
- As a starting point for discussions about innovative approaches to clinical teaching and development
- To structure mid-term appraisal and end-term assessment.

Deciphering all those acronyms

ACF or ACFJD	Australian Curriculum Framework for Junior Doctors
AMC	Australian Medical Council
AHPRA	Australian Health Practitioners Regulation Agency
CPMEC	Confederation of Postgraduate Medical Education Councils
DPET	Director of Prevocational Education and Training
EDMS	Executive Director of Medical Services (also DMS – Director of Medical Services)
GCTC	General Clinical Training Committee
HETI	Health Education and Training Institute
IMG	International Medical Graduate
JMO	Junior Medical Officer
LHD	Local Health District
MBA	Medical Board of Australia
MEO	Medical Education Officer
MoH	Ministry of Health
NCPT	Network Committee for Prevocational Training
PGY	Postgraduate year (number denotes years since graduation, assuming engagement in full time clinical practice)
PMC	Postgraduate Medical Councils – bodies across Australia that oversight prevocational medical education and training – in NSW, this is undertaken by the Medical Portfolio of HETI
PAC	Prevocational Accreditation Committee (HETI)
PRF	Progress Review Form – the form used for assessment of prevocational trainees which is completed by term supervisors
PvTC	Prevocational Training Council (HETI)

Resources



The DPET Guide a handbook for Directors of Prevocational Education and Training
(see HETI website)



The Superguide – a handbook for supervising doctors in training
(see HETI website)

Australian Medical Council
<http://www.amc.org.au>

Australian Curriculum Framework for Junior Doctors
<http://curriculum.cpmecc.org.au>

PART THREE

Managing junior doctors

Working with doctors

As a JMO Manager, many of your professional interactions are likely to be with doctors. Whilst you will obviously have regular contact with junior doctors, you will also likely have frequent contact with senior doctors, including the DMS, the DPET and Term Supervisors. Effective JMO Managers work to establish collaborative relationships when working with doctors and appreciate that sometimes doctors and managers may have different perspectives.

Despite an increasing recognition on the importance of team work within the healthcare setting, medical training at the university level largely teaches doctors to be individualistic, with a focus on the doctor having primary responsibility for patient care. Whilst junior doctors will be very closely supervised during the prevocational training period, postgraduate medical training, particularly vocational training is concentrated on doctors taking increasing responsibility for clinical care under gradually decreasing levels of supervision.



Medical training can also be a highly competitive and at times a stressful enterprise. Junior doctors are on a very steep learning curve, particularly in the immediate postgraduate period. They must adapt to working in increasingly complex healthcare environments whilst frequently changing rotations. With every change of term they must adapt to working with a new team (not just their medical supervisors but also with respect to the other healthcare team members – nursing, allied health and ward administrative staff).

Postgraduate medical training is a very significant undertaking involving a high level of commitment, long hours of study, the ability to successfully pass a number of barrier exams, all whilst working (usually) full time. Rotations provide opportunities for junior doctors to experience different clinical specialties, get to know the senior doctors in those specialties and make important decisions regarding their future specialty or career pathway. As a result, junior doctors, even during the prevocational training period, can be very focused upon working toward their particular training goal or specialty. This can sometimes become a point of tension as training needs are from time to time prioritized over other work obligations.

Effective JMO Managers who recognise these different perspectives and work to establish cooperative and supportive relationships with prevocational trainees are able to have a significant impact upon the way in which doctors interact within the organisation.

Welfare and support

The prevocational trainee period represents a significant touchpoint in the medical career, as they make the transition from medical student to medical practitioner. Whilst most prevocational trainees enjoy the challenge, many also report that at times it can be stressful⁴.

The reasons for this can be numerous but include:

- Loss of a structured learning environment coupled with increased demands on knowledge and performance
- Longer hours
- New responsibilities and confrontations with life and death experiences
- Unprecedented levels of administrative duties that may conflict with the trainee's self-image as a professional clinician
- Frequent changes in work environment, patients, team partners and bosses.⁵

Given the regular contact that they have with prevocational trainees, JMO Managers are well positioned to provide support to them. This can be a fundamental component to the role and one that many JMO managers report as being the source, when done well, of considerable professional satisfaction. Implicit in this is a supportive but firm approach in managing prevocational trainees.

The way in which JMO Managers work with trainees can have a major impact on the morale of the junior doctor group. This might range from having an open door policy, promoting a culture of cooperative working relationships, a can do attitude and a positive approach to resolving issues. This approach is highly valued by junior doctors.

The fact that the JMO Manager sits somewhat to the side of the medical hierarchy means that many junior doctors may be more willing to confide in the JMO Manager (rather than a more senior doctor) about their concerns and anxieties.

JMO Managers are often very adept at picking up those junior doctors who may be struggling and may be involved in managing trainees in difficulty, often with the support and assistance of others (refer to later section for more information). Some resources and references that JMO Managers may find useful are included at the end of the section.

Performance management

JMO Managers are often responsible for first line management of performance issues involving prevocational trainees, sometimes in collaboration with clinical unit heads. This can include ensuring that prevocational trainees meet their obligations with respect to public sector employment policies and related human resource matters, such as turning up for work on time, submitting appropriate leave forms, responding to a complaint from a nurse, completing discharge summaries and so on.

JMO Managers will be involved in developing and supporting systems that provide prevocational trainees with regular feedback, both informal and formal about their performance.

All public health organisations have well-established policies and procedures with regards to the performance management of employees and these should be followed. You will undoubtedly seek assistance when required from the DMS, DPET, Clinical Head of Department, HR and a range of others depending on the context of the specific issue.

4 Markwell AI, Wainer Z. The health and wellbeing of junior doctors: insights from a national survey. *Medical Journal of Australia* 2009; 191: 441–444.

5 Health Education and Training Institute. *The Superguide: a handbook on supervising doctors in training*. Sydney: HETI. 2013.

Trainee in difficulty

As the JMO Manager you may often be the first to recognise that a prevocational trainee is experiencing difficulties. Whilst the way in which a prevocational trainee in difficulty may present might vary, all require appropriate support and timely intervention. Generally, the DPET and JMO Manager will be involved at an early stage. This overview is taken from "Trainee in Difficulty" – a management guide for DPETs developed by HETI. Further information about this resource is included at the end of the section.

Many JMO Managers report that dealing with trainees who are experiencing difficulties is one of the most challenging aspects of their work. The reasons for this are numerous and include the following:

- The legal and industrial frameworks are complex and there are multiple public sector policies to consider.
- Those involved must negotiate the interface between the roles of the prevocational doctor as both trainee and employee.
- Working with prevocational trainees experiencing difficulties can be demanding, particularly those who have problematic attitudes and behaviours. Effective communication skills are required.

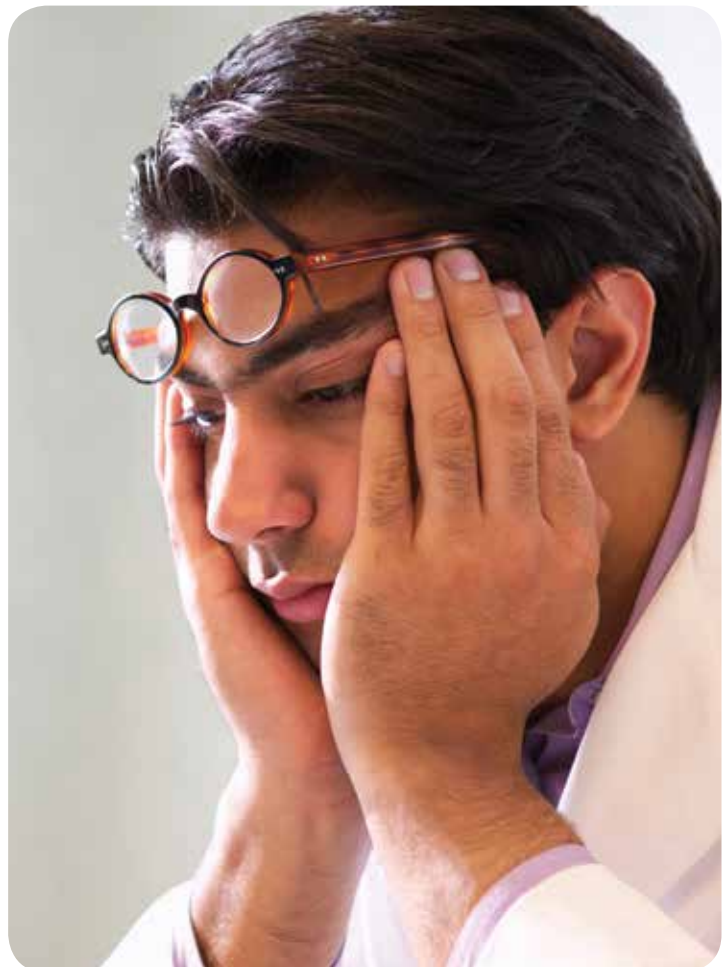
Employers have a legal responsibility to ensure that industrial conditions and legislated requirements pertaining to employment are upheld. This includes responsibility for managing performance and disciplinary matters, and ensuring that performance issues are responded to in a timely, fair and objective way.

Every public health organisation has processes for identifying, investigating, managing and supporting prevocational trainees who are experiencing difficulties. The DPET has a central role in responding to prevocational trainees and they will often involve the JMO Manager. Some situations will additionally require assistance from medical administration or human resources.

Early signs of a trainee in difficulty

- The disappearing act
- Low work rate
- Ward rage
- Rigidity
- Bypass syndrome
- Career problems
- Insight failure.

Adapted from Paice, E. *The role of education and training*. In Cox J, King J, Hutchinson A, Editors. *Understanding doctors' performance*. Oxford: Radcliffe Publishing. 2006.





Key messages

- Most trainees in difficulty can be assisted, over time, to become competent clinicians. A supportive approach, with common sense interventions, coordinated and monitored by the DPET, usually leads to a satisfying result for the trainees and their clinical supervisors.
- “You cannot unknow what you know”— do not accept someone telling you something “off the record.”
- Any risks to patient safety, risk to trainee safety or allegations of criminal conduct require immediate action and referral.
- All prevocational trainees should be encouraged to have their own general practitioner and should seek early advice from their GP in the event of emerging health issues.
- There are other individuals within any healthcare organisation who have particular expertise in dealing with these matters.
- The JMO Manager is often the first to notice that something is amiss. Some trainees experiencing difficulties may be at risk of self-harm and need timely escalation to expert health practitioners such as a general practitioner or mental health clinician. As the JMO Manager, you will need to adopt an attitude of early referral to the DPET or the DMS if you are concerned about a trainee.

3 key principles

1. Patient safety should always be the primary consideration.
2. Prevocational trainees require supervision and support.
3. Prevention, early recognition and early intervention are the preferred approach.

Trainee in difficulty – what are the potential underlying issues? (trainee, supervisor, system)

Work environment	Competence	Psychological issues
<ul style="list-style-type: none"> • Unfamiliar discipline of being a hospital employee, not a student • Junior status: having to respond to the immediate demands of other staff • Frequent transitions to new work environments • Interpersonal conflict within the team • Excessive workload • Inadequate support for medical and administrative tasks • Inadequate supervision and support • Inadequate role definition/orientation • Bullying or harassment • Sexual harassment. 	<ul style="list-style-type: none"> • Deficient knowledge • Poor communication • Poor time management • Poor record-keeping or documentation. 	<ul style="list-style-type: none"> • Heightened stress reaction or burnout • Lack of self confidence • Highly self critical • Perfectionist or obsessive tendencies • Heightened distress over patient death • Detachment, loss of empathy • Poor attitude • Lack of insight • Lack of motivation • Emerging or existent mental illness (anxiety, depression, bipolar disorder, anorexia) • Alcohol or drug abuse • Difficult personality traits.
	Lifestyle issues	
	<ul style="list-style-type: none"> • Ill health • Poor general health • Fatigue • Unhealthy lifestyle – poor nutrition, lack of exercise, lack of relaxation and recreation. 	
	Extrinsic factors	
	<ul style="list-style-type: none"> • Relationship issues • Accommodation and transport difficulties • Pregnancy and parenting • Financial issues • Visas and migration issues • Language and cultural issues. 	

Source: Health Education and Training Institute. *Trainee in difficulty. A management guide for Directors of Prevocational Education and Training*. 2nd edition. Sydney: HETI, 2012.

Trainee in difficulty: management outline

CONCERN EXPRESSED ABOUT A TRAINEE

ASSESS THE SEVERITY

Patient safety?

Trainee safety?

Misconduct?

Preliminary assessment of concern

- Consider potential underlying issues
- Consider need for further investigation.

Speak with the trainee

- Listen and assess
- Consider seeking advice from HR/DMS.

Further investigation

- Note findings
- Consider referral to expert practitioner.

Agree action plan and review date

- Seek agreement of trainee
- Document the action plan.

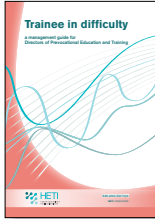
Implement action plan

- Ensure trainee is adequately supported.

Review

- Reach a conclusion: matter resolved or requires ongoing review or referral.

Resources



Trainee in difficulty – a guide for Directors of Prevocational Education and Training

Further reading

- Cox J, King J, Hutchinson A, McAvoy P, editors. *Understanding doctors performance*. Oxford: Radcliffe Publishing, 2006.
- Firth-Cozens J, Morrison LA, Sources of stress and ways of coping in junior house officers, *Stress Medicine* 1989; 5: 121–126.
- Paice E, Rutter H, Wetherell M, et al. Stressful incidents, stress and coping strategies in the pre-registration house officer year. *Medical Education* 2002; 36: 56–65.

Dealing with grievances and complaints

Given their regular contact with prevocational trainees, it is not surprising that JMO Managers report that dealing with grievances and complaints can sometimes occupy a significant proportion of their time. The circumstances and context can vary – from involving an issue of an incorrect pay; interpersonal tensions between a prevocational trainee and another doctor or nurse on the team; through to more complex issues, such as an allegation of bullying.

All public health organisations have clearly documented grievance policies. Managers should be well aware of the relevant organisational grievance policy. The principles and policies expressed in these documents should always be followed.

The vast majority of issues or complaints from prevocational trainees that cross your desk are likely to be able to be resolved without the requirement for escalation or significant interventions by adopting a supportive and fair, but firm approach.

It is worth remembering that responding professionally to situations in the workplace where one might justifiably feel upset, irritated or angry is an important learning point for prevocational trainees. Sometimes just having someone listen to their side of the story or concerns is enough. By giving them the opportunity to debrief and express frustration they will then be able to work constructively towards a resolution.

The obvious exceptions to this are significant grievances or complaints that involve patient or junior doctor safety or serious allegations involving other staff. These matters can be very complex to investigate and manage. The JMO manager should be alert to the requirement for timely referral and escalation to the DPET, medical administration or the human resource department for assistance and support.

PART FOUR

Term allocations and rostering

"Rosters are crucial to the functioning of any healthcare service as they ensure that staffing resources are allocated appropriately in order to provide high quality and efficient patient care."

NSW Health Rostering Resource Manual 2012

Term allocations

Like with rostering dealt with later in this section, the interface between trainee and employee is no more keenly felt than when it comes to term allocations. This is reflected in the amount of time that (if it falls under your area of responsibility) you will spend engaged in sorting out both!

On one hand you will have a responsibility to the organisation to ensure that all units and rotations (including at nights and on weekends) are adequately covered by junior medical staff. On the other, you will be trying to juggle everybody's specific training and other requirements. It can sometimes feel like trying to complete a 5000-piece jigsaw puzzle blindfolded – only a lot less fun!

During the first twelve months of training, the year one prevocational trainee is required to complete a number of rotations (currently five terms of between ten to twelve weeks duration combining to provide a minimum of 48 weeks clinical experience), with core terms in medicine, surgery and emergency medicine. The core requirements were described in an earlier section.

Most facilities or networks have a number of available terms beyond the core requirements. Most prevocational trainees may undertake terms across a range of specialty areas in a variety of settings.

Towards the end of the clinical year, as JMO Manager, you may have the challenging task of assigning prevocational trainees to the terms for the following year often with the assistance of the DPET. This is usually done immediately following the recruitment period.

In addition to core requirements there are a number of other factors to consider in the allocation of terms. These include: individual trainee preferences*; capacity to undertake a term in a rural setting; timing of a particular term in relation to annual leave requests; prerequisite requirements for college training programs; and so on.

Summary of factors to be taken into consideration when doing term allocations:

- Core term requirements
- Trainee preference
- Filling of rural terms
- College prerequisites
- Leave requests
- Range of exposure (generalist model).

* This is particularly important in the second postgraduate year where a trainee may not only want to undertake particular terms but may well want the timing of those terms to be at the commencement of the year, well ahead of the following recruitment cycle.

Given all of these considerations it is no wonder that term allocations can sometimes be very complex and there is a range of ways to approach this task. Whilst you may be put under pressure by some individual trainees to provide terms to meet college prerequisites, this must only be done where a fair and equitable term allocation can still be made for all the prevocational trainees. The principles of fairness and equity of access are important here and should underpin whatever approach is taken.

Most JMO Managers start this process early (particularly in the bigger sites or networks) and seek the assistance of others – (for example the DPET). Some form a small subcommittee of junior doctors to help. Others send out a term allocation list (often along with a leave request form) giving prevocational trainees the opportunity to list their preferences. For the intern year, this is often done as soon as medical graduates are allocated places in the Network. For PGY2s this is done toward the end of the intern year. An example of a form used to collect preferences is provided in the template section of this guide. JMO Managers will need to work with others in the Network to ensure alignment and coordination of rotations.

Once term allocations have been completed, it is useful to maintain two spreadsheets, the first cut by rotations (to ensure that there are no vacant terms) and the second by individual prevocational trainee (to ensure that each junior doctor has an appropriate range of terms).

Why term allocations are important (from an educational perspective)

The two-year generalist training program provides the foundation of a skilled medical workforce with a broad range of training experiences across specialties and in different contexts, including tertiary, outer metropolitan and rural hospitals, general practice and community settings.

From a medical education and training perspective, term allocations provide the opportunity for trainees to gain important clinical experience within a clinical specialty. This can provide them with a sense of what the specialty (and the training program for that specialty) might be like, through their work with consultants and vocational trainees. Experience in a particular specialty can have a very significant impact in making career choices, by seeking greater clarity about which specialty they would like to pursue, and just as importantly, which ones they don't.

From a service provision point of view, you as the JMO Manager will be concerned about ensuring that all terms across the Network or in your facility are adequately staffed with junior doctors with the appropriate seniority and skill mix.

From the prevocational trainee point of view, having the opportunity to complete a particular term can be very important. Put simply, term allocations can have a very significant impact on their choice of career. As the numbers of trainees in the system increases and with it, competition for training places, the decisions around term allocations are likely to become more contentious. JMO Managers should have transparent systems in place for allocating terms, based on the principles of fairness and equity of access.

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Rostering

Rostering of junior medical staff can be a complex business. JMO Managers who work in large metropolitan networks or facilities will often have responsibility for coordinating, in consultation with the various clinical departments, over 50 different rosters involving junior medical staff. Even JMO Managers responsible for much smaller cohorts of junior medical staff, will find that they spend a significant amount of their time managing rosters and associated tasks.

In recognition of the complexity of the rosters, NSW Health developed and published the *NSW Health Rostering Resource Manual (the Manual)*. This manual is a practical guide designed to assist managers in rosters of all clinical staff (medical, nursing and allied health). It contains a number of principles and guidelines, including the industrial obligations where they are applicable.

The principles underpinning the development of best practice rosters contained within the Manual are shown in the box below. The remainder of this section highlights some particular considerations with regards to rosters of prevocational trainees, particularly as it relates to their education and training. JMO Managers should refer to the Manual, relevant industrial instruments, policy directives and LHD policies for specific information on rosters practices. A link to the Manual is shown at the end of this section.

At the commencement of their medical careers, prevocational trainees may have had little experience with working on a roster. Working after hours, weekends, evenings and nights can be a new experience. Many junior doctors report that the work they undertake outside of normal hours, where supervision arrangements and skill mix of staff may differ from that available during *business* hours can be stressful. Rosters that give consideration to the skill mix and appropriate supervision (Principle 4) are particularly important in this context.

Experienced JMO Managers will also confirm that as increasing numbers of prevocational trainees are entering the system, rosters templates for this cohort are changing. One of the most significant changes, at least in the larger centers, is the reduction in rostered overtime hours with a simultaneous increase in the number of ordinary hours worked outside of the traditional business hours for an individual junior doctor.

When developing rosters for prevocational trainees in this context, access to the formal education program and other teaching opportunities (which for medical staff continue to be held predominantly in normal hours) needs to be taken into consideration.

Junior doctors adjusting to working shifts, particularly night shifts, require support. In recognition of this, the Royal College of Physicians in the UK developed a guide for junior doctors that provides useful advice to doctors working night shifts. A link to this document is contained at the end of this section.

- Transparent processes
- Fair distribution of work
- Safe hours
- Take into account preferences (overriding principle is provision of patient care).

Overarching principle

Delivering services to patients is the first consideration

The principles that guide rosters in NSW are:

Principle 1: Rosters must ensure that there are sufficient and appropriately skilled staff rostered to work, in order to provide appropriate patient care and to meet anticipated service demands.

Principle 2: Rosters must conform to relevant regulatory frameworks, including antidiscrimination, occupational health and safety legislation, industrial awards, and NSW Ministry of Health and LHD policies.

Principle 3: Rostering processes should ensure staff are rostered fairly, while still providing appropriate flexibility to facilitate meeting unit staffing needs.

Principle 4: Rosters must make appropriate provision for adequate staff supervision, training and clinical handover.

Principle 5: The organisation must have appropriate governance structures in place to oversee roster planning, creation, approval, monitoring and reporting.

Principle 6: Rostering practices in NSW Health are based on co-operation between rosters managers and staff, in order to promote fairness in rosters and to deliver appropriate care to patients.

Rostering Process



Source: NSW Health Rostering Resource Manual – for full version of the rostering process see page 10 of the Manual.

Budget and finance management

Many JMO Managers have responsibility for managing budgets and finances relating to the junior medical workforce. This extends to managing rosters and medical overtime in ways that are cost effective and within budget. JMO Managers undertake this work in collaboration with clinical units, finance and other key individuals within the organisation. As a JMO Manager you should be familiar with the financial reporting systems within your facility.

Many JMO Managers are also responsible for implementing policies and processes around rosters and overtime, in addition to monitoring the compliance of junior doctors with requirements. Central to this is the development of clear communication with junior doctors regarding their responsibilities in meeting obligations regarding rosters and overtime, including timesheets and approval processes.

HETI offers a Financial Management Program designed to support NSW Health clinical managers and other staff who oversee financial management and analyse the financial performance of their cost centres and/or units. Further information can be found on the HETI website.

In addition to the above, some JMO Managers are also responsible for assisting the DPET in the management of funding provided for prevocational training that is administered through HETI. Further information regarding funding for the education and training of prevocational trainees is available in the DPET guide.

Monitoring prevocational trainees workload

JMO Managers frequently have responsibility for setting up systems to monitor trainee workload. This may range from monitoring rostered and unrostered overtime, call backs (in the case of PGY3+) through to patient loads on individual teams. A number of factors may impact upon workload at the level of the individual trainee. These can include the following:

- Rosters (ordinary hours)
- Rostered overtime
- Unrostered overtime
- Patient numbers and clinical complexity
- Senior medical officer rosters (as JMOs are generally assigned to a number of senior medical staff within a given specialty, changes to senior medical staff rosters or senior medical staff leave and cover arrangements can significantly impact on individual junior doctor workload)
- Numbers and skill mix of other junior doctors in the term, including leave arrangements
- Seasonal fluctuations in patient numbers in some terms
- Individual trainees (particularly at the commencement of the year, trainees may take longer to complete tasks compared with the end of the year).

Systems that monitor workload should be in place and significant issues escalated to the relevant individual. Depending on the organisational context this may be the DPET, DMS or Clinical Head of Department.

Supporting effective clinical handover

JMO Managers are well positioned to support effective clinical handover practices in their facilities or Networks. Clinical handover refers to the “transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis”⁶.

In view of the critical importance of effective clinical handover practices to safe patient care, a considerable amount of work has been undertaken over the last few years to develop appropriate systems and handover tools. Some of these have been developed specifically for junior doctors.

Given the nature of their roster and rotation arrangements, prevocational trainees need to develop and engage in effective clinical handover practices as a critical component of their work, appropriately supervised and supported by more senior medical staff.

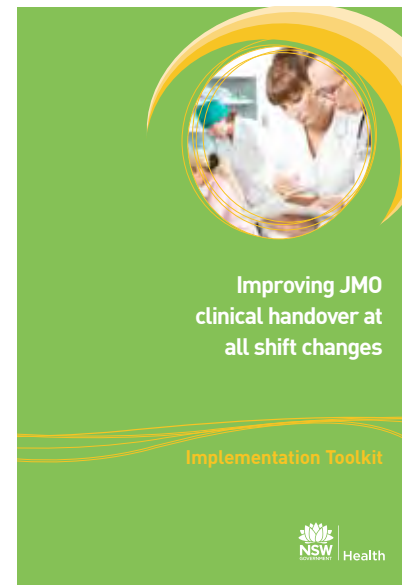
At the end of handover, the junior doctor, be it at the end of a shift or at the end of the term, should have a clear understanding of:

- Sick, deteriorating and unstable patients
- Outstanding actions, procedures, test or results to be reviewed
- Other important factors that will impact work on the following shift.

JMO Managers have an important role in developing systems that support effective clinical handover. JMO Managers who are familiar with the range of tools and resources developed to support effective clinical handover practices for junior doctors will be able to actively promote them amongst their junior doctor cohort.

JMO Managers can also assist effective clinical handover in the following ways:

- Development of roster templates that facilitate time for handover – this implies that there is provision for rostered shift overlap and that punctuality with start and end times of shifts with junior doctors is reinforced.
- Incorporate requirement and responsibility for clinical handover into junior doctor position descriptions and term descriptions.
- With respect to the end of term changeover, coordinate with Network partners to ensure that rostering practices are aligned to maximise opportunities for incoming and outgoing junior doctors to provide clinical handover of patients, (in addition to other considerations such as time to travel, management of fatigue and so on).
- Participate (with other relevant staff) in audit and monitoring of clinical handover practices within your facility. A checklist has been developed to assist facilities with this.



6 NSW Health Improving JMO Clinical Handover – Implementation Toolkit available at <http://www.archi.net.au/e-library/safety/clinical/nsw-handover>.



Resources

NSW Health Rostering Resource Manual September 2012 | Version 1.1

Available at <http://intranet.hss.health.nsw.gov.au>. Accessed May 2013.

AMA National Code of Practice (Safe Hours) available at

<https://ama.com.au/national-code-practice-hours-work-shiftwork-and-rostering-hospital-doctors>. Accessed May 2013.

Further information on finance management education program

<http://www.heti.nsw.gov.au/programs/financial-management-education-program>



Royal College of Physicians. Working the night shift: preparation, survival and recovery A guide for junior doctors UK. 2006

Available at <http://www.rcplondon.ac.uk/publications/working-night-shift-preparation-survival-and-recovery>. Accessed May 2013.

PART FIVE

Recruitment and selection

Overview

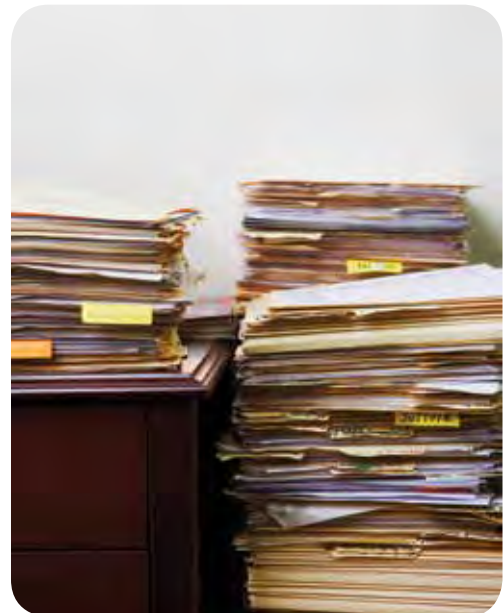
Junior doctors (including both prevocational and vocational trainees, in addition to non-streamed doctors) are employed within NSW Health on temporary contracts, which generally have a start and end date aligned with the clinical year. This means that junior doctors must apply for positions at various points in the training continuum and this is managed by a general recruitment period that runs from July through to October each year. The exception to this is that final year medical students are recruited to PGY1 positions through separate processes managed by HETI usually commencing in April each year, several months prior to the main recruitment period. Further details of medical graduate recruitment are provided later in this section.

The specific dates for the commencement of the clinical year (currently mid-January) and subsequent term rotation dates are set by the MoH and reflected in a policy directive. Appointments of junior doctors at all stages of the training continuum are generally aligned with these dates. In NSW, prevocational trainees are generally on two-year contracts. Many other junior doctors are provided temporary contracts of varying length, usually ranging from 12-months up to four years. In this way, contracts may be matched to a particular training position at a particular level of training.

During the recruitment period junior doctors at the vocational training level apply for positions within the NSW Health system, often in parallel with application for candidacy or training positions with a Specialist College. Many, but not all of the junior medical positions at PGY3 level and above are accredited for vocational training with the relevant Specialty College. In some cases, the College may allocate a particular trainee to a specific training post but generally vocational trainees will make direct application to the hospital or facility for a training position. There may also be a number of other non-streamed positions at the PGY3+ level to fill in addition to these training positions.

The annual recruitment process is centralised, and involves structured steps across parts of NSW Health in addition to the JMO Management units and LHDs. This includes HealthShare, (who are responsible for the e-recruitment process), and the MoH (responsible for setting relevant recruitment and selection policies and governance arrangements).

All junior doctors should be appointed through processes articulated in MoH policies and procedures. Each LHD will have well-established policies and procedures, developed to align with MoH policy directives to ensure that legislative and industrial requirements are met and these should always be followed.





Experienced JMO Managers will tell you that the period May through to October represents a very busy five to six months of the year. Some JMO Managers, particularly at the larger facilities, will deal with thousands of applications during this period. Given the complexity of the task, a systematic approach to the recruitment period, often working in collaboration with others (Clinical Heads of Department, medical administration and the human resources department) is required.

All junior doctors should be appointed through processes articulated in MoH policies and procedures. Each LHD will have

well-established policies and procedures, developed to align with MoH policy directives to ensure that legislative and industrial requirements are met and these should always be followed.

Preparing for the general recruitment period

Preparation for the recruitment period begins well ahead, usually several months before the positions are advertised. In the first instance, many JMO managers will be responsible for confirming the budgeted FTE (including at what level) of all junior medical staff and seeking approval for the proposed recruitment action. At facilities that have 500 plus junior medical staff, this can take some time and preparations are best commenced early.

The box below contains a number of core tasks that are required to be completed in the lead up to the recruitment period. JMO Managers should be aware that changes may occur from year to year and the relevant policies should be accessed to ensure up to date procedures are being implemented.

Tips from JMO Managers on preparations for the annual recruitment period

- Refer to recruitment policies to ensure currency of understanding and compliance
- Review recruitment systems and processes within the JMO Management Unit (however named) to maximise efficiency
- Check budgeted FTE and obtain approvals
- Review position descriptions
- Prepare advertisements – check currency, particularly with regard to contact information
- Work with Clinical Heads of Department/HR/Medical Administration and other relevant people as required
- Organise selection panels
- Book senior medical staff for selection panels early
- Consider office requirements for recruitment period and plan ahead (for example, stationary orders and diary management)
- Prepare recruitment packs (these might include letter templates, forms and information about Network or hospital).

Medical graduate recruitment

This section provides information on the processes managed by HETI in relation to medical graduate recruitment. Further information about the recruitment to all other junior doctor positions can be found by following the links at the end of this section.

Final year medical graduates are invited to apply for PGY1 positions within the NSW system about 7 months prior to the commencement of the clinical year. Applications are provided through the prevocational trainee application process (PTAP), an on line form with opportunity for each medical graduate to provide preferences to Networks. Once eligibility of applicants has been confirmed, they are processed through the optimised preference allocation, with the exception of those placed through the RPR pathway (see section overleaf).

Applicants are then offered a particular position within a Network and given an opportunity to accept. At the end of the process, Networks (usually through the JMO manager) will be advised of which junior doctors have been allocated to their Network. Once a Network is notified by HETI of the medical graduates who have accepted positions and allocated prevocational trainees to specific facilities, the relevant JMO Manager will need to undertake the necessary pre-employment checks, clearances, generation of contracts and associated paper work. Term allocations will also be undertaken (refer to earlier section).

Whilst the majority of medical graduates accessing PGY1 positions will do so by providing an application through HETI and then being part of the optimised preference allocation, there are several other pathways that they can access. Given that this is currently a very dynamic system, responding to increasing numbers of medical graduates, the remainder of this section provides general information only. Specific information should be sought by accessing the relevant links.

Building Capacity of the Aboriginal Medical Workforce in NSW Program

The Building Capacity of the Aboriginal Medical Workforce in NSW program offers Aboriginal medical graduates a recruitment pathway from medical school to a prevocational trainee position in the NSW health workforce.

The purpose is to promote the success of Aboriginal medical graduates by recruiting them to prevocational training positions in a rural preferential hospital or prevocational training Network of their first choice. The medical graduates that apply for this recruitment pathway provide information to HETI about the support they wish to access at a particular training hospital and or in the geographic areas covered by a Network. Further information about this program may be found by following the links overleaf.

Rural preferential recruitment (RPR)

The Rural Preferential Recruitment (RPR) is a merit based recruitment process for final year medical students who are interested in working within a rural setting. A number of rural hospitals participate in this system. The RPR process is undertaken prior to processing applications through the optimised preference allocation. An interview schedule of participating facilities is generally published on the HETI website and following the interviews of eligible applicants, facilities (through HETI) offer successful applicants positions. Upon accepting those positions applicants are allocated to that facility and removed from the PTAP process. Applicants who are unsuccessful in obtaining a position through the RPR process remain in the PTAP process.

Regional preferential allocation

The Regional Preferential Allocation process gives priority to filling regional and outer metropolitan prevocational training positions. The aim of this program is to provide a sustainable medical workforce in regional and outer metropolitan NSW, in part by providing a pathway linking undergraduate training to postgraduate medical training positions. Further information regarding the regional preferential allocation, including the participating Networks, can be found by following the links below.



Resources and further information

Medical Graduate Recruitment in NSW

<http://www.heti.nsw.gov.au/programs/internship-nsw>

Building Capacity of the Aboriginal Medical Workforce in NSW Program

<http://www.heti.nsw.gov.au/programs/internship-nsw/building-capacity-of-the-aboriginal-medical-workforce-in-nsw/>

Rural Preferential Recruitment (RPR)

<http://www.heti.nsw.gov.au/programs/internship-nsw/rural-preferential-recruitment-rpr/>

Rural Preferential Allocation

<http://www.heti.nsw.gov.au/programs/internship-nsw/regional-preferential-allocation/>

Ministry of Health

<http://www.health.nsw.gov.au/>

PART SIX

HETI accreditation

Overview of accreditation standards

The Medical Board of Australia in granting provisional registration to interns has a requirement that interns can only work in terms or rotations accredited by a postgraduate medical council or equivalent body.

In NSW, HETI has the responsibility for accrediting facilities and posts for prevocational year one training posts (from the Medical Board of Australia) and prevocational year two training posts (from NSW Ministry of Health as the employer).

The accreditation standards have three primary goals:

- The facility ensures prevocational trainees have the appropriate knowledge, skills and supervision to provide quality patient care.
- The facility provides a wide range of educational and training opportunities for prevocational trainees to ensure that they are competent and safe.
- The facility promotes the welfare and interests of prevocational trainees.

The standards measure performance of the facility or practice in the following areas:

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

General Practice Prevocational Education and Training Accreditation

To accommodate the expansion of the Prevocational General Practice Placement Program (PGPPP) in NSW, HETI has introduced a streamlined accreditation model for the general practice environment and along with it, a set of General Practices Education and Training Standards. The standards have been developed with reference to a range of other accreditation standards and include the expectations that HETI has in terms of how the Standards will be met and what indicators might be required through the accreditation process. Further information on the General Practice Accreditation Model can be found by following the links at the end of this section.

Accreditation process

The accreditation process is predicated on a peer review system, whereby a team usually comprising a senior clinician and/or a medical administrator, a prevocational trainee and often a JMO Manager visit the facility to make an assessment of the facility's performance against the standards.

The process commences with a self-assessment conducted by the facility several months prior to the survey visit. Staff responsible for prevocational training at the hospital or facility complete the self-assessment section of the report, and collate evidence to support the self-assessment. This report is sent back to HETI who then assemble a team to conduct the site visit (usually lasting between 1–2 days).

At the survey visit, the survey team interview key staff involved in prevocational training – trainees, term supervisors, the DPET, JMO Managers, Hospital Executive and others in addition to reviewing the documentation provided by the hospital in order to make an assessment against the standards.

The survey team then completes a report that is subsequently forwarded to the Prevocational Accreditation Committee (PAC) within HETI. Contained within the report will be a number of recommendations made by the survey team in the interests of addressing any major deficiencies as well as encouraging continuous improvement.

In considering the report, the PAC makes a recommendation regarding awarding of accreditation status as well as prioritizing the recommendations, determining required actions and evidence in relation to any high level recommendations (referred to as provisos). These will be communicated to the hospital or facility and they will be expected to address the provisos and report back to the PAC within a given time frame (usually between three and six months). The remainder of the recommendations made by the survey team are included in the report and it is expected that actions addressing these will be monitored by the GCTC over the intervening survey cycle.

Accreditation processes not only ensure that minimum standards regarding prevocational trainee supervision, education, training and welfare are met, the process also encourages quality improvement and striving for excellence with regards to the provision of medical education.

As the JMO Manager you will be very involved in both the preparation and conduct of the survey. The rest of this section provides further information to assist you in preparing and participating in the accreditation process.

Preparing for the survey

The survey process relies on the provision of evidence across all standards – it has a systems focus with attention to what structures and processes are in place that support prevocational training. As the JMO Manager, working with the assistance of the DPET, you may be responsible for ensuring that many of these systems are in place.

You should be familiar with the content and structure of the standards, particularly with respect to the specific requirements, guidelines and evidence requirements. You will note that significant emphasis is placed on monitoring, collecting evidence, evaluation and continuous improvement. Whilst not all of the requirements in the standards, or the evidence needed may necessarily fall to your responsibility, it is very likely that you will be involved in at least assisting the organisation's preparation for the survey visit. Experienced JMO Managers who have been through the survey process advise that one of the most helpful things to do is to keep the documentation or evidence that you will need to provide for the survey team as you go. It can also be very useful to participate as a surveyor in a survey of another hospital prior to going through your own hospital survey process. By being familiar with the standards at an early point in time, you will be guided as to what information to collect.

This equates to setting up systems where either you or the DPET keeps hard copies of documents in ring binder folders or the like. Be wary of collection of documents in soft copy. Ensure that if staff use electronic systems to store or file that they are held where all relevant staff can access them.

Collecting information or evidence as you go (particularly in the twelve months prior to survey), makes the job of completing the self-assessment report and producing the evidence in the lead-up to the survey a whole lot easier.

It is also useful to maintain a hard copy master file (or ensure that the Chair/secretariat does) of the GCTC and Network Committees containing not just agendas, minutes and action plans but also correspondence and any reports that are tabled. Keeping master files may save considerable time in preparing for the survey and generally also provide a good record of activities pertaining to prevocational education and training that are being undertaken mid survey cycle when it comes to filling in the detail of the self-assessment report.

Tips from JMO Managers well drilled in preparing for HETI surveys are included in the box below.

The self-assessment report is completed a couple of months prior to survey. It asks for details around how the facility believes it has progressed against the standards and criteria (including the specific requirements and guidelines) in the period since the previous survey. It also includes a section to report on previous recommendations.

The self-assessment report is often the first contact the surveyors have with your hospital. Therefore the information contained in the survey self-assessment helps form the surveyor's opinions even before the first day of the survey visit.

In completing the survey self-assessment, if that responsibility falls to you, engage the support of others (DPET, Chair of the GCTC, and so on). The self assessment material is required back at HETI six weeks prior to survey so aim to start the process at least two months prior to that. Some facilities convene a sub-committee of the GCTC to progress the completion of the pre-survey report. As your facility nears the time of the survey visit, it is likely that you will have increased contact with the Network Coordinator from HETI – they can be a useful resource to assist and support your preparation.

Tips from JMO Managers on preparing for surveys

- Review and become familiar with the Standards
- Consider becoming a surveyor and doing a survey of another hospital prior to your own survey
- Understand which parts of the standards you may be responsible for in your facility and collect evidence as you go
- Start preparations early
- Keep master file for GCTC
- Keep master file for NCPT
- If using electronic storage, ensure all relevant staff have access and know where to find documents
- Collect evaluation forms in folders
- Once dates of visit are known, arrange for meeting times with key staff
- Any issues – speak with Network Coordinator.

What to expect at survey

Generally speaking by the time of the survey visit, most of the hard work from your point of view will be complete. The self-assessment report has been finalised and the evidence folders are sitting on a bookshelf ready for the survey team.

During the survey visit, the survey team will meet with prevocational trainees, term supervisors, the DPET, the Chair of the GCTC, members of the JMO Management team and members of the hospital executive. They will also review all the documentation that has been provided in addition to completing a tour of the hospital.

Your Network coordinator will have more information on the actual process and you should speak with them well before the survey if required, particularly if this is your first survey as a JMO Manager.

At the conclusion of the survey, the team will meet with the hospital executive and the DPET for a formal debrief in order to provide a summary of their main findings. In some instances, depending on the facility, you as the JMO Manager may attend. The debrief provides an opportunity to deliver the findings, check any potential inaccuracies and summarize the main strengths and issues identified at survey. Whilst it is not the role of the survey team to make a recommendation of the accreditation outcome, it is their role to alert the hospital to any major problems. Given that the report is presented to the PAC prior to it being forwarded to the hospital, it may be two to three months following the survey visit before the hospital or facility receives the report. Clearly if there are significant concerns identified the hospital will likely want to address these (or at least start to) prior to receiving the formal report.

Post survey

As the JMO Manager you will most likely receive a copy of the survey report, through medical administration or the DPET, once it has been finalised through HETI. It will also be forwarded to the CE of the LHD, hospital executive and Chair of the GCTC.

The hospital report will contain a number of recommendations and (if significant concerns have arisen) provisos. Provisos will need to be responded to within the timeframe determined by the PAC. The GCTC will play a major role in either addressing these or monitoring the implementation of any improvements. As the JMO Manager you may be involved in responding to the provisos and recommendations, though this responsibility generally falls to the DPET, with the assistance of the Chair of the GCTC or DMS.

Term accreditation

All prevocational trainees must work in terms accredited by the Prevocational Accreditation Committee (PAC). The Medical Board of Australia may consider that time worked in non accredited terms completed by a postgraduate year one trainee as not counting toward registration.

Whilst all accredited or provisionally accredited terms in a particular site are evaluated during the survey visit, facilities wishing to develop new terms (or make significant changes to existing terms) during the intervening period must submit a term description with all the required elements. Refer to the HETI website for the term description template.

The term description should be signed by the term supervisor and endorsed by the GCTC. The term description, usually with a letter of endorsement by the GCTC (or a copy of the minutes of the meeting where the term was considered) is then submitted to the PAC for provisional accreditation.

Once the PAC has approved the new term, it will remain provisionally accredited until the next scheduled survey visit. Further information about accrediting new terms can be found by following the links included opposite.

Resources:



Network principles for prevocational medical training

<http://www.heti.nsw.gov.au/resources-library/network-principles-for-prevocational-medical-training/>

Accreditation Program

<http://www.heti.nsw.gov.au/programs/accreditation/>

General Practice Prevocational Education and Training Accreditation

<http://www.heti.nsw.gov.au/programs/accreditation/general-practice-prevocational-education-and-training-accreditation-main/>

College accreditation of training posts

Given that most JMO Managers are responsible for the management of other junior doctors, it is very likely that they will also become involved from time to time in College accreditation processes. The Australian Medical Council (AMC) is responsible for accrediting education and training providers of specialist medical training. The MBA delegates this function to the AMC who complete periodic surveys of Colleges to ensure that the standard of education and training and requirements for specialist medical training is at a particular level.

Only Fellows of specialist medical colleges accredited by the AMC are eligible to be registered as specialists with the MBA. As part of the requirements set down by the AMC, all Colleges are required to have processes in place whereby the College accredits training posts or facilities. There is variation in the way in which Colleges undertake this. Some accredit posts, others facilities, but generally many of the same themes which are features of the prevocational accreditation standards are present in the College accreditation. Whilst as a JMO Manager you would not normally be involved in completing the pre college assessment information, you might well be asked to provide some information.

Other information regarding College assessment processes can be obtained via the relevant College website.

PART SEVEN

Support structures

This section provides information on the support structures that may be available to you as the JMO Manager, with a focus on support and systems in place for the prevocational training period.

Medical administration

Although the governance and executive arrangements of facilities differ depending on location and context, many hospitals have retained a medical administration department with a Director of Medical Services (or equivalent) providing oversight of professional matters for senior and junior medical staff, often in addition to a number of other functions. Directors of Medical Services (DMS) are qualified medical practitioners, often with a specialist qualification in medical administration. As the JMO Manager it is most likely that you will be part of the medical administration unit (however named) within the hospital or Network.

Directors of Prevocational Training (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. As the JMO Manager you will likely work very closely with the DPET in providing support and management of prevocational trainees.

General Clinical Training Committee (GCTC)

Each facility with prevocational trainees must have a General Clinical Training Committee (GCTC). The responsibility of the GCTC is to provide oversight of prevocational supervision, training, education and welfare, thereby supporting HETI's mission of ensuring that trainees are clinically competent for safe practice and provision of quality patient care. Further information about the GCTC is provided by following the links at the end of this section.

Network Committee for Prevocational Training (NCPT)

Each prevocational training network will have an established Network Committee for Prevocational Training to provide governance to the training network and support the efficient running of training across all included facilities and rotations. JMO Managers, particularly those with responsibility for large facilities, are likely to be on the NCPT. All JMO Managers within the Network should have access to the minutes of the meetings. Further information about the NCPT is provided by following the links at the end of this section.

HETI

As an outcome of the Director-General's Governance Review on the future directions for NSW Health completed in 2011, the Health Education and Training Institute was established to provide leadership for health workforce education and training in the NSW public health system.

The HETI Medical Directorate is responsible for the prevocational training program in addition to a number of other programs. Much of the material covered in this Guide describes activities related to prevocational training.

Through the Medical Directorate, a prevocational training forum is organised annually usually held mid year, which many JMO Managers attend, along with DPETs and others involved in prevocational training.

JMO Managers Forum

Within NSW, there is a regular meeting of all JMO Managers (called the Statewide JMO Managers forum). This provides opportunities for JMO Managers to meet to discuss issues of common interest and exchange information on a regular basis.

Resources

General Clinical Training Committee

<http://www.heti.nsw.gov.au/resources-library/terms-of-reference-general-clinical-training-committee/>

Network Committee for Prevocational Training

<http://www.heti.nsw.gov.au/resources-library/terms-of-reference-network-committee-for-prevocational-training/>

Information about the HETI Prevocational Education and Training Forum

<http://www.heti.nsw.gov.au/events/>

PART EIGHT

Enjoying the JMO Manager role

Building and managing your team

Depending on the size and context of the facility, many JMO Managers are responsible for managing other staff within their team. As the Manager you will rely on the support of your direct report but will also work collaboratively with many others, including the DPET and in some cases a medical education officer (MEO).

If your position has responsibility for managing a number of staff you will undoubtedly set up systems and processes to facilitate effective working relationships. Fostering collaborative relationships where all staff feel valued, with clear communication and regular team meetings will support this.

Given the nature of the work, many JMO Managers promote a flexible approach where everyone in the JMO Management team has an understanding of each other's roles and are therefore able to assist each other during the busy peak times, such as the orientation and recruitment period or provide cover during leave. Some tips from JMO Managers for building and maintaining a cohesive team are included in the box below.



Tips from experienced JMO Managers

- Always keep your sense of humour
- Hold regular team meetings, especially during busy times
- Maintain clear communication – be on the same page (this also helps keep any advice or information provided to trainees consistent)
- Consider flexible work arrangements to ensure coverage of unit across required hours
- Look for opportunities for staff to develop skills (for example participate in or run projects, attend meetings or represent unit on wider committees)
- Consider activities (appropriate to the workplace) that will boost team morale – for example celebration of events with a morning team or lunch get together, mufti days
- Make a point of thanking staff and recognising efforts.

Career planning (your own!)

JMO Managers come to the JMO Management role from a variety of backgrounds and professional experience. No matter what your pathway to the JMO Manager role, it is important that you are able to access professional support during the role and beyond.

Given the varied roles and responsibilities involved in being a JMO manager (which are dependent on context and location, type of facility) your professional development needs may vary. It can also at times be challenging to make time for professional development activities but these are essential to sustaining enjoyment and further development within the role.

There are lots of professional development activities on offer. You can find out more by speaking with your local HR department. In addition, HETI now has the responsibility for leading education and training of both non-clinical and clinical staff within the NSW public health system. This includes convening a prevocational training forum each year which many JMO Managers attend. Further information can be found by following the links to the HETI website.

You should have a performance review each year. This might be used as an opportunity to identify areas that you would like to work on and strategies to assist you in this.

Beyond the JMO Manager role

Many JMO Managers find that they gain a great deal of knowledge and skills during their term as JMO Manager and they find working with, managing and supporting junior doctors, particularly those in the very early postgraduate years very professionally satisfying. In addition the role of JMO Manager often brings with it opportunities to work and collaborate with others across the NSW Health system in the medical education and training space.

There are a number of ways in which JMO Managers can continue to contribute to prevocational training, including:

- Contribute to statewide JMO Management forum
- Undertake quality improvement project in some aspect of junior doctor management or training
- Presentation at Prevocational trainee Forum (NSW or National)
- Membership on Prevocational Training Committee
- Surveyor for HETI surveys
- Committee membership at LHD governance level
- Committee membership to various HETI prevocational governance structures
- Committee membership to various MoH governance structures.

Further information about ways in which JMO Managers can contribute to prevocational training is available on the HETI website.

Resources

Australian Curriculum Framework for Junior Doctors

<http://curriculum.cpmech.org.au>

Australian Health Practitioner Regulation Agency

<http://www.ahpra.gov.au>

Australian Medical Council

<http://www.amc.org.au>

Confederation of Postgraduate Medical Councils

<http://www.cpmech.org.au>

Health Education and Training Institute

<http://www.heti.nsw.gov.au>

Medical Board of Australia

<http://www.medicalboard.gov.au>

Ministry of Health NSW

<http://www.health.nsw.gov.au>

Templates

ROVER

JMO Rolling Term Handover (ROVER) Form

This form is designed as a resource written by and for JMOs about the specific, practical, day to day responsibilities involved in a particular rotation. It is a rolling document that may be modified or updated as different JMOs rotate through the term. It supplements the information provided in the Term Description. ROVER forms are to be kept in electronic form. For medication and protocol advice – this should be checked with members of your team.

There are 6 sections to this form. It is not mandatory to fill in all the sections – they are intended as a guide only.

TERM NAME		CONTACT NUMBERS
TERM SUPERVISOR		
OTHER STAFF		

Role and Responsibilities

(For example: start times, daily routine, average patient load, how ward rounds are run, entries in notes, general expectations, role of other doctors)

Resources

(For example: Useful protocols, go-to people, roles of allied health, where to find information for patients etc)

Referrals

(For example: how to get an allied health referral or send someone to a rehab facility or refer for investigations)

Common Conditions

(For example: conditions commonly encountered on this term and routine management ie: general management measures, length of stay)

Miscellaneous Tips

(For example: particular consultant preferences, ward quirks and hints for getting things done)

Intern (PGY1) Term Preference 2013

Name _____

Career interests _____

In line with APHRA's Policy each Intern must complete a term in Emergency, Surgery and Medicine in addition to a relief. Please complete each section separately. You must rank each term. Incompleted forms will not be processed. Term allocations will be given out when you have completed your online modules.

Emergency Terms	Hospital	Please rank from 1 to 4 (1 being your first preference)
Emergency	Hornsby	
Emergency	Manly	
Emergency	Mona Vale	
Emergency	Sydney Adventist Hospital	
Other Terms		Please rank from 1 to 15 (1 being your first preference)
General Medicine	Hornsby	
General Medicine	Manly	
General Medicine	Mona Vale	
General Medicine	Sydney Adventist Hospital	
Aged Care/Rehab	Hornsby	
Aged Care/Rehab	Manly	
Aged Care/Rehab	Mona Vale	
General Surgery	Hornsby	
General Surgery	Manly	
General Surgery	Mona Vale	
Orthopaedics	Hornsby	
Orthopaedics	Manly	
Orthopaedics	Mona Vale	
Orthopaedics	Sydney Adventist Hospital	
Psychiatry	Manly	
Leave must be taken during your relief term. Please rank the terms from 1 to 5 to indicate the preferred term for your relief term (1 being your first preference). Do not write the dates. You will be supplied with an annual leave application form once you commence employment.		
Term 1, 2013 (21st January – 7th April 2013)		
Term 2, 2013 (8th April – 16th June 2013)		
Term 3, 2013 (17th June – 25th August 2013)		
Term 4, 2013 (26th August – 3rd November 2013)		
Term 5, 2013 (4th November – 2 February 2014)		

Comments _____

The JMO Manager's Guide

to managing and supporting prevocational trainees

JMO Managers make a significant contribution to the healthcare team through effective management and support of junior doctors, particularly those in the early postgraduate years.

This practical guide provides information for JMO Managers about many aspects of prevocational education and training including:

- Medical training pathways and how junior doctors learn
- Assessment processes
- Working with junior doctors
- Trainee in difficulty
- Term allocations
- Rostering
- Recruitment and selection processes
- HETI accreditation
- JMO Management support structures

This book also includes links to relevant websites, further readings and other useful resources in addition to tips and advice from experienced JMO Managers to assist others in fulfilling this important role.