Australian Medical Council Limited

Review of the National Framework for Prevocational Medical Training

Part 2 Consultation questions: Review and development work

This is the third and final consultation of Phase 2: Review, Development and Testing. Near final content is presented for confirmation.

Your feedback

We would like to confirm the final content and direction with you. We will consider all the feedback we receive when finalising the documents. The AMC will communicate a summary of its consideration and response to the feedback provided and confirm final direction in late 2021. Final documents are expected to be released in early 2022.

The AMC's primary responsibility is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community and the final content of the National Framework must reflect this. If you would like further information about how to engage with the review please visit the AMC website.

We are seeking feedback by **28 September 2021. (Extension granted by AMC to Queensland Health – to 28 October 2021)**

To enable efficient evaluation of the feedback our preference is for responses to be provided in a **Word document** using this **template** to prevac@amc.org.au. If this is not possible, please provide a non-protected PDF.

This template

This template provides updates and questions against each major component of the Framework for consultation, as follows:

1. Framework overall
2. Training and assessment
3. Training environment
4. Quality assurance
5. E-portfolio specifications
6. Plans for Phase 3: Preparation and Phase 4: Implementation

This template should be read in conjunction with the **Part 1: Consultation Paper**, which outlines the background and review process. Relevant attachments include:

ATTACHMENT A: Training & Assessment: Requirements for prevocational training programs – Draft for consult Aug 21

ATTACHMENT B: Training Environment: National standards and guidelines for prevocational training programs – Draft for consult Aug 21

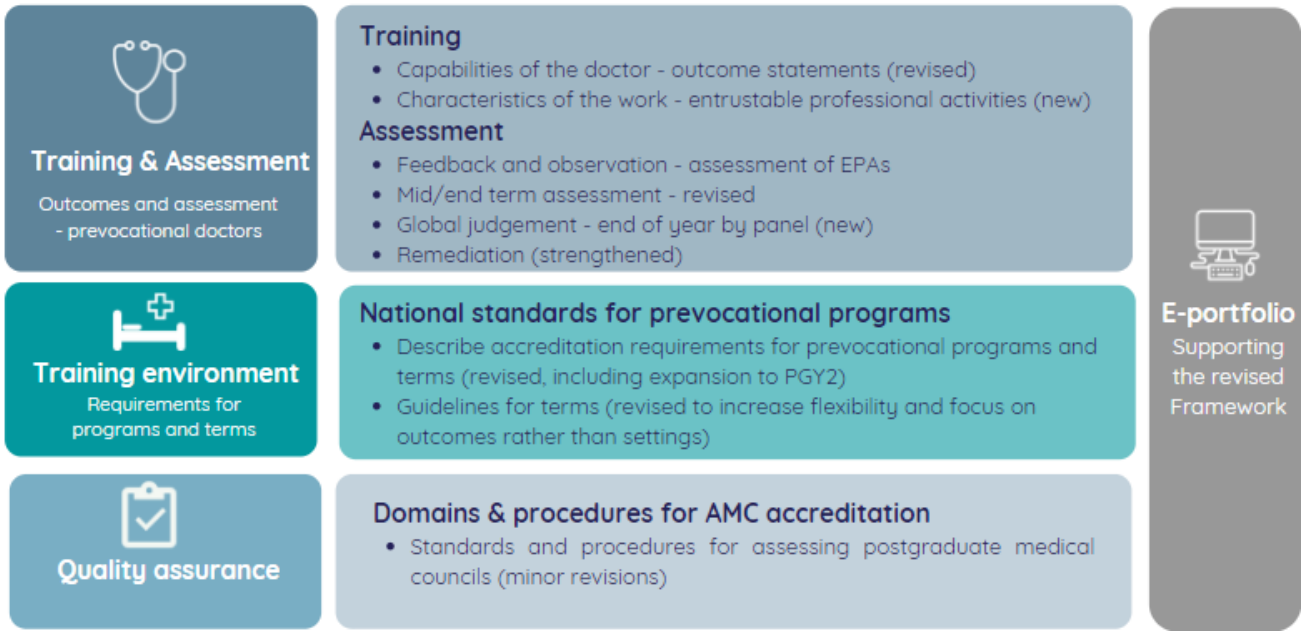
ATTACHMENT C: Quality Assurance: AMC accreditation of prevocational training accreditation authorities – Draft for consult Aug 21

ATTACHMENT D: High-level specifications for prevocational e-portfolio – Draft for consult Aug 21

We recognise that all questions will not apply to all stakeholders. Please only respond to those that are of relevance to you. There are also spaces for general comments.

1. Framework overall

A summary of the major components of the proposed framework, including the change from one to two years, is provided in the table. It is important to note that that while the National Framework will be expanded to include postgraduate year 2, the point of change to general registration will remain at the end of postgraduate year 1. The intention is to provide additional support and structure for PGY2 while continuing the flexibility for prevocational doctors to enter specialist training programs. The revised two-year framework builds on the existing National Framework with revisions and new developments. There are some significant changes planned, in particular to assessment, program structure and the development of an e-portfolio. Details regarding these changes are outlined in the relevant sections below.



The Medical Board of Australia has finalised its new Continuing Professional Development Registration Standard. PGY1 doctors in an accredited program are exempt from the requirements as are PGY2 doctors who are participating in a structured program (the Framework) leading to a certificate of completion.

Questions

i. Do you have any final comments on the Framework overall? Overall, the framework is clear and follows a logical process and order. The definitions of PGY1 and PGY2 could be further refined. While the definition of a PGY1 being an individual with provisional registration is clear, that of a PGY2 or an individual completing the PGY2 component of the framework has the potential to be less clear, particularly for those in the PGY3 year or later who have yet to successfully complete the PGY2 component of the program. The definition should reference the successful completion of the program rather than a level of experience as a year of practice.

The governance of the program overall needs further consideration. The framework has an inherent dependence on the e-portfolio and as such the governance of both the framework and e-portfolio should be considered in concert. In addition, national oversight of implementation should be considered within the governance framework.

2. Training and assessment

The AMC is proposing some significant changes to prevocational Training and Assessment. A summary of the review and development work to date is provided below.

ATTACHMENT A - describes the training and assessment requirements for prevocational programs. A summary of areas for consultation and status in review is provided below:

Component	Section	Status in review
Training	2A. Outcome statements	Draft revised document consulted on in September – November 2020 and March – April 2021. This draft includes feedback and changes made in response to previous consultation as well as new outcomes related to Aboriginal and Torres Strait Islander health.
	2B. Entrustable professional activities	Initial draft document consulted on in September – November 2020. Draft revised document consulted on in March – April 2021. This draft includes feedback and changes made in response to previous consultation and new behaviour descriptors related to Aboriginal and Torres Strait Islander patients.
	2C. Record of learning	Draft outline was consulted on in March – April 2021. No new major changes.
Assessment	2D. Assessment process	Draft revised document consulted on in March – April 2021. This draft includes changes made in response to feedback in the previous consultation as well as processes for assessing Aboriginal and Torres Strait Islander outcomes.
	2E. Forms – EPA assessment form	The initial revisions to the term assessment form were included in the March-April 2021 consultation. This draft includes changes made in response to feedback in the previous consultation and has no new major changes.
	2F. Forms – Term assessment form	The first draft of the EPA form was included in the March-April 2021 consultation. This draft includes changes made in response to feedback in the previous consultation and has no new major changes.

A. Prevocational outcome statements – characteristics of the prevocational doctor

The Prevocational Training – outcome statements state the broad and significant outcomes that prevocational (PGY1 and PGY2) doctors should achieve by the end of their programs.

Revisions to the outcome statements were part of the Sept-Nov 2020 and March - April 2021 consultation processes. Broadly stakeholders have been supportive of the proposed outcome statements and changes have been made in response to feedback.

What is different? The final draft of the outcome statements are presented for confirmation. The outcomes contain minor wording changes in response to the last consultation and importantly new Aboriginal and Torres Strait Islander outcomes.

The prevocational outcome statements are aligned with the medical school graduate outcome statements. The AMC considers this alignment important. A review of the medical school accreditation standards has commenced and it is intended that the outcome statements for each phase of training will continue to be aligned.

The revisions to the outcome statements are at **SECTION 2A ATTACHMENT A.** This includes a summary of the changes made in response to feedback in the April 2021 consultation. A summary of the revisions is provided below:

Stakeholder feedback	Response
Feedback on revisions to the outcome statements was broadly supportive with detailed suggestions of mostly minor changes to wording in the domains.	Further minor adjustments made to wording in response to March – April 2021 stakeholder feedback (in green text).
Stakeholder feedback was broadly supportive of an individualised procedural list captured in the e-portfolio.	The AMC has confirmed that there will be a learner-centred list, captured in the e-portfolio which will include a basic list as a drop-down menu and free text spaces for additional procedures.

There was emphasis on the importance of consulting with Aboriginal and Torres Strait Islander stakeholders for relevant domains.	A Sub Group of the AMC Aboriginal, Torres Strait Islander and Māori Committee has developed new outcomes for broader consultation. Consultation will include targeted workshops with Aboriginal, Torres Strait Islander and Māori organisations.
Stakeholders mentioned the increasing impacts of climate change on health, and the importance of addressing environmentally sustainable healthcare within the domains.	Additional text has been added to the introduction to Domain 3 to include reference to the impact of broader systemic issues on health. The introductory text of Domain 4 has been adjusted to emphasise the importance of system "stewardship".

Questions

i. In line with community health needs and related national and AMC strategic commitments, the scope of the review included strengthening Aboriginal and Torres Strait Islander health in the Framework. A Sub Group of the AMC Aboriginal, Torres Strait Islander and Māori Committee has developed new Aboriginal and Torres Strait Islander outcomes. The consultation on these outcomes will include targeted workshops with Aboriginal and Torres Strait Islander organisations. Do you have any feedback on the new and revised outcomes?

The revised outcomes are welcome and supported.

Note: further information about the assessment of these outcomes is included in **SECTIONS 3A-C ATTACHMENT A** and will include a process for demonstrating achievement of any outcomes that cannot be observed in clinical practice.

ii. Do you have any other final comments on the prevocational outcome statements?

Overall, we support the revised outcome statements, however a number of suggestions for modification are provided below:
In Domain 2: The Prevocational Doctor as a Practitioner

- Suggest consideration for a statement on the rapidly evolving ethical framework of healthcare. In Queensland there have been two legislative changes that shift the ethical environment such as the *Termination of Pregnancy* and *Voluntary Assisted Dying* laws.
- Provisions exist for conscientious objection from practitioners to providing care for the above patient cohorts however the Doctor as a Practitioner, would need to ensure that patient care is adequately handed over if they are not ethically in a position to provide care.
- This may be an extension of statement 2.2

Domain 4: The prevocational doctor as a professional and leader

- 4.4 Take increasing responsibility for patient care
- Suggest this might be reworded to: Take increasing responsibility **as experience progresses** - otherwise there is no concept of time or practice maturity in the statement.

B. Entrustable professional activities – characteristics of the work of the PGY1 and PGY2 doctors

The AMC has drafted four entrustable professional activities (EPAs) as part of the revised two-year framework. The EPAs aim to describe the key clinical work of PGY1 and PGY2 doctors, providing clarity about the most important work and learning activities. Anchored to the prevocational outcome statements, the EPAs help to align the role, outcomes and assessment of PGY1 and PGY2 doctors and reinforce the importance of clinical work. The assessment of EPAs will increase structured opportunities for observation, feedback and learning, and inform global judgements at the end of terms/years. The draft EPAS have been developed using the Royal Australasian College of Physician Basic Training Curriculum EPA structure and content, with permission.

The AMC's thinking on the EPAs in the prevocational context is as follows:

- An EPA is a description of work. This contrasts with outcomes or capabilities which describe characteristics of the doctor.
- An EPA is not an assessment tool but performance of an EPA can be assessed. The assessment of EPAs will include judgements about entrustability, the level of supervision required for the prevocational doctor to perform the work safely.

- While the same EPAs will be assessed for PGY1 and PGY2 doctors, they will be assessed at a higher level for PGY2 doctors based on the complexity, responsibility, level of supervision and entrustability, as well as the context of PGY2 doctors' work.

The AMC held workshop sessions in June 2021 to test the draft EPAs with small groups of stakeholders (including Directors of Clinical Training, Medical Education Officers, supervisors, registrars and interns) in each state/territory. Feedback from these groups was broadly positive, and supportive of the structure and content of the draft EPAs with some suggestions for revision. The AMC has also sought expert input from Dr Claire Touchie, Chief Medical Education Advisor, Medical Council of Canada, on the draft EPAs. Dr Touchie evaluated the EPAs using the EQual rubric[1] and her feedback on the draft EPAs was that they were largely of good quality.

Overview of the EPAs:

EPA	Summary
EPA 1: Clinical assessment	Conduct a clinical assessment of a patient incorporating history, examination, and formulation of a differential diagnosis and a management plan. (Based on RACP's EPA 1)
EPA 2: Recognition and care of the acutely unwell patient	Recognise, assess, escalate appropriately, and provide immediate management to deteriorating and acutely unwell patients. (Based on RACP's EPA 7)
EPA 3: Prescribing	Appropriately prescribe therapies (drugs, fluids, blood products, inhalational therapies including oxygen) tailored to patients' needs and conditions, either in response to a request by the treating team or self-initiated. (Based on RACP's EPA 4)
EPA 4: Team communication – documentation, handover and referrals	Communication about patient care, including accurate documentation and written and verbal information to facilitate high quality care at transition points and referral. (Based on combining RACP's EPA 3 (documentation) and 5 (transfer of care))

The draft EPAs were part of the September-November 2020 and March – April 2021 consultation processes. Broadly stakeholders have been supportive of the proposed changes and further changes have been made in response to feedback.

What is different? The final draft of the EPAs are presented for confirmation. The EPAs contain minor wording changes in response to the last consultation and importantly new Aboriginal and Torres Strait Islander content.

The AMC is conducting a targeted trial of the draft EPAs and draft EPA form (See **Section 2F** of this document) in August – September 2021 to test the draft EPAs with health services across jurisdictions.

The draft revised EPAs are at **SECTION 2B ATTACHMENT A.** This includes a summary of the changes made in response to feedback in the April 2021 consultation. A summary of the revisions is provided below:

Stakeholder feedback	Response
Overall, there was support for revisions made to the EPAs and the changes made appear to have responded to earlier feedback.	Additional minor revisions have been made in green text.
Some stakeholders requested specific EPAs or components of EPAs (e.g. mental health).	The EPAs are intended to include mental health presentations. Additional text has been added to EPA 2 to indicate that the EPA includes recognition and care of a rapid decline in mental health.

Questions
i. In line with community health needs and related national and AMC strategic commitments the scope of the review included strengthening Aboriginal and Torres Strait Islander health in the Framework. A Sub Group of the

[1] Taylor DR, Park YS, Egan R, et al. EQual, a Novel Rubric to Evaluate Entrustable Professional Activities for Quality and Structure. Acad Med. 2017;92(11S Association of American Medical Colleges Learn Serve Lead: Proceedings of the 56th Annual Research in Medical Education Sessions)

AMC Aboriginal, Torres Strait Islander and Māori Committee has developed new behaviours related to Aboriginal and Torres Strait Islander patients. The consultation on these behaviours will include targeted workshops with Aboriginal and Torres Strait Islander organisations. Do you have any comments on the new behaviours?

The inclusion of the new behaviours is supported, however further detail on how these and the associated processes will be implemented is required.

Note: further information about the assessment of the EPAs is included in **SECTIONS 3A-C ATTACHMENT A**.

ii. Do you have any other final comments on the entrustable professional activities? The approach to entrustable professional activities is supported, however feedback from the sector remains mixed in regard to the number of EPA's, and varies from those who feel the number is excessive to those who feel more would enhance the interns learning experience. There is also a consistent concern regarding the workload associated with the EPA's on supervisors and all efforts should be made to ensure that the systems enabling this process to decrease the administrative burden on supervisors.

The success of the EPA's is largely reliant on the e-portfolio platform. Implementation of the EPA component of the framework prior to implementation of a on-line system to enable this process is not supported. As mentioned in section 1 above, the dependence of the framework on the e-portfolio system is inherent and the governance arrangements for the framework should be holistic and extend to include that of the e-portfolio.

C. Record of learning

The review is proposing that a record of learning will be incorporated into the revised framework and captured in an e-portfolio. This would include components such as:

Access to training and assessment material:

- Outline of and access to training requirements (outcome statements and EPAs).

Record of training and assessment:

- Record of longitudinal achievement/progress against outcome statements and EPAs.
- Record of assessments.
- Record of additional education training (export/ import) e.g. Basic Life Support or hand hygiene.
- Record of procedures - for prevocational doctor to add procedures (not a prescribed list).
- Space for prevocational doctors' goals and reflections

The proposal that a record of learning be incorporated in the revised framework and captured in the e-portfolio was part of the March – April 2021 consultation process. Stakeholder feedback was supportive of the record of learning and suggested areas to be included. The specifics will be developed alongside the e-portfolio.

The draft revised record of learning is at **SECTION 2C ATTACHMENT A**. This includes a summary of the changes made in response to feedback in the April 2021 consultation.

Questions

Important note: Further information about the e-portfolio is provided in **Section 5** of this document.

i. Do you have any other final comments on the record of learning?

Nil further comments.

D. Proposals for revisions to assessment (including improving performance and certifying completion)

In line with the confirmed scope and evaluation feedback, the AMC has developed some proposals for revisions to assessment processes for PGY1 and PGY2 doctors.

There are three principles guiding the proposed changes to assessment:

- Strengthening the quality, consistency, relevance and longitudinal nature of assessment, including increasing opportunities for feedback.

- An e-portfolio will support the revised assessment process; as a mechanism to facilitate a longitudinal approach to assessment and to streamline the process.
- Supervisor training and engagement will be critical. The review is proposing that supervisor training requirements be strengthened. The AMC will develop online training materials for supervisors of prevocational trainees. This will include training and support for registrars. Prior training completed for supervision of other cohorts (such as medical students or college trainees) would be recognised.

The revisions to the assessment processes were part of the September - November 2020 and March – April 2021 consultation processes. Stakeholder feedback was broadly positive and suggestions for change were minor. Most feedback had been raised in previous discussions and there were no new areas for discussion.

What is different? The final draft of the assessment process is presented for confirmation. The assessment process contains minor wording changes in response to the last consultation and importantly a new process for assessing Aboriginal and Torres Strait Islander outcomes.

The draft revised assessment process is at **SECTIONS 3A-C ATTACHMENT A**, including a summary of the changes made in response to feedback in the April 2021 consultation.

Questions
SECTION 3A ATTACHMENT A - Assessment approach i. Do you have any other final comments on the assessment approach? **SECTION 3B ATTACHMENT A** - Improving performance (previously "Remediation") ii. Do you have any other final comments on the improving performance process? **SECTION 3C ATTACHMENT A** - Certifying completion iii. Do you have any other final comments on the certifying completion process?

E. Revised - Term assessment form

The Intern Training - Term Assessment form was designed to facilitate assessment against the intern outcome statements. The assessment form, last revised in 2014, is used during the mid-term and end of term assessments of PGY1 doctors. In some States and territories the form is also used for PGY2. The form allows initial self-assessment by the intern for discussion with the supervisor. The form is nationally available but is not currently mandated and there has been some adaptation of the form at the local level in each State and Territory. To ensure consistency of implementation, the AMC is proposing to mandate the use of a new revised form within the e-portfolio. Note: This form will be translated into an online version prior to implementation. To reduce the burden on supervisors completing the form, most of the details in the form will be pre-populated in the e-portfolio.

The initial revisions to the term assessment form were included in the March-April 2021 consultation process.

What is different? The final draft of the term assessment form is presented for confirmation. The form contains minor wording changes in response to the last consultation.

The revised term assessment form is at **SECTION 3D ATTACHMENT A**. This includes a summary of the changes made in response to feedback in the April 2021 consultation. A summary of the revisions is provided below:

Stakeholder feedback	Response
Broad support to record additional evidence to demonstrate progress against an outcome where it has not been observed.	The review will continue with proposed approaches to global term ratings and capacity for additional evidence to support assessment of achievement of outcome statements that have not been observed in clinical practice.
Stakeholders support the proposed change in wording from 'borderline' to 'conditional'.	The wording in the Global Rating scale at the end of the assessment form was changed from 'borderline' to

	'conditional pass' to reflect the principle that assessment is a longitudinal process across the year.
Support for a mandated national form to increase consistency and standardisation as well as portability across the country.	The review will proceed with mandating the form and make no further changes based on the feedback received.
Concern that a level of detail will be lost when making ratings against the domain and that the removal of "clinical anchors" may make using the form more difficult for supervisors.	As stated, the review will progress with global ratings and will consider mechanisms for tracking individual outcomes across the year in the development of the e-portfolio.

Questions

i. Do you have any other final comments on the term assessment form?

The content of the assessment form appears appropriate, however feedback from the sector, sees concerns raised over the length and complexity of the form and highlights a risk that the length and complexity of the form may detract from reliable and robust assessment processes and outcomes. No suggestions, however as to how the length of the form may be addressed are offered, however it is hoped that the translation of the form into a online format and the associated formatting may assist in the delivery of a form that appears less overwhelming and complicated.

Once again, our position is that the implementation of the framework should not progress until such time as an electronic platform for the assessment forms and the subsequent integration into a e-portfolio is available.

F. Revised - Entrustable Professional Activity assessment form

An assessment form has been developed to assess the new entrustable professional activities (EPAs) (**SECTION 3E ATTACHMENT A**). The form will be translated into an electronic format for the e-portfolio. Multiple existing forms and processes have been considered in the development of this draft, including The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Confirmation of Entrustment forms, the Western Sydney University Medical School EPA trial and the Royal Australasian College of Physicians EPA form. The first draft of the form was included in the March-April 2021 consultation process. Stakeholder feedback was supportive of the form. Minor changes have been made in response to stakeholder feedback.

Note: This form will be translated into an online version for use in the e-portfolio prior to implementation. Most of the details in the form will be pre-populated in the e-portfolio.

What is different? The final draft of the EPA form is presented for confirmation. The form contains minor wording changes in response to the last consultation.

The EPA form is at **SECTION 3E ATTACHMENT A**. This includes changes made in response to feedback in the April 2021 consultation.

Questions

i. Do you have any other final comments on the EPA form? No further comments. Please refer to the comments above.

3. Training environment

The AMC is proposing some significant changes to prevocational program and term requirements in line with stakeholder feedback received during the evaluation phase of the review.

ATTACHMENT B describes the accreditation requirements for prevocational programs. A summary, including areas for consultation is provided below:

Component	Status in review
Section 2. National standards for programs	Proposed changes were consulted on in November 2020 and April 2021. Further minor wording changes have been made based on responses to recent consultation. New standards related to Aboriginal and Torres Strait Islander Health.
Section 3. Requirements and guidelines terms and programs (previously Intern Training – Guidelines for Terms)	Proposed changes were consulted on in November 2020 and April 2021. Further detail has been added and a number of changes have been made based on responses to the recent consultation.
Registration standard	The Medical Board of Australia standard on granting general registration to Australian and New Zealand medical graduates on completion of internship sets out the current term requirements. The registration standard will need to be amended to reflect the revised framework in consultation with the Board and stakeholders.

A. Proposals for change to the National standards for programs

The previously titled Intern Training – National Standards for Programs outlines the requirements for process, systems and resources that contribute to good intern training. Postgraduate Medical Councils are currently required to map their accreditation standards to these program standards.

The revisions to the national standards were part of the September -November 2020 and March – April 2021 consultation processes. Stakeholder feedback was broadly positive.

What is different? The final draft of the national standards is presented for confirmation. The national standards contain minor wording changes in response to the last consultation and importantly new Aboriginal and Torres Strait Islander content.

The revised national standards are at **SECTION 2 ATTACHMENT B**. This includes a summary of the changes made in response to feedback in the April 2021 consultation. A summary of the revisions is provided below:

Stakeholder Feedback	Response
Broad support for the changes overall with many stakeholders saying changes have increased the clarity of the standards and reduced duplication. Stakeholders suggested increased emphasis on: • Supervisor support (dedicated supervision time and wellbeing are areas of note) • Prevocational doctor wellbeing, especially in relation to burn-out and rostering	There have been minor wording changes to emphasise prevocational doctor wellbeing and strengthen language around resourcing and educational training.
<u>Mandated national standards</u> Broad support for mandated national standards to increase consistency of training. Stakeholders commented that the language of the standards was 'hospital-centric.'	• The AMC will mandate national standards with flexibility for additional state/territory level requirements. • The AMC will review the standards through the lens of rural and general practice to ensure standards can continue to apply in range of settings.

Mandated supervisor training Broad support for mandated supervisor training within the proposed timeframes, with the burden on supervisors being the greatest concern.	The review will propose mandatory training for all term supervisors (with recognition of other relevant training) within three years of implementation and will develop resources to support supervisors.

Questions

i. In line with community health needs and related national and AMC strategic commitments the scope of the review included strengthening Aboriginal and Torres Strait Islander Health in the Framework. A Sub Group of the AMC Aboriginal, Torres Strait Islander and Māori Committee has developed new and revised standards related to Aboriginal and Torres Strait Islander health and doctors. Consultation on these standards will include targeted workshops with Aboriginal and Torres Strait Islander organisations. Do you have any comments on the new standards?

The new standards are welcome and supported. Some feedback from the sector has raised concerns in regard to how these will be assessed, and the equivalence of 'real life' experience to that of the completion of an 'accredited training course'. It is suggested a guideline on the interpretation of these standards and the associated processes would be of benefit.

ii. Do you have any other final comments on the national standards? No further comments.

iii. Based on previous consultations the AMC is proposing to mandate the use of the national standards by accreditation authorities (Postgraduate Medical Councils), still allowing state and territories to develop additional requirements to support their local context. Are there any additional key areas or requirements that need to be included nationally if the standards are mandated?

Mandating the use of the national standards is supported, however, to fully achieve what is considered to be the intent of this approach, national oversight of the implementation is required. This should be considered, when the overall governance of the framework is considered, as the effective and consistent implementation will support the achievement of the intended outcomes of the framework and the overall review process. In considering national oversight of the implementation of the framework, there should be opportunity for each of the jurisdictions and PMC's to provide input, with representatives involved at the governance level.

The framework will need to be supported by a range of supporting and interpretive documents including guidelines on the interpretation of ratings and standards and processes for 'substitution' of experiences should these not be available within the assigned clinical environment, such as is the case for the Aboriginal and Torres Straight Islander competencies.

As the framework will extend into the PGY2 (and possibly further) year, movement of individuals between facilities and jurisdictions will occur. A nationally consistent approach as to how this movement, at various times throughout the training period will be managed is also required to reduce the burden on employers and individuals wishing to change employers. Such a process would be assisted by a national approach to interpretation and implementation of the framework.

B. Proposals for change to the requirements and guidelines for programs and terms

The previously titled Intern Training – Guidelines for Terms outlines the experience that interns should obtain during terms and builds on the Medical Board of Australia's general registration standard. The September – November 2020 consultation proposed concepts for change. The term guidelines have been revised in response to stakeholder feedback and a number of significant changes are proposed.

One of the proposed changes is to discontinue the current mandatory term model. Feedback from stakeholders suggests that the mandatory term model has been challenging to implement in the current healthcare environment and does not necessarily meet the intended purpose of standardising the intern experience. Key issues raised by stakeholders during previous consultation include:

- The current acute public hospital model is not reflective of community health needs

- The model restricts flexibility to explore and take advantage of valuable learning experiences in expanded settings (outside acute public hospitals)
- Defining the setting does not necessarily ensure relevance, quality or consistency of the learning experience
- Capacity constraints and changing models of care (e.g. high acuity, short stay, increasing specialisation) have resulted in significant variations in interns' experience of mandatory terms. Health services report that they face challenges in providing enough terms that meet current requirements.

The proposed revisions are aimed at improving the longitudinal nature and flexibility of prevocational training programs and the quality and relevance of learning experiences.

The Medical Board of Australia's Registration Standard "defines the supervised intern (provisional registration year) training requirements that must be completed in order for graduates of Australian and New Zealand medical programs accredited by the Australian Medical Council and approved by the Medical Board of Australia to be eligible for general registration."

The registration standard defines the current mandatory term requirements, which the review is suggesting should be revised. If this occurs the registration standard will require review. Detailed proposals will be included in a future Medical Board of Australia consultation process.

The term guidelines were revised in response to stakeholder feedback and a number of significant changes are proposed, including the introduction of parameters for programs and terms to replace the current mandatory term requirements. The draft revised requirements and guidelines document, including parameters to replace current mandatory term requirements, were part of the March - April 2021 consultation process.

What is different? The final draft of the requirements and guidelines for programs and terms is presented for confirmation. The requirements and guidelines have been restructured and minor wording changes made to address stakeholder feedback.

The revised requirements and guidelines for programs and terms for consultation is included in **SECTION 3 ATTACHMENT B.** A summary of significant changes to the requirements and guidelines for programs and terms is below:

Stakeholder Feedback	Response
Overall There is broad support for the changes to this section of the Framework. Feedback received in sessions with health service representatives across jurisdictions and formal consultation feedback suggested further clarity and restructuring was required.	• The review will continue with the proposal to replace the current mandatory term requirements. • Proposed parameters have been re-structured into program level requirements and term level requirements, and re-classified by intent.
Proposed parameters Many stakeholders agree the suggested parameters meet the proposed aims, with strong stakeholder support for promoting generalism and for reflecting the reality of health care delivery and settings. Further clarity was requested, especially definitions of "service terms", "after-hours", "being part of a team", "major discipline" and "sub-specialty discipline". Breadth parameters: General agreement that the four areas of care (A, B, C, D) are appropriate. The main concerns were whether small sites could offer all 4 care types, and if a term could be classified in more than one area and how this would be determined.	• Parameters have been restructured and wording has been clarified to address feedback. • The AMC will provide examples of how current terms fit into proposed parameters.

Maximum length of PGY2 training Stakeholders gave mixed feedback regarding the maximum period of 3 years to complete PGY2 training.	• Requirements regarding length of training should be clearly stated to provide national standardisation. • The review is proposing to extend the maximum time to complete PGY2 to 4 years.
Different requirements for PGY1/2 There is broad support for the difference in proposed parameters for PGY1 and PGY2 and strong support for increased flexibility in PGY2.	• The goal of the review is that PGY1 and PGY2 doctors have broad exposure across a range of disciplines or specialties. • A requirement for all prevocational trainees to work outside standard hours (with appropriate supervision) will be moved into the standards
Mandated community terms There was broad in principle support for the proposal to introduce mandatory community terms in the future to reflect the reality of patient care, to provide a valuable learning experience and to help address workforce issues. Positive feedback was received regarding the Prevocational General Practice Placements Program (PGPPP). Stakeholders' main concern was resource constraints and it was suggested that funding to support community terms would be required, and potentially changes to Medicare billing rules. Stakeholders also want to ensure that prevocational doctors would not be disadvantaged by variability between GP settings.	• The review will continue to recommend mandatory community terms at some time in the future.

Questions

i. Do you have any other final comments on the requirements and guidelines for programs and terms?

The revised guidelines for programs and terms appear sound, and separation of these is welcomed. It is our understanding that implementation of the framework will likely occur as a staged implementation with programs assessed in accordance with the four-year accreditation schedule. A nationally consistent approach to the implementation 'milestones' would be welcomed as would a national approach to the translation of currently accredited terms, being a 'core' or 'non-core' term to the revised requirements. Further guidance is also required on how the depth and breadth of terms should be considered to ensure consistency in interpretation and application through accreditation processes.

We would also like to draw attention to the fact that Queensland does not currently have an established PGY2 accreditation program and therefore cannot be readily compared to other states and territories that have existing and established programs. This should be considered in any implementation planning.

4. Quality Assurance

Under the current National Internship Framework, the AMC accredits the bodies that accredit intern training programs. The AMC does this on behalf of the Medical Board of Australia. A separate organisation in each state/territory is responsible for accrediting intern training posts and programs.

The AMC began the accreditation of intern training accreditation authorities in 2013, and has completed the first cycle of accreditations of the established authorities.

The AMC assesses the performance of each of the intern training accreditation authorities against the requirements in Intern training – Domains for assessing accreditation authorities. The Domains were last reviewed in December 2016 when changes were made to clarify expectations about prevocational doctor wellbeing and processes for responding to known patient safety issues.

The AMC has standardised policies on the conduct of its accreditation processes. These describe how the AMC manages confidentiality, conflicts of interest, complaints and appeals, and the key steps in any accreditation process, such as appointment of a team to complete the assessment, the activities of the team, and the interactions between the team and the organisation being reviewed.

The AMC procedural documents for each training stage are broadly aligned, with some differences in the processes. Additionally, the AMC conducts regular evaluations of its accreditation processes across the training continuum and adjustments are made to all the procedural documents as required. The procedures for assessment and accreditation of intern training accreditation authorities by the Australian Medical Council are available here. These procedures were last updated in 2019.

Based on evaluation and consultation activities in 2019 and 2020, the review proposed that major changes were not required to AMC domains or procedures for accrediting postgraduate medical councils (intern accreditation authorities). Initial proposals for changes to the Domains and Procedures were part of the March-April 2021 consultation process.

What is different? The final draft of the Domains and Procedures is presented for confirmation. The Domains and Procedures contain minor wording changes in response to the last consultation.

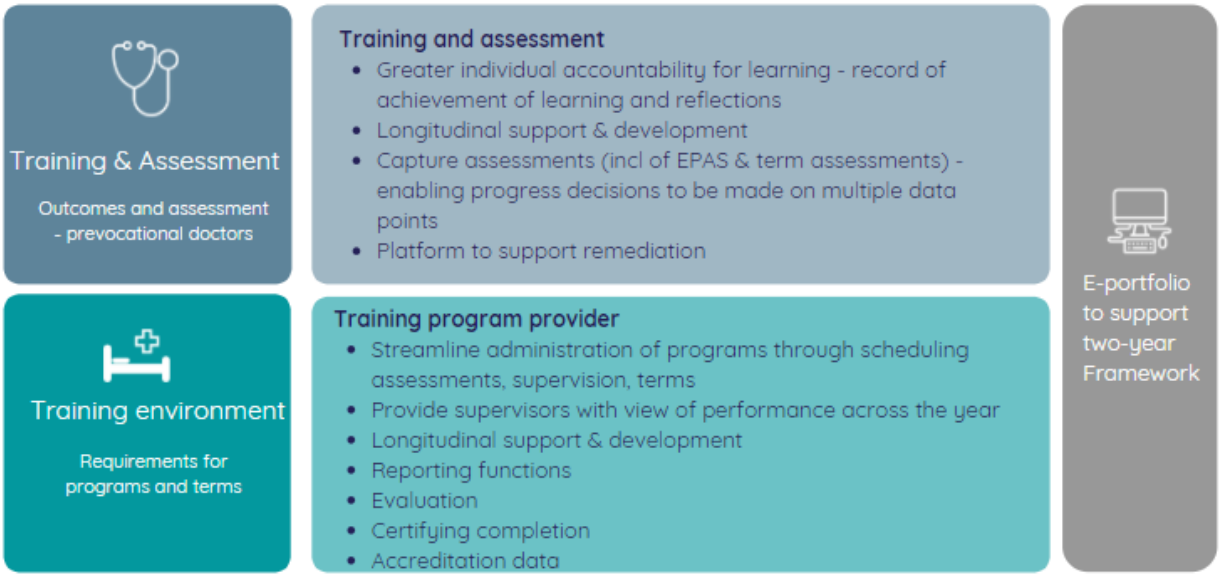
The revised Domains and Procedures are at **SECTIONS 2-3 ATTACHMENT C**. This includes a summary of the changes made in response to feedback in the March - April 2021 consultation.

Questions
i. Do you have any other final comments on the Domains for assessing prevocational accreditation authorities?
No further comment
ii. Do you have any other final comments on the Procedures for assessing prevocational accreditation authorities?
No further comment

5. E-portfolio specifications

The AMC was appointed by the Australian Health Ministers' Advisory Council (now the Health Chief Executives Forum) to develop e-portfolio specifications to support the implementation of a two-year capability and performance framework.

The prevocational e-portfolio is a critical component of the revised Framework. It is intended to provide greater individual accountability for learning and support the assessment processes. It will also facilitate a longitudinal approach to prevocational training, providing a mechanism to support development across the two years, and streamline administration of the program. A diagram illustrating possible functions of the e-portfolio is provided below.



The draft high-level e-portfolio specifications developed on the basis of other similar systems (for example the Medical Council of New Zealand's E-Port) were part of the September - November 2020 and March – April 2021 consultation processes. Stakeholders were broadly supportive of the direction of the specifications.

What is different? The final draft of the high-level e-portfolio specifications is presented for confirmation. The high-level e-portfolio specifications contain minor wording changes in response to the last consultation.

The revised high-level e-portfolio specifications are at **ATTACHMENT D**. This includes a brief summary of the changes made in response to feedback in the April 2021 consultation.

Important note: The 2018 Health Ministers' response to the 2015 Review of Medical Intern Training included a recommendation for national specifications for an e-portfolio with development and implementation at state and territory level. In consultations the AMC has received strong feedback from stakeholders supporting a national approach to development and implementation of a prevocational e-portfolio. Reasons have included national consistency, efficiency and cost effectiveness. The AMC has put forward a proposal to the Health Chief Executives Forum and is engaging in discussions with relevant stakeholders.

Questions

i. Do you have any other final comments on the high-level e-portfolio specifications?

Overall, the specifications are supported, however a number of suggestions are provided below:

Page 3 Draft detailed specifications of e-Portfolio
Section B – Training and Assessment- certifying completion
Second dot point

- For PGY2 data reported to the AMC – there is a need for clarity as to what the AMC will do with this data, how will it be assessed, reviewed, outcomes applied. We suggest that rather than the data being reported to the AMC directly that the employing facility has the responsibility to report to the AMC on the successful completion (or otherwise) of the PGY2 year for each individual. It is appropriate that the AMC has access to statistical data (de-identified) but not that of individuals. While it may be appropriate that the AMC issues a certificate of completion or the like, the responsibility for a recommendation based on interpretation of the data available should be the employers
- Suggest that for PGY2 there may be an interest from the Speciality Medical Colleges to have data access at a high level – could be applied to fast-track trainees based on levels of clinical experience etc. While there is significant benefits in this approach, the 'ownership' of the data needs to be clarified and a permission cascade should be used prior to the ability of Speciality Medical Colleges to access this data.

Page 13
Table C Training environment – delivery and management
PGY1/2 Doctor information

- This should include a record of service option
- This should include the ability to provide a summary of employment information especially when staggered start times and mid-year intakes are commenced

In addition to the specifications, the document would be enhanced by the inclusion of a general introductory statement about the intended scope of the e-portfolio – and out-of-scope elements. For example: would not expect that the information in the e-portfolio be used as a recruitment and selection process. The consent, privacy provisions and data sharing agreements of the e-portfolio are important to protect the user, with the appropriate use of these to be considered in the overall governance of the e-portfolio. Please also refer to the comments above re the requirements for clear governance of the e-portfolio system.

6. Phase 3: Preparation and Phase 4: Implementation

The Review will progress to Phase 3: Preparation in 2022. The following provides an outline of plans for Phase 3: Preparation and Phase 4: Implementation. The AMC is seeking feedback from stakeholders on these plans in this consultation and will be engaging in further discussions in 2021 to shape its thinking. After consideration of this feedback a detailed implementation plan will be produced in early 2022.

2022 – Phase 3 – Preparation: Communication and resources

2022 will be a year for the prevocational training and accreditation system to plan and prepare for the phased implementation of the revised Framework beginning in 2023. There will be regular communication activities to support preparation for process changes, revision of policies and procedures, and training of accreditation team members,

supervisors and others involved in prevocational training. The AMC will develop and test resources to support implementation of the revised two year framework.

Communication activities and resource development will be staged, as summarised in the table below, which has been drawn up in response to feedback from stakeholders on issues they would like to be addressed in the training material.

	AMC
Stage 1 (2021)	**Communication** • Sessions with stakeholders - targeted and general – on changes to the framework. The AMC welcomes opportunities for discussions with stakeholders. **Testing** • Paper-based trial of the EPAs and EPA forms in health services across jurisdictions (September 2021) • Desktop trial of changes to term structures with health services across jurisdictions (September – October 2021) **Resources** • Development and distribution of communication packs to assist stakeholders in preparation and communication activities • Webinars to present and discuss changes to the framework (early 2022) focussing on: o Changes to training and assessment processes o Changes to national standards and program and term requirements (for health services and accreditation authorities)
Stage 2 (Early – Mid 2022)	**Communication** • Further sessions with stakeholders - targeted and general – on changes to the framework. • Updated communication packs as required – to assist stakeholders in preparation and communication activities **Resources (planned - TBC)** • Written guidelines: o Training and Assessment – Describing changes to training and assessment processes, including assessment of entrustable professional activities, to support participants in prevocational training, including prevocational doctors and health services,. o PGY1/PGY2 guide – Revision of the current Guide to Intern Training document. o Aboriginal and Torres Strait Islander content – describing changes and providing links to resources o e-portfolio – a user guide will be developed to support an e-portfolio if a national system is agreed (late 2022) • Videos: o Training and Assessment – Outlining: changes to training and assessment, including the assessment panel, assessing EPAs and improving performance processes. o Training environment - Changes to national standards and program and term requirements (for health services and accreditation authorities) o e-portfolio (TBC) - to be developed to support an e-portfolio if national system developed. (late 2022) **Testing** • e-portfolio – if a national system is agreed.

2023 – Phase 4 – Implementation: Phased implementation of changes

The AMC is planning a phased approach to implementation of the revised Framework. It is acknowledged that there are some significant changes proposed and that implementation will need to be flexible and incremental. It is planned that the new framework will be implemented for PGY1 in 2023 and for PGY2 in 2024. The following table provides an outline of a phased implementation. The AMC is seeking feedback from stakeholders on these plans in this consultation and will be engaging in further discussions in 2021 to shape its thinking. Based on this feedback a detailed plan will be provided in early 2022.

Note: the timing in the table below is based on the development of a national e-portfolio. The AMC has developed a separate plan in the event of a decision that e-portfolios should be developed in each state/territory or if its development is delayed. Under these circumstances it is expected that implementation of components of the framework that are strongly supported by the e-portfolio (e.g. the EPA assessments) would be delayed.

	Training and assessment	Training environment	Quality assurance	E-portfolio
2023	**Health services:** Implement training and assessment changes for PGY1, including: • Revised training (outcomes & EPAs) • Revised assessment (EPAS) • Assessment panel	**Health services:** Implementation of new national standards and program/term requirements for PGY1. Some components of the national standards will have extended implementation timeframes, for example term supervisor training within three years of implementation. * **PMCs:** Accreditation of health services to follow current cycle with monitoring reports to describe progress towards implementation of the new framework.	**PMCs:** Implementation of changes for PGY1. **AMC:** Accreditation following current cycle with monitoring reports to describe progress towards implementation of the new framework	Support introduction of new framework for PGY1.
2024	**Health services:** Implement training and assessment changes for PGY2, including certification of completion of PGY2. **AMC:** Certification of completion of PGY2.	**Health services & PMCS:** Implementation of new national standards and program/term requirements for PGY2. Some components of the national standards will have extended implementation timeframes .	**PMCS:** Implementation of changes for PGY2. **AMC:** Accreditation following current cycle with monitoring reports to describe progress towards implementation of the new framework.	Support introduction of new framework for PGY2.

Questions

i. The AMC is seeking your feedback on the outline of plans for Phase 3: Preparation, including plans for communication activities and resource development. Are there additional topics, resources or activities that should be included?

Please refer to comments above re the need for a nationally consistent approach to implementation, with key milestones identified. This should be included in phase 3 and should involve significant consultation with PMC's in the development of such an approach, with extends to a planned transition of currently accredited programs and posts. To suppose increased consistency during the implementation, phase a number of templates for PMC's to use for communication and guidance on interpretation of key standards, particularly the guidelines for programs and terms will also be of assistance. There is a degree of angst re what the term experience requirements are and how these documents should be interpreted at a program level.

ii. The AMC is seeking your feedback on the outline of plans for Phase 4: Implementation. What are your perspectives on the proposed phased approach and timelines. Are there any components that will be particularly challenging to implement? What information would you like to see included in the implementation plan?

The phased approach to implementation is supported and seems like the most sensible approach, however the timeline of implementation commencing in 2023 is very tight, particularly in light of the fact that many of the resources to support implementation will not be developed till mid-2022. Commencement of a phased approach to implementation in 2024 is much more realistic and will provide jurisdictions, PMC's and training providers adequate opportunity to consider the framework in its entirety and how this will be implemented in the local context. At this stage, with the supporting resources not yet developed or implemented by the AMC and the framework itself, yet to be finalised, the ability of jurisdictions, PMC's and providers to consider the full implications and resources required for implementation is impeded and the successful implementation, including acceptance by the sector is likely to be negatively impacted by what could be considered a 'rushed' implementation.

The sequence of the activities outlined in phase 4 above is supported, however our position is that postponing these activities by 12 months would support a more successful implementation.