General Practice Training and Accreditation Project (GPTAP)

Final Report

12 February 2013

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GLOSSARY

Accreditation	The process by which certification is granted to an organisation which meets the relevant standards and criteria
ACFJD	Australian Curriculum Framework for Junior Doctors
ACRRM	Australian College for Rural and Remote Medicine
AGPAL	Australian General Practice Accreditation Limited
AGPT	Australian General Practice Training
CPMEC	Confederation of Postgraduate Medical Education Councils
GP	General Practice or General Practitioner
GPET	General Practice Education and Training
GPTAP	General Practice Training Accreditation Project
Intern	Doctors in the first postgraduate year of training after graduation from medical school; also called PGY1
JMO	Junior Medical Officer
Junior Doctor	A Prevocational doctor and/or Registrar
MBA	Medical Board of Australia
NPSC	National Project Steering Committee for GPTAP
NTGPE	Northern Territory General Practice Education Ltd
NTPMC	Northern Territory Postgraduate Medical Council
Parent Hospital	The hospital providing a prevocational doctor on rotation to a general practice
PGPPP	Prevocational General Practice Placement Program
PGY	Post Graduate Year (usually PGY1, PGY2 or PGY3)
Pilot Study	A small study conducted in advance of a planned project, specifically to test aspects of the research design and to allow necessary adjustment before commitment to the final design
PMC	Postgraduate Medical Council or equivalent prevocational training accreditation authority
PMCV	Postgraduate Medical Council of Victoria

PMCWA	Postgraduate Medical Council of Western Australia
Prevocational Doctor	A medical practitioner in the early years of clinical practice (PGY1/2/3/4+) who has not yet entered a vocational training program
RACGP	Royal Australian College of General Practitioners
Rotation	A defined period of employment in a unit/department/medical practice
RTP	Regional Training Provider
SGPT	Southern General Practice Training
Standards	The specific objectives, processes or procedures to be achieved and the rationale for the objectives to provide quality education to prevocational or vocational doctors
Supervisor	Clinician designated as being sufficiently qualified and experienced to monitor and direct the clinical learning of a medical trainee
Survey Team	A group of surveyors chosen for their individual expertise to undertake an accreditation survey visit of a health service or facility
Surveyor	An individual trained in all aspects of an accreditation program who acts on behalf of the authorised accrediting body to visit a health service or facility and assess its compliance with the accreditation standards
VMA	Victorian Metropolitan Alliance
WAGPET	Western Australian General Practice Education and Training Ltd

EXECUTIVE SUMMARY

The General Practice Training Accreditation Pilots Project (GPTAP) provides an assessment of the extent to which streamlined and integrated prevocational and vocational training practice accreditation process has delivered robust and consistent accreditation outcomes.

The aim of the GPTAP was to undertake and evaluate pilots in the Northern Territory (NT), Victoria (VIC) and Western Australia (WA) of models of streamlined and integrated prevocational and vocational training practice accreditation. The pilots were designed to assess the applicability and reliability of a single survey and data collection process to support the prevocational and vocational accreditation of training practices by the relevant accreditation bodies in the three jurisdictions.

In all three jurisdictions significant progress was made to implement integrated models. The WA pilots were successful and the parties are now looking at scaling the model on a state-wide basis provided the necessary resource support can be acquired. Part of the success in WA was due to the parties having a previous history of engagement. In addition a lot of preparatory work had been done by Western Australian General Practice Education and Training Ltd (WAGPET) prior to the commencement of the project. They were also helped by having some project team members who were conversant with the requirements of prevocational and vocational training accreditation.

In NT and VIC, a significant amount of time was required to lay groundwork for cooperation between the various parties involved in the accreditation of general practices. The project was as much about generating culture change as it was a technical exercise in streamlining processes and documentation. The key stakeholders previously had little engagement on general practice accreditation matters. Despite the very tight time constraints, significant progress was made in both VIC and NT to develop streamlined and integrated accreditation models for general practices. VIC was able to undertake three joint surveys. In the NT specific local issues meant that the tools developed could not be trialled during the project period.

Each of the jurisdictions prepared a report on the pilot evaluations in their states summarising the work undertaken in the three jurisdictions and these were circulated to the GPTAP National Project Steering Committee (NPSC). This Final report provides a synthesis of those reports. It sets out the background to the project, the governance structures and objectives and gives a brief overview of the three jurisdictional reports. It then draws out the key achievements of the project, highlights some of the challenges addressed, benefits perceived by stakeholders, and the lessons learnt. The report also summarises the comments on the draft final report from the stakeholders represented on the NPSC.

The report concludes with six recommendations:

- GPET to host a symposium on GPTAP to communicate the results of the project and consider ways of embedding the streamlining process further.
- Build on the momentum generated by GPTAP by identifying areas for further development with jurisdictions that were involved in the pilots as well as those who were not part of GPTAP's first phase.
- Develop a more robust costing model for evaluating the impact of integrated models of general practice accreditation
- Aligning of RTP documentation and processes in states with multiple RTPs
- Clarifying governance arrangements for prevocational arrangements in general practice settings
- Widely communicating the findings from GPTAP

In all three jurisdictions the parties have agreed to continue to work together to build on the progress under GPTAP. Indeed, in VIC and WA the parties are already using the model developed under GPTAP to accredit general practice sites not included in the pilot studies. The goodwill created makes it all the more imperative to recognise that some of the beneficial outcomes of the project will continue to flow. In this regard, the project has already demonstrated that integrated surveys are feasible with the right amount of communication and goodwill. The challenge will be to build on the momentum generated and ensure that the gains made are properly embedded.

CPMEC appreciates the opportunity given to manage this project. We acknowledge the work undertaken by NTPMC, PMCWA and PMCV in coordinating the local projects. Special thanks are due to stakeholders from RTPs, Colleges and other organisations who participated as members of project teams at the local and national levels. We would also like to acknowledge the leadership of Professor Rick McLean as Chair of the NPSC in steering the project so effectively.

This project would not have materialised without the support of GPET. We would like to acknowledge the funding support and inputs provided by GPET. Special thanks go to Mr Erich Janssen and Mr Glenn McMahon for their support for the project.

1. BACKGROUND

1.1 GPET and Prevocational Training Accreditation

General Practice Education and Training Limited (GPET) has responsibility for the coordination and delivery of prevocational and vocational training in community based practice through the Prevocational General Practice Placements Program (PGPPP) and Australian General Practice Training (AGPT) programs respectively. GPET funds Regional Training Providers (RTPs) to provide this training across Australia. As part of the overall government objective of providing high quality general practice education and training, one of GPET's plans has been to ' improve the alignment between the AGPT and the PGPPP to improve the transition between the two programs to provide an integrated pathway through the general practice training process'. In this regard GPET noted that in 2012-13, it would 'complete a pilot for an integrated accreditation process which will identify optimum approaches for the consolidation of training practice accreditation across both levels of training.'[1]

The context in which GPTAP had been undertaken was that the Australian Government substantially increased the PGPPP program and also transferred responsibility for management of the PGPPP to GPET whilst RTPs had also become participants in the accreditation of PGPPP sites. PMCs are accountable to the Medical Board of Australia for development and monitoring of accreditation standards to allow interns to meet general registration requirements in all jurisdictions. Furthermore, in some jurisdictions PMCs are also accountable to state health departments for the accreditation of PGY2 posts and beyond. Additionally, jurisdictions have varying approaches to junior trainees being able to access training through the PGPPP. Some states allow interns to undertake these terms whilst others do not. Another significant contextual influence was the previous history of engagement of PMCs with their local RTPs. These ranged from being relatively strained through to largely non-existent relationships.

1.2 CPMEC and General Practice Accreditation

CPMEC is an advocate of streamlining accreditation processes to promote greater national consistency and reduce the burden on health service providers. This has been previously manifested in the work undertaken to develop the Prevocational Medical Accreditation Framework (PMAF)[2]. In relation to GPTAP, CPMEC is supportive of streamlining the PGPPP accreditation process to reduce the burden on the general practice and its supervisors. Some PMCs were a little hesitant about attempts to streamline the process noting the following concerns:

[1] GPET – Agency Budget Statements – Outcomes and Planned Performance, p. 436
[2] CPMEC, Prevocational Medical Accreditation Framework, 2009

- PMCs had been involved in accreditation processes for junior doctors for more than a decade and had built up significant expertise in the accreditation of community postings including PGPPP posts
- The development of different jurisdictional approaches to PGPPP accreditation has been driven historically by a different level of, and motivation for, involvement in the program. Those with longer experience in PGPPP have adopted a largely incremental approach, adapting principles of hospital accreditation standards to the general practice context. In most cases there is some documentation to recognise the differences between hospital and GP learning environments. Others such as NSW had to develop a fast-tracked process to accredit a large number of PGPPP sites at short notice
- It was highly desirable that prevocational doctors continue to have the opportunity to experience a GP rotation irrespective of the subsequent specialisation.
- There were some elements of education and training requirements that were common for doctors in training at all levels from early prevocational to advanced training such as infrastructure and facilities. However, some elements were more important for prevocational doctors, who have different requirements with regard to welfare, education and supervision. Any move towards a streamlining of accreditation processes needed to ensure that the specific requirements at the prevocational level would be specifically addressed.
- PGPPP accreditation standards should address both governance and program management, in line with the national standards developed and agreed to by all PMCs under the Prevocational Medical Accreditation Framework (PMAF)[i]. PMCs have found this categorisation of standards to be useful in separating issues around facility structures from accreditation of individual units in their own PGPPP accreditations.
- Any streamlined accreditation model will need to acknowledge the role and responsibilities of the various groups involved in PGPPP accreditation. This will include recognition of RTPs as leaders and coordinators of the PGPPP, with PMCs as having accountability for setting standards for prevocational training and retaining the right to review any practice where concerns are raised.
- PMCs would need to develop a process with RTPs to ensure that the education and training functions of the RTP as they relate to prevocational training meet accreditation standards. CPMEC acknowledges that the details of the accreditation process may require some degree of flexibility to reflect local jurisdictional imperatives.

1.3 Pre-project Consultations

CPMEC noted that progression towards agreement on a streamlined PGPPP accreditation

process and on national standards would require extensive consultation and collaboration between all key stakeholders including PMCs, RTPs, GPET, RACGP & ACRRM, and junior doctors themselves.

Past consultations had culminated in a workshop convened in Melbourne in May 2011 by GPET to discuss ways of streamlining accreditation of general practices that would meet the needs of prevocational and vocational trainees. Arising out of the Melbourne workshop, the following were agreed:

- GPET would fund some pilot projects to consider joint surveys
- In order to achieve a streamlined approach, PMCs would need to work closely with the RTPs in their jurisdictions as well as the RACGP and ACCRM.

Subsequently, the Postgraduate Medical Council of Victoria (PMCV), the Postgraduate Medical Council of Western Australia (PMCWA), and the Northern Territory Postgraduate Medical Council (NTPMC) agreed to host pilots to trial joint surveys in their jurisdictions.

1.4 Agreement to Implement GPTAP

A project agreement between CPMEC and GPET was signed late in October 2011. The three PMCs were advised in November 2011 to proceed with developing specific state-based project plans. The move to develop a streamlined accreditation process for general practices represented a significant advance in terms of PMC commitments. At the Melbourne 2011 workshop, a number of PMCs were still opposed to the notion of a joint accreditation survey process. CPMEC for its part had played a significant role in convincing PMCs to participate in the Melbourne meeting. The possibility of trialling a few pilot visits to see how a streamlined process might work was aimed at addressing concerns of a number of PMCs and also build on the goodwill generated at the Melbourne meeting.

From the perspective of the participating PMCs and CPMEC, the project was not seen as *fait accompli*; that is, a single survey and information collection process was the inevitable outcome. In this regard, CPMEC on behalf of the participating PMCs had specifically asked for the project objective to note that the pilots and the evaluation would provide an assessment of the applicability and reliability of single survey and information collection process.

It was also recognised that the three participating jurisdictions who had volunteered to be involved in the pilots represented quite diverse contexts. This had the potential to lead to three very different approaches to address the project's objectives. As noted earlier, the previous level of engagement between the three PMCs and the RTPs had varied significantly. There had been very little interaction between some of the parties prior to the

project on the one hand, whilst there had been a significant degree of mistrust on the part of others. As CPMEC ultimately had to rely on persuasion rather than having resort to any administrative fiat to get PMCs to undertake projects, there was a need for strong local ownership for the pilots to succeed.

2. PROJECT GOVERNANCE

The project was overseen by a National Project Steering Committee (NPSC). Each jurisdiction in turn had a local Project Steering Committee. These meetings were supplemented by meetings involving CPMEC and the three PMCs and meetings between GPET and the CPMEC.

As the local project arrangements are highlighted in the individual reports from the three participating PMCs, I will confine my comments in relation to project governance at the national level in this final report. In particular I will take cognisance of the views of the NPSC.

2.1 GPTAP National Project Steering Committee (NPSC)

The membership criterion for the NPSC was expertise and/or experience in vocational and prevocational medical accreditation and education/training. The Committee comprised the following members and organisations:

- An independent Chair nominated by CPMEC. Prof Rick Mclean accepted an approach by CPMEC to be the independent Chair of the Steering Committee based on his roles with government, Colleges and, very recently, PMCV.
- GPET: Mr Glenn McMahon (Ms Susannah Littleton and Mr Richard Kingsford were alternates)
- CPMEC: (2 nominees one of whom represented PMCs involved in the pilot surveys) – Dr Luis Prado and Prof Richard Tarala (Ms Carol Jordon was Dr Prado's alternate in two meetings)
- RTPs: (2 nominees with at least one from a RTP participating in the pilot surveys) - Dr Mark Rowe and Dr Tamsin Cockayne whose appointment was made after the first Steering Committee meeting upon advice from Mr Peter Harrison from ACE of RTPs. (Dr Colleen Bradford was Dr Rowe's alternate in one of the meetings).
- ACRRM– Ms Lynn Saul
- RACGP– Mr Michael Murphy
- Project Manager: Dr Jag Singh (CPMEC)

The NPSC met three times during the course of the project by teleconference on 2 March, 8 June and 13 September 2012 respectively. The following were the agreed Terms of Reference for the Committee:

- Oversee the delivery and management of the project according to the project scope
- Ensure the project plans align with the project scope including the approval of project plans, agreed survey and information collection instruments, and evaluation methodology
- Review draft report on the pilot surveys.

- Provide the project team with guidance on project issues as requested
- Address issues that have major implications for the project
- Monitor risks that have major implications for the project

3. PROJECT OBJECTIVES, DELIVERABLES AND DURATION

3.1 Project Aim & Objectives

GPTAP aimed to undertake and evaluate pilots in the Northern Territory (NT), Victoria (VIC) and Western Australia (WA) of models of streamlined and integrated prevocational and vocational training practice accreditation. Whilst CPMEC had overall carriage for the project, it was the responsibility of each PMC to develop and implement a project plan to realise the aims of the project. Following the development of the project plan, the other phases of the project were:

- agreement on the survey and information collection instruments and methodologies
- carrying out surveys as per agreed numbers in each jurisdiction
- evaluation of pilots by each PMC

To help the PMCs facilitate this, part-time project staff support was made available to each of the PMCs. In addition, CPMEC also paid for other incidentals to the participating PMCs upon production of invoices.

The key deliverable was for CPMEC to present a report within one (1) month of completion of the project that would address the following evaluation goals:

- The extent to which the streamlined and integrated prevocational and vocational training practice accreditation process delivered robust and consistent accreditation outcomes across the pilot medical practices
- The perspective(s) of stakeholders, including supervisors, RTPs, Colleges and PMCs involved in accreditation in relation to process and outcome quality; costs; scalability of the process; and other organisational, practice and program impacts.

3.2 Anticipated Benefits

It was anticipated that successful implementation of this project would yield the following benefits:

- Meet the objective to streamline training practice accreditation in the Minister for Health's Statement of Expectations 2011
- Reduce the practice accreditation burden for supervisors by eliminating multiple site visits and information collection
- Reduce College, PMC and RTP accreditation costs

Streamlining Training Practice Accreditation

The report summarises the work done to streamline accreditation of practices in the three pilots. WA is significantly advanced in streamlining documentation and survey visits, VIC has

made significant advances from a position of no previous collaboration, while NT has worked on getting their documents and processes in place. Each of the reports provides details of the work done in this regard.

Reducing Practice Accreditation Burden for Supervisors

The reports for both WA and VIC demonstrate that having joint and/or integrated visits has reduced time requirements for supervisors managing trainees across the postgraduate medical training continuum.

Reducing Accreditation Costs

It was difficult to obtain a detailed analysis of the costs as a result of the pilot surveys. However, the report provides a template for a possible way forward on this matter.

3.3 Project time lines

The project commenced December 2011. The final report was initially due in July 2012 but by mutual agreement extended to 31 October 2012 following consultations between GPET and CPMEC. In large part this was due to an under-estimation of the time required to consult and arrange the surveys in each of the three jurisdictions. However, all three participating jurisdictions had agreed to operate within these tight timelines.

3.4 Risk Management Plan

A risk management plan was presented and approved by the NPSC at its second meeting. Two major issues that emerged during the project were:

- Very tight timelines for the project. Implementation in the three jurisdictions proceeded at different rates due to a number of factors, some of which were outside the control of the PMCs involved. The signing of the agreement in late October also meant slow progress in some jurisdictions – especially in terms of recruiting a project officer because of the intervening holiday period. Putting together the Steering Committee also took a while longer than anticipated. The issue of timelines was addressed by direct dialogue between CPMEC and GPET.
- The difficulties in the Northern Territory which resulted in a review of the project plan as they were not able to undertake any joint survey during the duration of the project. This was brought to the attention of the Steering Committee once CPMEC became aware of the difficulties that they were facing.

To monitor progress in relation to the project, and take appropriate action as required CPMEC undertook the following:

- Regular meetings with each of the PMCs to ascertain progress and discuss issues arising
- Following up with phone calls and where there were continuing concerns, instigated face-to-face meetings with the PMC to agree upon a course of action to progress matters
- Joint meetings with the three PMCs involved in the pilots (although the value of these tended to diminish as the pilots proceeded along vastly different paths as described in this report)
- Regular meetings for the duration of the project with GPET to discuss concerns and raise them with the PMCs.
- Raising matters at the NPSC level

CPMEC was significantly guided by advice from the three PMCs who, in turn, were supported by their local project teams. It was agreed that the local committees were well placed to address issues and CPMEC got involved when issues required follow up such as submission of documentation and progress reports.

4. OVERVIEW OF THE PILOT PROJECTS

Detailed reports of the pilots in the three jurisdictions are attached separately. This report seeks to synthesise some of the key issues to emerge from those reports. Reference is made extensively to process and outcome quality; costs; scalability of the process; and other organisational, practice and program impacts. The synthesis provides a basis for the recommendations arising out of the project.

4.1 Northern Territory

NTPMC developed a detailed project plan that was endorsed by the NPSC at its inaugural meeting. The early identification of a project officer, Ms Julia Chalmers, facilitated a quick start to the project in the NT. However, the project began to face severe challenges in identifying pilot survey sites because of the conditions sought by the key stakeholders. NT hospitals wanted guarantees that there would be PGPPP places for junior doctors whilst the RTPs and practices wanted a guarantee that there would be someone to take up the training post if accredited. NTPMC was not in a position to offer either of these given the traditional difficulty that NT always had in filling all their intern places. Furthermore, unlike many other PMCs, the NTPMC does not look after the intern application and matching process. The situation in the NT was further compounded by other historical and geographical issues as well as the transitory nature of practice staff and owners. Project timelines became an issue in identifying pilot sites. Another contributing factor was that Northern Territory General Practice Education (NTGPE) itself was undergoing significant internal changes simultaneously which had compounded difficulties in achieving project objectives.

However, despite this setback the following achievements from the pilot project were noted by the NTPMC:

- They had mapped the NTPMC standards against RACGP and ACRRM standards to identify areas where mutual recognition could promote greater efficiencies and ensure prevocational and vocational training standards were met.
- Development of a draft single-survey visit tool between NTPMC and Northern Territory General Practice Education (NTPGE) for integrating prevocational and vocational standards.
- NTPMC have a gained a better understanding of the diverse and rich training environment with practices including remote and rural settings
- The project has delivered the necessary 'buy-in' for future cooperation in this domain
- The project has raised awareness at a political level for the Northern Territory and secured stakeholder engagement on the issue including the capacity to expand internships.

- The positive outcome has been NTPMC will continue this consultation and collaboration with the NTGPE.

NTPMC acknowledge that not testing the combined survey document was a major setback for the project in the NT. However, they are continuing to work with NTGPE to start a formal process of cooperation and undertake a joint survey in the future. They also agreed that as the work progresses further in the NT, there would be a need to bring Colleges into the stakeholder project team.

Future activities NTPMC will be undertaking include:

- Seeking formal endorsement from NT Medical Board for intern placements in PGPPP. NTPMC would seek support from their Board to facilitate this.
- The development of new working relationships between key organisations and a series of formal inter-organisational discussions to progress the placements of postgraduate year 1 (PGY1 or intern) doctors into general practice placements.

By their own admission NTPMC had entered the project with very high aspirations. One major aspect they had overlooked in planning to complete the project within the allocated time frame was that no formal dialogue had been previously initiated within the NT on the issue of accrediting general practices for intern placements. In essence the project was starting from scratch, and establishing working relationships between the key organisations took much more time than originally anticipated.

Despite the major setback in not being able to undertake a joint survey, the NTPMC report demonstrates an extensive amount of preparatory work undertaken. An example of this is in Table 1 below which highlights the differences between the PMC and RTP accreditation processes in the NT.

Table 1: Major differences between NTPMC and NTGPE accreditation processes

Accreditation component	NTGPE	NTPMC
Regularity of accreditation visits and monitoring	rolling 12-month accreditation	4 year terms, with quality assurance monitoring and reporting throughout
Structure of visits	flexible and informal structure	highly structured
Formality	less formal	very formal
Evidence base	relies on self-reporting, professional insight and established professional relationships	relies on self-reporting, documentation, and triangulation of evidentiary sources.
Recommendations	no formal recommendations made	formally made to NTPMC accreditation committee and to the NT Board of the Medical Board of Australia
Decision making	decisions made by NTGPE	decisions made by NT Board of the Medical Board of Australia

4.2 Victoria

The project plan submitted by PMCV was endorsed by the NPSC at its first meeting. There had been limited previous contacts between PMCV and the RTPs in relation to accreditation issues. Further, there are four RTPs in operation each with individual accreditation processes in place. A Project Officer, Ms Judy D'Ombrain, was appointed to coordinate the pilot surveys in Victoria. A Working Group of relevant Victorian stakeholders was convened and met at regular intervals for the duration of the project.

Pilot survey visits were undertaken at the following pilot sites:

- Clocktower Medical Centre, Sale - Southern General Practice Training (SGPT)
- Kardinia Health, Belmont, Geelong - (SGPT)
- Preston Family Medical Centre, Preston - Victorian Metropolitan Alliance (VMA)

Clocktower was the only pilot site with an intern post where a previous prevocational accreditation survey had been undertaken by PMCV. The other two sites have PGY2 posts, but neither had previously been accredited by PMCV for intern placements. The Preston site is classified as metropolitan, and the other two sites as regional. There are no RA-5 classified general practices in Victoria.

Regular communication took place between PMCV, SGPT and VMA, prior to the visits to identify opportunities for streamlining and to develop appropriate tools and processes. The resulting collaborative pilot tools and processes were submitted for approval to the NPSC after the visits. The pilot survey visits occurred in May 2012. At the conclusion of each pilot visit, a paper-based feedback survey was distributed to all general practice staff involved in the pilot survey in order to assess their response to the pilot process.

At the conclusion of the three survey visits, a 24-question online evaluation survey was distributed to all twenty-three participants in the pilot project. This survey aimed to obtain detailed feedback on every aspect of the pilot project in Victoria using a combination of Likert rating scales, closed questions and qualitative comments. The data collected from both surveys was then analysed and measured against the stated aims and objectives of the Victorian pilot project; the outcomes form the basis of this report.

In the Victorian project there was some discussion on whether the project documentation required a single instrument or streamlined and integrated survey information collection instruments and methodologies. CPMEC and member PMCs have noted that the emphasis of the project was to evaluate an integrated process in the pilot sites to deliver accreditation outcomes that met the needs of PMCs and Colleges. It was always their expectation that the pilots would be undertaken differently in each of the jurisdictions to reflect local circumstances. Given that the project was the first opportunity for PMCV and the RTPs to work together, the extent of integration of the documents reflected some of the issues involved in bringing about change. In any case, the feasibility of having a single document for the survey process in Victoria was further complicated by the fact that there are four RTPs in Victoria, each with its own accreditation processes especially in terms of documentation. Despite this, the evaluation data from Victoria reveals that pilot participants were satisfied with the information collection process at each visit. PMCV did undertake an exercise to match its standards with that of RACGP and ACRRM and this is attached as Appendix 10 in their report.

Victorian stakeholders identified a number of duplications and gaps in the existing general practice accreditation instruments and processes, as well as shortcomings in the overall governance structure for prevocational general practice accreditation. Streamlining

modifications undertaken included the following:

- Alignment of vocational and prevocational accreditation cycles and visits to general practices
- Partial streamlining of pre-visit documentation;
- Joint survey visits and integrated interviewing sessions during the accreditation visits; and
- Establishment of ongoing collaborative working relationship between RTPs and PMCV.

A summary of the major challenges encountered were:

- Under the existing GPET/PGPPP guidelines, there is a lack of clarity regarding responsibility for accreditation of general practice prevocational training posts and no funding provided to undertake this role. The RTPs are mandated to carry out general practice accreditation at the vocational level, but the prevocational level is outside the scope of the RACGP/ACRRM standards. The RTPs administer funding for each GP placement, but it is unclear if this funding allocation covers the accreditation function. PMCV is delegated by the Medical Board of Australia to accredit all PGY1 placements in Victoria, but receives no funding for accrediting GP posts established under the PGPPP scheme.
- The cost impact of the combined pilot accreditation surveys proved difficult to measure and evaluate from the perspective of general practices, RTPs and PMCV, since there are no benchmark costing or funding allocation breakdowns in respect of general practice accreditation.
- The logistics of working initially with the four Victorian RTPs to identify general practice sites for accreditation pilots in Victoria within the project timelines that were scheduled for both RTP and PMCV accreditation approximately around the same date so that joint visits could be undertaken. (Two RTPs could not provide sites within the timeframe of the project but requested to remain involved in the pilot project). There were also logistical challenges in setting up local stakeholder meetings and finding suitable accreditation surveyors at short notice.
- Since there had been limited previous interaction between RTPs and PMCV regarding general practice accreditation, initiating discussions about streamlining documentation and processes, where separate sets of documents and processes already existed, was challenging and time-consuming.

The Victorian GPTAP pilot surveys had facilitated the development of broad streamlined accreditation of postgraduate medical training in general practice. The streamlined

accreditation process successfully implemented in the pilots in Victoria resulted in an accreditation framework which emphasises optimised integration and sharing of pre-visit documentation by PMCV with RTPs; alignment of survey visit dates and cycles both for initial and re-accreditation and credentialing of surveyors for both vocational and prevocational accreditation.

The accreditation framework was limited in the sense that full integration of the standards utilised by PMCV and the RTPs (RACGP/ACRRM) was not achieved; however, all parties in Victoria agreed that alignment of the standards should be pursued and were willing to participate in such a project should funding be made available.

For the future, it is the intention of the Victorian group involved in this project to continue to pursue alignment of accreditation survey dates; implement a program for co-credentialing of surveyors; to further integrate and align pre-visit documentation; and arranging accreditation visits with PMCV in the future.

In terms of outcomes, the surveyed facilities were accredited for both prevocational and vocational training. With regard to reporting accreditation outcomes to practices, streamlining did not occur in the pilot project, chiefly because of separate accountabilities of the accreditation agencies. The accreditation visit reports would initially be separate but PMCV and the RTPs looked at each other's standards and would look at opportunities to merge the reports.

Opinion remained divided as to the desirability of developing one fully integrated report, or separate vocational and prevocational sections within a joint report, largely because of the perceived difficulty in achieving this satisfactorily without having in place one integrated document setting out standards of all key parties. Some issues about confidentiality and privacy emerged that would need to be addressed if reporting was to become integrated. PMCV has always prepared a formal accreditation report on the basis that it is confidential between them and the health service undergoing accreditation. There are similar reporting protocols for RTPs with their Boards. Clearly, there is need for all parties including the practices to be comfortable on the processes for sharing accreditation reports. Feedback from the parties suggest that this issue is resolvable with further dialogue and discussions between PMCV and the RTPs and if more work is done in the integration of the standards into one document.

As also noted by NTPMC, the project has given PMCV and the RTPs a better understanding of the issues involved in attempting integration of general practice accreditation to cover both prevocational and vocational trainees. It is the intention of all parties to keep working together on these matters in future and build on the understanding of each other processes,

policies and standards achieved through this project.

PMCV noted that despite the very tight time frame for the project, they were pleased that they managed to complete 3 pilot surveys. A positive outcome of the project is that PMCV have just worked with the Victorian RTP's to identify all accreditation General Practice visits required until the end of 2014, so that joint accreditation visits can be scheduled. The PMCV report notes that perhaps the most important benefit has been the new working relationship that has developed between the RTPs and PMCV in regards to accreditation, producing a level of collaboration that all involved are keen to maintain into the future.

It was hard to measure costs during the project but PMCV feel that with joint visits, reduced paperwork and a more consolidated approach costs should be reduced. PMCV also plan to use smaller survey teams and have some joint surveyor training to reduce the size of accreditation teams in future.

PMCV has noted that the project also highlighted the need for greater clarification by government bodies regarding accreditation responsibilities at the prevocational level, and has demonstrated improved communication and stronger links between RTPs, general practices and parent health services should be forged, especially with regard to prevocational evaluation, assessment and feedback processes and, in particular, the provision for ongoing management and support of junior doctors experiencing personal or professional difficulties.

4.3 Western Australia

While PMCWA took some time to get the required project documentation to the NPSC, there had already been ongoing discussions taking place between PMCWA and Western Australian General Practice Education and Training Ltd (WAGPET) in relation to the project. The fact that PMCWA itself was undergoing a leadership change at the time the project commenced also contributed to some delay in the appointment of a suitable project officer.

The NPSC gave conditional approval to the approach adopted by PMCWA to manage the project. The PMCWA was quickly able to get the pilot surveys in place, which was helped to a large degree by the work that had been done previously by the WAGPET to map the standards of PMCWA with that of RACGP and ACRRM. In this regard, they were significantly helped by having Dr Colleen Bradford, WAGPET's Director of Training, on the Project Steering Committee as she was an accredited surveyor for both PMCWA and WAGPET. Unlike Victoria, WA were also fortunate in having to deal with only one RTP and minus the contextual difficulties that NT faced.

The three pilot survey sites in WA were:

- Banksia Medical Centre, Esperance (Rural) - Reaccreditation - rural practice that has hosted prevocational residents and GP Registrars for many years.
- Mt Hawthorn Medical Centre (Perth Metropolitan) -New Accreditation - new training practice only ever having had medical students on site.
- Ocean Keys & Currambine Family Practices (Perth Outer Metro) – Reaccreditation – two sites that have prevocational and vocational doctors in training

The WA project was run by a small group including Dr Bradford; Ms Marece Bentley, the PMCWA Coordinator; Ms Stephanie Walker, WAGPET's Training and Education Manager; and Prof Richard Tarala, the Chair of PMCWA. This made decision making relatively easier and more streamlined.

PMCWA did not change any of their accreditation standards but simply aligned them to the WAGPET matrix noting that it would be a dynamic process that would be informed by subsequent joint surveys. Whilst they have explored joint reporting, the intention is to continue with joint accreditation visits but still maintain separate reporting to the PMCWA Accreditation Committee and WAGPET /Colleges.

The feedback from the WA practices in the pilots was that the accreditation process was much more efficient with less documentation for them, and was less demanding time-wise. PMCWA and WAGPET have been looking at ways to publicly acknowledge the progress that they have made. This included a presentation by Prof Tarala to the 17th Prevocational Forum held in Perth in November 2012.

PMCWA noted that the project went smoothly with no 'bureaucratic barriers' despite some initial concerns referred to earlier in the report. We understand that 'bureaucratic barriers' refers to the desire of the parties in WA not to get too caught up in refining paperwork and documentation but focusing more on the process itself to ensure good learning outcomes for trainees. WA also had the advantage of a surveyor, Dr Bradford, who had been accredited by both WAGPET and PMCWA. WA is actively exploring the possibility of co-credentialing surveyors in future. PMCWA also noted that the evaluation was 'resoundingly positive' from the WA general practice staff who felt it ran smoothly and was less work than the two separate processes; to the surveyors who felt it addressed the needs of both PMCWA and WAGPET while being more efficiently run compared to the separate processes.

WA is very keen to support a more comprehensive implementation of this pilot model, including further understanding of costing, with the intention of a full implementation of the new model in 2014.

Based on the overview of the pilot studies in the three jurisdictions, the next section draws out some of the key achievements of the projects, the hurdles and constraints, the benefits perceived by stakeholders, challenges and gaps identified, and some lessons learnt.

5. SYNTHESIS OF THE PILOT PROJECTS

Managing a project such as GPTAP is challenging. In the context of this project, CPMEC had a central role overseeing the project, whilst participating member PMCs roles were best understood as parts within a 'loose federation' who enjoyed 'considerable project autonomy'[3] and would approach the task to reflect their local needs and circumstances. Managing this centre-periphery nexus is therefore quite challenging but rewarding if successful. CPMEC also recognised the critical need for effective local engagement between PMCs, RTPs and other key local stakeholders to make the project feasible within the three jurisdictions. The NPSC also played a supporting role as facilitator.

5.1 Achievements

Each of the three individual reports has highlighted achievements within each jurisdiction and the conclusion in each case has been that the GPTAP has been a positive experience in promoting integration of postgraduate medical education and accreditation processes in general practices. There is little doubt that the very tight timelines have influenced some of the outcomes. From a project management perspective, there have been very positive outcomes which could be underplayed by the project being brought to a premature closure.

Some of the achievements that CPMEC has identified include the following:

I. Relationship Building

There has been significant investment in building relationships between the key stakeholders and especially the PMCs and RTPs. Each of the three jurisdictions started from a different base in this regard. In the case of Victoria and Northern Territory, the parties were starting from little previous history of engagement and considerable time and effort was consumed to establish these working relationships. In the case of WA, the process proceeded quite smoothly because the parties had previous history of interaction. It was helped by having surveyors with knowledge of accreditation processes in both the prevocational and vocational domains.

The project allowed parties to gain better insights into issues relating to placement of interns in general practices, differing accreditation cycles between teaching hospitals and general practices, and specific local contextual differences.

This reinforces the need to consider what Heifetz[4] termed 'technical' and 'adaptive' challenges in any change management activity. The latter includes the various non-technical components of any change initiative. Achieving culture change in projects such as GPTAP requires, i*nter alia*, the support of a strong guiding coalition. It is boosted by demonstrating

[3] David Gann, *et al,* 2012, 'Inside the World of the Project Baron', MIT Sloan Management Review, Spring 2012, p.63
[4] Heifetz, R. 1998, Leadership Without Easy Answers, Harvard University Press, Cambridge, MA

some quick successes. Even in the case of NT, the fact that progress was made in developing memorandums of understanding and highlighting issues of particular importance was seen as a positive step.

II. Framework for Future Collaboration

The fact that parties in each of the three pilots have agreed to continue to work together in future is further testimony to the goodwill generated by this project. Each of the three jurisdictional reports has highlighted future areas of collaboration as well as a framework to shape those interactions. This is very well set out in the Victorian report which suggests that the pilot model be viewed as 'Stage 1' of a progressive process towards streamlining General Practice accreditation. It notes that the achievements of this stage have been to streamline the accreditation cycle between the PMCV and RTPs, and the introduction of a single combined accreditation survey visit. The logical progression to 'Stage 2' would involve the introduction of joint RTP/PMCV accreditation surveyor training, and the consequent reduction in the size of survey teams attending GP accreditation visits. This stage is planned to come into effect in early 2013. Beyond this, a possible 'Stage 3' would see the introduction of fully streamlined documentation and reporting processes, while 'Stage 4' would venture into the territory of producing a single combined set of accreditation standards. Clearly, a considerable amount of additional work and collaboration, as well as additional funding, would be required before Stages 3 and 4 could be implemented. Using this Victorian framework, WA is in Stage 4 whilst NT is in Stage 1.

III. Scalability

From the individual state reports, it is apparent that the processes adopted in the pilot surveys will be relatively easily scalable at the state level. In Victoria, the process is already in use to accredit sites and in WA, there seems to be a commitment to do the same. The issue of national scalability raises the dilemma of balancing the need for uniformity and consistency with appropriate cognisance of the local context.

The following principles to streamline the accreditation process were determined:

- Extensive consultation, discussion and agreement between key stakeholders (GPET, RTPs, Colleges, PMCs) on the appropriate process to streamline accreditation.
- Accounting for any specific issues that might promote or hinder attempts to streamline accreditation processes (this may include logistical and environmental factors as was the case with NT)
- Develop pre-visit and survey documentation that will promote streamlining and promote efficiencies whilst meeting the needs of the various stakeholders Undertaking a joint survey to demonstrate quick success and viability of the streamlining approach
- Further refine documentation as part of a continuous improvement cycle

- Develop a program of cross-credentialing surveyors to maximise efficiencies
- Develop a future program of cooperation based on identified priorities.
- Disseminate experiences, lessons and effective practices through various knowledge sharing forums.

IV. Pilot Surveys

Pilots were delivered in WA and Victoria, while a model was developed in the NT to form the basis of future joint surveys. In WA, the joint survey process built on work previously done by WAGPET which served to significantly accelerate the pilot surveys. They were also helped by having to deal with only one RTP. In Victoria, there were significant additional challenges that were overcome including having to deal with multiple RTPs with different documentation processes.

V. Future Work

The following areas were identified where further streamlining can occur, including:

- Further refinement of the joint accreditation survey documents that would identify specific areas where integration of prevocational and vocational documentation and sharing of pre-visit documentation would increase the efficiency of visits.
- Sharing information to align logistical arrangements such as planned survey visit dates and cycles for initial accreditation and subsequent re-accreditation
- Streamlining the accreditation reporting process that would meet requirements of prevocational and vocational training agencies whilst respecting any privacy and confidentiality concerns
- Cross-credentialing surveyors to minimise accreditation costs and reduce the size of survey teams
- Ensuring that the gains from the pilot projects are not lost by embedding joint surveys of general practices in future accreditation visits where appropriate.
- In the NT, parties have already committed to ensuring that NTPMC representatives would be included as observers in appropriate practice accreditations.

VI. Positive Externalities

Other benefits resulting from the project include:

- PMCV using the model developed during the pilots to accredit non-pilot general practice training sites
- NT proactively pursuing the placement of interns into general practice in the NT through consultation with the Medical Board of NT, NT hospitals, NT government and the NTGPE.

VII. Practical Example of Integration

Although limited in scope, GPTAP has demonstrated that with goodwill, appropriate funding support and the involvement of stakeholders, there is significant potential to streamline accreditation processes. The achievements of GPTAP should be shared widely with others in postgraduate medical education and training.

5.2 Project Challenges

I. Time Constraints

CPMEC and GPET recognise the significant time constraints under which the pilots were undertaken. A key factor was the amount of time required to establish working relationships with stakeholders. This turned out to be a greater challenge than initially envisaged.

II. Standards

Consideration of standards was a specific exclusion of the project. This was undertaken to ensure the project objectives were achievable within the timeframes, and to provide assurances to the state PMCs the project would not impact on aspects of accreditation over which it had no control.

III. Evaluation of Costs

Measuring the financial cost of accreditation was difficult due to the challenge of unbundling the accreditation survey visit costs. Both the WA and Victorian reports highlight this as an area requiring further research and development.

PMCV's very preliminary estimates suggest the surveys were at the least cost-neutral in the pilot surveys. One would expect that the visit set-up costs would decline in subsequent re-accreditation. Additionally, if co-credentialing of surveyors occurred, this could bring down costs further.

An additional complication in relation to costing is whether there are any benchmarks to compare costs. If it is a re-accreditation there is some basis for cost comparisons. However, if it is a new site, comparison becomes a more difficult proposition. Allowing for these challenges, an indicative template for cost comparison is suggested in Table 2. The model is designed to cater for both re-accreditation and new site visits.

Table 2: Template for Cost Comparison

	SEPARATE VISITS				JOINT SURVEYS			
ACTIVITY	*PMC*	*RTP*	*PRACTICE*	**TOTAL**	*PMC*	*RTP*	*PRACTICE*	**TOTAL**
Initial Meeting costs								
Coordinating costs								
Pre-visit Documentation								
Survey visit travel accommodation, meals, etc.								
Surveyor training, briefing and fees								
Survey costs (includes downtime for clinicians & trainees)								
Administration & overheads allocation								
Reporting costs including reviews and adjustments								
Other costs								
TOTAL COSTS								

IV. Generalising from Project Findings & Potential Bias

Given the limited number of sites involved in the study, bias and generalisations need to be considered in any discussion of the project findings. These issues include:

- the limited number of jurisdictions and sites involved;
- the need for a more comprehensive consultation and evaluation process; and
- bias in the selection of visit sites.

As these factors were known before the project commenced, they did not greatly impact on the evaluation of the project in the three jurisdictions. Given the time and logistical constraints, these limitations had to be accepted as part of the trade-off involved in undertaking these pilots.

5.3 Benefits Perceived by Stakeholders

The project has yielded a number of benefits perceived by stakeholders. These include the following:

I. Reduced Burden

The reduced burden of practices of having to deal with one combined visit instead of two separate ones was identified in both the WA and Victorian pilot surveys. Whilst there was an expected increase in paperwork initially to deal with both phases of training, it was recognised that having it all done in one visit would provide significant efficiencies later.

II. Viewing the Entirety of Training Continuum

Where joint surveys occurred GP supervisors noted they were able to capture the requirements of the trainees across the continuum of postgraduate medical training in its entirety rather than just segments. Surveyors who were not previously involved with both phases of the medical accreditation continuum also obtained a better insight into the commonalities and differences between the requirements at different levels. At the organisational level PMCs and RTPs have developed a fruitful working relationship that would facilitate accreditation of practices more smoothly in future.

III. Costs

It would seem that there has been no significant increase in costs arising from the pilots for PMCs and the RTPs. No doubt, GPET funding for the three project officers significantly assisted in dealing with additional costs including the work undertaken to promote collaboration and mutual understanding where this had not been the practice before the project. There is little doubt that without the GPET support and having dedicated project officers playing a coordinating role, some of the achievements would have been significantly eroded.

IV. Quality Outcomes

In terms of process outcomes, there has been every indication that the quality outcomes continue to be maintained in the practices surveyed. As noted in the survey results from the Victorian report, 'the opportunity for surveyors to meet with all general practice trainees, both vocational and prevocational, and to become familiar with the accreditation requirements for both levels, provided new insight and an awareness of similarities and

differences that was previously not achievable'. This would suggest that, if anything, the quality has been enhanced by having joint and/or integrated visits. The project has also fostered greater recognition of the commonalities that exist between prevocational and vocational training. Further, parties have developed a better perspective of strengths and contributions of the various groups in fostering postgraduate medical education and training.

None of the pilots have indicated that the accreditation process for either prevocational or vocational training has been compromised by this integration of survey visits. If anything, the overwhelming feedback from stakeholders has been that it has enhanced the process through sharing of processes and requirements.

V. Identified Scope for Future

The surveys identified scope for further developments that would enhance streamlining. These include further refinement of the pre-visit documentation to eliminate duplication; reducing the number of surveyors on visits; improved coordination of visits; and looking at ways of reducing reporting requirements so that the needs of all parties are met.

It would also be instructive to consider who could play the coordinating role going forward that was undertaken by the project officers funded through GPET funding. WA has suggested that WAGPET undertake that role in their jurisdiction but in states with multiple RTPs this may require further consideration. PMCs and RTPs not involved in the pilots would no doubt have their own views on this matter.

A further development is that with new RACGP standards to be implemented, there is a need to align streamlining accreditation processes with these new standards.

5.4 Lessons learned:

I. Project Timelines

All parties acknowledge that the time constraints for the project were much greater than originally envisaged. With the benefit of hindsight, a phased approach may have been more optimal. Starting the project in December was not ideal either. Knowledge sharing can be a time consuming process. However, despite this constraint, the parties showed a remarkable degree of commitment and willingness to work together to realise the project objectives.

II. Project Design

The project design was made challenging by excluding standards but the project became feasible by allaying concerns about the possible takeover of roles. This dose of pragmatism has helped the project develop significantly with parties agreeing to work beyond the duration of the project.

However, a dimension not fully factored into the original project design was the different prior interactions of the key stakeholder groups and the impact it would have on approaches adopted and degree of success achieved in the pilots.

III. Understanding Context

In managing projects that span a diverse range of jurisdictions, it is imperative to understand the various regional factors that influence outcomes. The pilot reports demonstrated some commonalities. As noted in the NTPMC report, an important lesson was that it took time to develop, negotiate and operationalize the partnerships between key stakeholders. It was difficult to anticipate all local issues. In relation to context, PMCs now have a better understanding and appreciation of the contexts of training hospitals and general practices.

IV. Balanced Focus on Process and Documentation

The challenge to create and use a single survey instrument to carry out an integrated approach to accreditation of general practices for postgraduate training generated debate during the project. Whilst PMCWA and NTPMC focused on the development of a single survey instrument, PMCV focused more on aligning the survey visits and sharing pre-visit documentation. As noted previously, the situation in Victoria was compounded by dealing with multiple RTPs with different processes.

An additional issue in this regard related to the importance of the accreditation survey process itself and the need to ensure that the tacit knowledge and skills of experienced surveyors was not under-utilised by an over-reliance on documentation.

6. STAKEHOLDERS PERSPECTIVES ON THE GPTAP PILOTS AND RECOMMENDATIONS – SUMMARY OF VIEWS FROM THE NPSC

At the 3rd meeting of the Project Steering Committee, members were asked specifically to provide their perspectives on the progress and recommendations offered. The following provides a brief summary of the responses.

6.1 Standardisation and/or Diversity

A significant amount of discussions centred on the extent to which one should have standardised processes and documents or allow for flexibility as long as accreditation standards were met. The following perspectives were offered:

- GPET as the project sponsor noted that there was complexity between vocational and prevocational phases and between the individual RTP's management of accreditation. Importantly, this may have implications for the project if it were extended to other states with multiple RTPs.
- ACRRM noted that colleges also experienced challenges as the two colleges did not have identical processes to each other or to the RTPs.
- RTPs were of the view that the key issue was to be able to demonstrate that the assessment process was robust to ensure that a practice met the relevant accreditation standards, rather than prescribing a 'one size fits all' approach. Using the same processes would not adequately account for local issues. The NT was used as an example of a situation where maximum flexibility was needed to interpret those standards to undertake accreditation. In this regard, it was noted that the consultations held during the accreditation visits were important. The role of experienced surveyors in facilitating consultation was critical. The forms and documentation should serve as a guide for the surveyors, supported by a collaborative approach, i.e., it was important not to reduce the process to simply ticking off a checklist. The role of having experienced surveyors was also supported by PMCs. GPET agreed the documentation process should not drive the decision making processes but rather support it.

Members also provided comments on the project itself and how they felt it had progressed. These comments are summarised below under each stakeholder group.

6.2 *College Representatives*

ACRRM noted the pilots have shown that it is possible to integrate prevocational and vocational accreditation processes. This has resulted in a mutual understanding and willingness for this work to continue.

ACRRM noted they are open to diverse ways meeting their College accreditation standards. RACGP representatives did not attend the last two Steering Committee meetings.

6.3 RTP Representatives

RTP representatives offered their congratulations to the pilot sites for successfully undertaking the project. It was noted that the state reports were well written, the findings were good and the pilots had identified areas of focus for future activities.

They reiterated the need to allow skilled surveyors scope to make determinations based on accreditation documentation and dialogue. This required the use of local or regional models to cater for diverse practice settings throughout Australia. The end result was to ensure quality learning environments for registrars, prevocational trainees and in the future students.

In relation to the Victorian pilots specifically, RTPs felt that the process had been handled well although there were things that still required to be worked through to promote further streamlining (e.g. streamlining reporting). The positive outcomes from the project were also echoed by WAGPET in a separate conversation recently.

There was also a call to share the different versions of the documentation developed during the pilots to save non-participating RTPs from having to 'reinvent the wheel'. It was hoped GPET would take feedback from the project on board and continue supporting these projects.

6.4 PMC Representatives

PMCs reiterated the need to build on the work done and would take note of how processes worked in each jurisdiction. PMCs also found benefit in working with RTPs to develop mutual understanding of their roles and accreditation processes.

PMCs also supported the view of RTPs that the accreditation process should be well supported by experienced surveyors. It was suggested the accreditation teams include a junior doctor with general practice experience.

6.5 GPET Representative

GPET noted that GPTAP had been a useful project to work with prevocational and vocational standards at a macro level and see how they mapped together. Local complexities have provided specific challenges when working with national standards.

GPET is committed to continuing its support of accreditation projects, with this project

laying the foundations for further work in refining the accreditation process. GPET noted with interest that jurisdictions felt that that alignment of standards would be one of the proposed actions moving forward.

GPET acknowledged the need to allow for diversity in RTP accreditation processes to reflect local needs, but still saw the need for further alignment of these processes to ensure a streamlined accreditation framework.

7. GPTAP PROJECT RECOMMENDATIONS

1. Hosting a GPTAP Symposium

GPET to host a symposium to communicate the results of the project and to provide stakeholders with the opportunity to consider ways of extending the benefits derived from the project. CPMEC and the three PMCs may present their reports along with inputs from other key stakeholders involved in the project. Invitations may also be sent to key stakeholders from other jurisdictions to identify ways of embedding the streamlining process further.

The meeting could also develop a consensus statement that lends support to the NTPMC to gain the endorsement of the NT Medical Board for their integrated accreditation of general practice facilities for PGY1 placements.

The symposium could be scheduled in the first half of 2013. A key outcome of the meeting to be an action plan to chart the way forward in terms of progressing the work done under GPTAP.

2. Build on Momentum Generated by GPTAP

This recommendation seeks to build on the positive momentum generated by the GPTAP in the three jurisdictions. There are several areas that GPET could consider with those involved in the pilots and the jurisdictions that were not involved.

With WA and Victoria, support further work to streamline processes and promote cooperation. Some of the areas identified in the reports include:

a. Initial meetings with practices
b. Pre-visit and survey visit documentation to minimise duplication of information sought
c. Process for co-credentialing of surveyors to reduce size of survey teams whilst ensuring that both prevocational and vocational training standards are addressed
d. Streamlining the reporting requirements to ensure that all reporting requirements are met
e. Further alignment of standards including any updating arising from the adoption of new RACGP standards
f. Building stronger links between RTPs, general practices and parent health services for ongoing management and support of junior doctors experiencing personal or professional difficulties
g. Processes utilised in other states that could be incorporated into their processes (for example the use of self-reporting surveys combined with reliance on accreditation triggers to address any concerns raised by trainees and other parties)

In the case of NT, continue to provide support for them to be able to implement the streamlined model that they have developed.

For those jurisdictions not involved in the pilots, this would involve establishing how the findings from the project could be utilised to streamline processes in their area. Some of these include:

a. The potential for more streamlined processes in their jurisdictions including consideration of possible sources of resistance and how they might be overcome
b. Exploring the optimal model that would facilitate the process

As all these have resource implications, GPET and other relevant stakeholders would need to work collaboratively. In this regard, GPET needs to address the issue of funding project positions that would coordinate this work both at the national and local levels. CPMEC is again willing to act as a facilitator in the process should GPET decide to continue this partnership.

3. Costing Model

There were significant difficulties in understanding the issues relating to costing and funding of general practice accreditation. There is little robust data in this area.

Further work may include the development of a costing model for general practice accreditation that more clearly set out the costs of combined and separate survey visits. The costing model could also assist in further rollouts.

4. Aligning RTP Documentation and Processes

There is scope for further alignment of documentation and processes in states with multiple RTPs. These have been elaborated elsewhere in this report.

5. Clarifying Governance

This is a challenging area, with the PGY2 year is contested space when it comes to accreditation. Some PMCs accredit PGY2 positions. There is a need for greater clarity around the governance and reporting structures for prevocational accreditation. This has become evident in relation to the initial accreditation of prevocational general practice training posts.

State/Territory PMCs, CPMEC, Medical Boards, Health Departments, RTPs, GPET and the AMC are all key stakeholders. A meeting of key players to delineate the roles and responsibilities is required. Underpinning these discussions is the need to maintain the independence and integrity of the accreditation process without increasing the burden on practices.

6. Communication of Project Findings

In addition to the symposium proposed there is a need to publicise the findings from the GPTAP to the wider medical training accreditation audience. The resultant outcomes have been a positive step in seeking to reduce 'accreditation fatigue'. Publication and circulation to the wider medical education and training community would be highly desirable as a first step.

CONCLUSION

GPTAP has served as an important vehicle in promoting a streamlined and integrated approach to prevocational and vocational training practice accreditation in VIC, WA, and the NT. The extent of success was clearly shaped by local circumstances and the extent of prior engagement between the parties.

GPTAP has demonstrated the feasibility of being able to develop integrated models of accreditation for general practices. This was done without an overly prescriptive approach which allowed the jurisdictions to develop a model that suited their requirements. The models that have been developed have considerable utility as they are being used to accredit other practices in the respective jurisdictions.

It may be useful to reiterate the key achievements of GPTAP. These have included:

- building of relationships amongst the key stakeholders involved in the accreditation of general practices;
- establishing a framework for ongoing collaboration;
- exploring the scalability of the models developed initially at the jurisdictional level;
- undertaking joint surveys in WA and VIC;
- highlighting areas where further streamlining could occur;
- generating positive externalities from the project; and
- providing a practical example of integrating accreditation processes in postgraduate medical education and training.

It is important to note that none of the key stakeholders considered the quality of the accreditation process was in any way compromised by the integrated approach. The practices seem to have greatly benefited from having one survey visit rather than two separate visits. Apart from this reduced accreditation fatigue other benefits highlighted include:

- being able to view the entirety of the training continuum;
- costs have not significantly increased;
- there have flow-on benefits already realised from the project;
- quality outcomes have been maintained; and
- areas for ongoing cooperation in the future have been identified.

CPMEC looks forward to building on the very collaborative relationship developed with GPET during the course of GPTAP. In this regard, the report has made a number of recommendations for consideration by GPET.

ACKNOWLEDGEMENTS

We thank all other stakeholders involved in this project at the local and national levels for their contributions. With that support and goodwill, the project was able to achieve very positive outcomes despite working to a very tight time frame. The project has demonstrated that working collaboratively and with some degree of flexibility, significant gains can be made in improving efficiencies in postgraduate training accreditation processes. Particular mention should go to the following:

- GPET for agreeing to fund the pilots and provide support and guidance throughout the duration of the project. Special mention must go to Mr Erich Janssen, Mr Glenn McMahon, Mr Richard Kingsford, Ms Susannah Littleton and Ms Linda Langford
- PMCV, PMCWA and NTPMC for agreeing to host the GPTAP pilots
- The three local project staff, Ms Julia Chalmers, Ms Judy D'Ombrain and Ms Liza Armstrong
- Prof Rick MacLean for Chairing the National Steering Committee for the project as well as all its members
- Ms Barbara Butterworth and Ms Lucy Gilbert from CPMEC for their administrative support to the National Project Manager
- The many other organisations and individuals who provided comments, inputs and advice.

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12 February 2013

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