



PREVOCATIONAL MEDICAL
ASSURANCE SERVICES

Attachment 6.1.1

Survey Report

Reaccreditation

Top End Regional Health Service

- Top End (Royal Darwin Hospital and Palmerston Regional Hospital)
- Big Rivers (Katherine Hospital)
- East Arnhem (Gove District Hospital)

July 2026

Reaccreditation Survey Report

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Introduction

The NT Accrediting Authority thanks the executive and staff of the Top End Regional Health Service (TERHS) for taking part in the 2026 reaccreditation survey. NT Accrediting Authority staff and the survey team led by Dr Nigel Gray (team leader) acknowledge the hard work and effort put in by health service staff to complete the relevant documentation.

TERHS is comprised of Royal Darwin, Palmerston Regional, Katherine and Gove District Hospitals with Royal Darwin Hospital (RDH) being the primary allocation centre for prevocational education, training and supervision with several offsite units. RDH is seeking to have all terms listed in the following Table of Terms accredited.

RDH is the NT's largest tertiary referral and teaching hospital providing acute hospital services to the residents of the Top End of the Northern Territory. RDH acts as a tertiary referral hospital for the remainder of the NT, the Kimberley Region of Western Australia and its northern neighbours in the event of a man-made or natural disaster in the region.

The terms listed at the back of the accreditation report are the only terms accredited for PGY1 and/or PGY2 trainees for this facility.

All terms that include prevocational doctors (PGY1 and PGY2) **must** meet the Australian Medical Council national standards for prevocational training programs and terms. An Intern's registration will be at risk if placed in an unaccredited term. Similarly, a PGY2 doctor's ability to achieve the PGY2 Certificate of Completion may be affected if their term is not accredited. In the event of the facility requiring additional terms, please contact the NT Accrediting Authority.

Table of accredited terms and requested terms for this survey

ACCREDITATION EXPIRES 30 SEPTEMBER 2026								
PRIMARY ALLOCATION FACILITY (Royal Darwin Hospital) + OFFSITE UNIT (Palmerston Regional Hospital) + OFFSITE UNIT (Katherine Hospital) + OFFSITE UNIT (Gove District Hospital) + Primary Care								
ACCREDITED TERMS			CURRENT			REQUESTED		
	PRIMARY SITE	AMC CATEGORY	PGY 1	PGY 2	TOTAL	PGY 1	PGY 2	TOTAL
EMERGENCY MEDICAL CARE								
Emergency Medical Care	RDH	A, C	10	16	26	10	20	30
MEDICINE								
General Medicine	RDH	B, C	12	12	24	17	15	32
Cardiology	RDH	B, C	2	3	5	3	4	7
Haematology	RDH	B, C	0	1	1	1	2	3
Neurology	RDH	B, C	0	1	1	1	1	2
IFD/HITH	RDH	B, C	0	2	2	1	2	3
Dermatology	RDH	B, C	0	1	1	0	1	1
INTEGRATED CARE								
Renal Medicine	RDH	B, C	2	2	4	5	5	10
Palliative Care	RDH	B	1	1	2	1	1	2
Oncology	RDH	B, C	0	2	2	0	2	2
SURGERY & CRITICAL CARE								
General Surgery	RDH	C, D	12	14	26	7	8	15
Surgical Acute Care Unit (SACU)	RDH	C, D	0	0	0	8	8	16
Urology	RDH	C, D	0	1	1	1	1	2
Vascular Surgery	RDH	C, D - PGY1 B, D - PGY2	1	1	2	1	1	2
Orthopaedics	RDH	C	0	4	4	0	6	6
Head and Neck (Maxillofacial)	RDH	C, D	2	1	3	2	2	4
ENT	RDH	C	0	1	1	1	2	3
Neurosurgery	RDH	C	0	1	1	2	2	4
Plastic Surgery	RDH	D	1	1	2	2	2	4
DIVISION OF WOMENS, CHILDREN & YOUTH								
Paediatrics	RDH	B, C	4	8	12	4	8	12
Obstetrics & Gynaecology	RDH	C	0	10	10	0	10	10

TOP END MENTAL HEALTH SERVICE								
Psychiatry/Alcohol and Other Drugs	RDH	B, C	0	5	5	1	5	6
OFFSITE UNIT/S								
Emergency Medical Care	PRH	A, C	4	15	19	4	15	19
Medicine	PRH	B, C	1	6	7	1	6	7
Rehabilitation Medicine	PRH	B	1	2	3	1	2	3
Geriatrics	PRH	B	1	2	3	1	2	3
General Surgery	PRH	C, D	0	6	6	0	6	6
Emergency Medical Care	KH	A, C	1	2	3	2	3	5
Medicine	KH	B, C	1	2	3	1	2	3
General Rural Term	GDH	A, C	3	0	3	3	0	3
<i>Gove Peninsula Rotation</i>	GDH	A, B	0	6	6	0	6	6
<i>Population & Primary Health Care Branch</i>	RDH	A, B	0	4	4	0	4	4
<i>Danila Dilba Health Service</i>	RDH	A, C	0	4	4	0	4	4
<i>Groote Eylandt</i>	GDH	A, C	0	1	1	0	1	1
<i>Mala'la - Population & Primary Health Care - Maningrida</i>	RDH	A, B	0	0	0	0	1	1
TOTALS			59	138	197	81	160	241

Report executive summary

Thank you for submitting the TERHS 2026 Reaccreditation survey submission. The NT Accrediting Authority reviews prevocational accreditation submissions provided by NT prevocational accredited training providers as part of its monitoring functions to ensure that accredited providers continue to meet the national standards.

The survey team appointed on behalf of NT Accrediting Authority and approved by the health service/training provider prior to the event included:

Dr Nigel Gray (Lead Surveyor)

MB ChB, FRACGP, GCHPE

Dr Kristof Wing (Team Member)

MBBS, BMedSci (Hons), DTM&H, Medical Registrar

Dr Jerida Keane (Team Member)

MBBS, BHIthSc (Hons), ACRRM Registrar

Doctor in Training Representative

Ms Silvia Bretta (Team Member)

Former Manager Rural Pathways and Rural Generalist Training (NT), RACGP

EXECUTIVE SUMMARY

The visit was conducted in a positive, enjoyable and respectful climate during which the survey team noted the marked improvement in facilitated governance of the training program compared to previous accreditation cycles. Moreover, the insight into this progress demonstrated by the Medical Education Unit (MEU) (Criteria 1.3.1) instils even greater confidence that the trajectory is sustainable.

There are therefore both high level commendations to be made and recognition of a number of robust initiatives arising from this progress.

The health service should be commended on the delivery of a program that affords a large number of unique and highly valued opportunities for exposure to generalist roles outside of traditional prevocational training settings.

The prevocational doctors' (PVD) experiences in turn reflected a breadth of exposure that has a clear focus on generalist learning, even within the acute environment.

Nonetheless, there remain significant challenges for the health service to surmount to further enhance the experience of all employed PVDs.

Notwithstanding the acknowledged difficulties in obtaining valid data, a workforce plan ensuring a safe workplace for Aboriginal and Torres Strait Islander PVDs needs to be developed; a plan that is enacted within a care partnership strategy utilising all appropriately placed staff members, specifically including the interpreter service (1.3.4).

There needs to be greater visibility of the PVD representative roles manifest by more effective communication between the office holders and their delegates (1.3.6, 4.3.1).

Full engagement with offsite units facilitated by reliable wireless internet access (3.5.1) is imperative as is the provision of safe physical environments for placements within those units (3.5.2). The survey team are also of the view that placement opportunities within rural generalism contexts remain under-utilised by this health service and its offsite units (1.5.2).

Supervisor training is another area worthy of additional focus. Any such program needs to be offered during the course of normal duties (3.3.2), its further development be subject to participant feedback (5.1.2) and evaluated by way of multi-faceted assessment of supervisor performance (3.2.5, 3.3.3). More specifically training needs to encompass the PVD assessment process(es), the provision of informal feedback to PVDs and the management of PVD performance concerns (2.3.3, 2.4.2, 2.5.1).

Drilling into finer detail, the survey team wishes to outline a number of other criteria where greater attention will lead to the awarding of Satisfactorily Met (SM) ratings during the lifetime of this cycle :

- A system supporting the provision of effective feedback to PGY2 PVDs regarding their performance (2.4.1)
- The availability of career advice services to PVDs (4.2.7)
- A more consistent approach to facilitating overtime claims within various units (4.4.1)
- The use of external data sources to inform the monitoring and evaluation of the program (5.1.4)
- A review of the alignment between supervisor and PVD rostering and mechanisms of workplace-based supervision within the Royal Darwin Hospital Emergency Department, to ensure supervisors are able to fulfil their training roles and responsibilities (3.3.4).

The survey team acknowledges the co-morbidity present in the obstetric population of the health service however were not satisfied that the extent of PVD exposure to managing the chronic components of obstetric and gynaecological care during this rotation meets clinical experience B. Broadened exposure of the PVDs in particular to outpatient clinics may assist if this is a priority for the service

Furthermore, Clinical Experience C has been removed by mutual agreement from the PRH Surgical term after review and triangulation of information obtained from both supervisors and the PVDs.

Requests for additional PVDs within the Head and Neck (Maxillofacial), Neurosurgery and ENT terms were also considered by the survey team however evidence gathered during the accreditation survey indicated that approving the full number of requested positions would risk compromising the quality of the clinical learning experience for currently allocated trainees as available clinical exposure opportunities are insufficient to support the proposed increase in trainee numbers.

In support of greater community experience for PVDs, an additional Palliative Care PGY1 position has been approved on the basis of heard evidence during the survey visit. It is hoped this will enable PGY1 doctors to gain quality place-based experience in palliative care.

The evidence shared during the survey visit reflects the intended changes in structure between the Infectious Diseases (IFD) and Hospital in the Home (HITH) terms. The survey team recommends that these two terms be accredited separately going forward should this structure be accepted by the training provider.

When it comes to identifying future terms for training, careful consideration should be given to the complexity and volume of a clinical unit's workload with its attendant impacts on its assigned PVDs as

assessed through multi-source feedback. PVD impressions of work intensity and quality clinical learning is imperative. Where requests are associated with new models of clinical service provision, this should be clearly identified in the submission. In addition, future submissions should consider the available supervisory capacity within the relevant terms (3.1.3).

Whilst the majority of later comments within this summary carry recommendations for change it should be re-iterated that the strategic focus; role delineation and ownership; motivated professional approach in the interests of PVD training and wellbeing; and quality improvement focus demonstrated by the health service and in particular its MEU are all highly impressive supports to a program showing clear signs of progress towards one of outstanding quality.

Please maintain such commitment and give due attention to succession planning in crucial roles to ensure progress is maintained.

With best regards,

Dr Nigel Gray
NT Accrediting Authority Lead Surveyor – TERHS Reaccreditation Survey Event

Summary of Standards

Standard 1 - Organisational purpose and the context in which prevocational training is delivered

Standard 2 - The prevocational training program – structure and content

Standard 3 - The prevocational training program – delivery

Standard 4 - The prevocational training program – prevocational doctors

Standard 5 - Monitoring, evaluation and continuous improvement

Summary of conditions/recommendations/commendations

*NOTE: Comments may provide further understanding when read with Conditions and Recommendations

Standard/Criterion	Comments Y/N	Condition/Recommendation/Commendation
1.3.2	Y	<u>CONDITION (Mala'la term only):</u> THAT Clinical governance systems to be demonstrated by QAP 2 stage.
1.3.4	Y	<u>RECOMMENDATION:</u> The health service develops a workforce plan that ensures a culturally safe environment for PVDs identifying as of Aboriginal or Torres Strait Islander origin. <u>RECOMMENDATION:</u> The health service develops a strategy which articulates a provision of care partnership between itself and its patients & their carers, facilitated by appropriately placed & skilled staff members.
1.5.2	Y	<u>RECOMMENDATION:</u> The health service ensures that future PEC meetings address a wider range of issues relevant to dispersed primary health care placements.
2.2.3	Y	<u>RECOMMENDATION:</u> The health service must ensure PVDs are supported to communicate effectively with Aboriginal and Torres Strait Islander patients through culturally safe communication training, clinical supervision, and access to Aboriginal Liaison Officers, Aboriginal Health Practitioners, interpreter services and other cultural support resources.
2.3.3	Y	<u>CONDITION:</u> THAT The prevocational training provider ensures all supervisors receive appropriate training to understand and effectively implement the assessment processes for PVDs by QAP2. <u>CONDITION (Cardiology term only):</u> THAT The prevocational training provider ensures the formal assessment processes for PVDs undertaking the cardiology rotation are completed within the required timeframes. This requirement must be addressed by QAP2.
2.4.1	Y	<u>CONDITION:</u> THAT The prevocational training provider must provide evidence, by QAP2, of an implemented and documented system that ensures PGY2 doctors receive formal supervisor feedback that is timely and structured, supporting their learning and progression through the prevocational training program.

2.4.2	Y	<u>CONDITION:</u> THAT The prevocational training provider will ensure term and clinical supervisors receive appropriate training and support to provide timely, specific and constructive informal feedback to PVDs, supporting their learning and continuous improvement. Evidence for this condition is required by QAP 2.
2.5.1	Y	<u>CONDITION:</u> THAT The prevocational training provider ensures that all PVDs who are not performing to the expected level are identified in a timely manner and receive appropriate support and remediation. Evidence for this condition is required by QAP 2.
3.1.1	Y	<u>COMMENDATION:</u> The health service is commended on the delivery of a PEPT that affords a large number of unique and highly valued opportunities for exposure to generalist roles outside of traditional prevocational training settings (i.e. acute and subacute hospitals).
3.2.1	Y	<u>CONDITION (General Surgery only):</u> THAT The health service ensures the adequate supervision of all PVDs at all times, including after hours. Immediate clinical supervisors must be adequate in number and sufficiently resourced to provide prompt assistance to PVDs when requested. Evidence to be provided by QAP 1.
3.2.2	Y	<u>CONDITION:</u> THAT The prevocational training provider ensures all supervisors receive appropriate training to understand and effectively implement the assessment processes for PVDs by QAP2.
3.2.5	Y	<u>CONDITION:</u> THAT That an effective process to evaluate the performance of supervisors and quality of supervision be implemented prior to QAP2.
3.3.2	Y	<u>CONDITION:</u> THAT By QAP2 supervisor professional development related to supervision, assessment and feedback, and cultural safety are permitted to occur in the normal course of duties and are remunerated as such.
3.3.3	N	<u>CONDITION:</u> THAT By QAP2 the PTP regularly evaluates the adequacy and effectiveness of prevocational doctor supervision as part of continuous quality improvement.

3.3.4	Y	<u>CONDITION:</u> THAT By QAP2 all supervisors are afforded sufficient paid, protected, non-clinical time to supervise and educate PVDs. <u>CONDITION (Emergency Medical Care – RDH only) :</u> THAT By QAP2 the PTP reviews the alignment between supervisor and PVD rostering, and mechanisms of workplace-based supervision, to ensure supervisors are able to fulfil their training roles and responsibilities.
3.5.1	Y	<u>RECOMMENDATION (Katherine Hospital):</u> That there is robust access to wireless internet to support modern technologies of learning.
3.5.2	Y	<u>CONDITION (Katherine Hospital):</u> THAT By QAP1 the PTP provides a safe physical environment through provision of secure accommodation, access to which is also safe.
4.2.2	Y	<u>RECOMMENDATION:</u> The health service develops a workforce plan that ensures a culturally safe environment for PVDs identifying as of Aboriginal or Torres Strait Islander origin.
4.2.7	Y	<u>RECOMMENDATION:</u> That the PTP ensures PVDs, especially those in PGY2, are afforded consistent career advice with a focus on the individual learner.
4.3.1	Y	<u>RECOMMENDATION:</u> That the health service provides evidence of continued Quality Improvement Processes regarding communication strategies with PVDs.
4.4.1	Y	<u>RECOMMENDATION:</u> That the health service conducts a review of the variants in procedures for claiming overtime across the service, aiming for consistent application.
5.1.2	Y	<u>CONDITION:</u> THAT Evidence is provided of consistent sourcing and utilisation of supervisor feedback in the development of the PTP by QAP2.
5.1.4	Y	<u>CONDITION:</u> THAT External sources of data need to be sought and used to inform evaluation of the PTP by QAP2.

Glossary

The following terms may be used throughout this document.

Term	Description
SM	Satisfactorily Met – Rating Scale
PM	Partially Met – Rating Scale
NM	Not Met – Rating Scale
TERHS	Top End Regional Health Service
CARHS	Central Australia Regional Health Service
DCT	Director of Clinical Training
DMS	Director of Medical Services
EDMCS/EDMS	Executive Director of Medical Clinical Services/Executive Director of Medical Services
HSEP	Health Service Education Program which refers to the formal education program comprised of a series of educational sessions provided for Interns/Prevocational doctors at your Facility
PTP	Prevocational Training Program - a period of 2 years of generalist, work-based, clinical training after graduation. Each year (PGY1 or internship, and PGY2) comprises 47 weeks of supervised clinical training that meets the requirements set out in the national standards and requirements for prevocational (PGY1 and PGY2) training programs and terms. Each year of the program includes orientation, formal and informal education sessions, and assessment with feedback, and may be provided by one or more training providers.
MEC (TERHS)	Medical Education Council (Prevocational Doctor Clinical Training Committee)
MTC (CARHS)	Medical Training Committee (Prevocational Doctor Clinical Training Committee)
MEO	Medical Education Officer
MEU	Medical Education Unit
MAR	Medical Administration Registrar
MER	Medical Education Registrar
OA	Outstanding Achievement
PMAS	Prevocational Medical Assurance Services
RDH	Royal Darwin Hospital
PRH	Palmerston Regional Hospital
KH	Katherine Hospital
GDH	Gove District Hospital
ASH	Alice Springs Hospital
TCH	Tennant Creek Hospital

Prevocational education & training program report

The Delegated Officer will ensure that the Prevocational Education and Training Program offered is *sufficient* to enable prevocational doctors who undertake the program to gain the skills and knowledge in clinical medical practice necessary to competently and safely practise the profession.

Standard 1 – Organisational purpose and the context in which prevocational training is delivered

1.1 Organisational purpose	Rating	Condition/Recommendation/Commendation	Comments
1.1.1 The purpose of the health services that employ and train prevocational doctors includes setting and promoting high standards of medical practice and training.	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
1.1.2 The employing health service's purpose identifies and addresses Aboriginal and Torres Strait Islander communities' place-based needs and their health in collaboration with those communities.	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
1.2 Outcomes of the prevocational training program			
1.2.1 The prevocational training provider relates its training and education functions to the health care needs of the communities it serves.	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
1.2.2 The training program provides generalist clinical training that prepares prevocational doctors with an appropriate foundation for lifelong learning and for further postgraduate training.	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
1.3 Governance			
1.3.1 The governance of the prevocational training program, supervisory and assessment roles are defined.	SM	Nil	The Health Service's self-rating of PM is noted. However the survey team are of the view that the governance structure and the role definitions

			underpinning this are of sufficient strength to warrant the awarding of a SM rating. The Service is nonetheless applauded for its demonstrated insight into the necessary quality improvement process in progress. To be reviewed at the scheduled Progress Report.
1.3.2 The health services that contribute to the prevocational training program have a system of clinical governance or quality assurance that includes clear lines of responsibility and accountability for the overall quality of medical practice and patient care.	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
	PM	<u>CONDITION (Mala'la term only):</u> THAT Clinical governance systems to be demonstrated by QAP 2 stage.	A significant majority of contributing health services are able to demonstrate adequate clinical governance arrangements that support safe clinical practice, quality training, trainee supervision, and continuous quality improvement. As Mala'la is a newly accredited term, evidence of the implementation, effectiveness, and comparability of these governance arrangements will be required as part of the QAP2 reporting schedule.
1.3.3 The health services give appropriate priority and resources to medical education and training and support of prevocational doctor wellbeing relative to other responsibilities	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
1.3.4 The health service has documented and implemented strategies to provide a culturally safe environment that supports: • Aboriginal and Torres Strait Islander patients / family / community care • the recruitment and retention of an Aboriginal and Torres Strait Islander health workforce.	PM	<u>RECOMMENDATION:</u> The health service develops a workforce plan that ensures a culturally safe environment for PVDs identifying as of Aboriginal or Torres Strait Islander origin. <u>RECOMMENDATION:</u> The health service develops a strategy which articulates a provision of care partnership between itself and its patients & their carers, facilitated by appropriately placed & skilled staff members.	The challenges facing the health service in gaining sufficient visibility of its workforce demographic is noted. The survey team identifies the role of the health service's interpreter service as being integral to this Recommendation.

1.3.5 The prevocational training program complies with relevant national, state or territory laws and regulations pertaining to prevocational training.	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
1.3.6 Prevocational doctors are involved in the governance of their training.	SM	Nil	Whilst involvement has been established, the visibility of the representational roles to those represented remains low. To be reviewed at the scheduled Progress Report.
1.3.7 The prevocational training program has clear procedures to immediately address any concerns about patient safety related to prevocational doctor performance, including procedures to inform the employer and the regulator, where appropriate.	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
1.4 Program management			
1.4.1 The prevocational training program has dedicated structures with responsibility, authority, capacity and appropriate resources to direct the planning, implementation and review of the prevocational education and training program, and to set relevant policies and procedures.	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
1.4.2 The prevocational training program documents and reports to the prevocational training accreditation authority on changes in the program, terms or rotations that may affect the program delivery meeting the national standards.	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
1.4.3 The health services have effective organisational and operational structures dedicated to managing prevocational doctors, including rostering and leave management.	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
1.5 Relationships to support medical education			
1.5.1 The prevocational training program supports the delivery of prevocational training through constructive working relationships with other relevant agencies, such as medical schools, specialist education providers, and health facilities.	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.

1.5.2 Health services coordinate the local delivery of the prevocational training program. Health services that are part of a network or geographically dispersed program contribute to program coordination and management across sites.	PM	RECOMMENDATION: The health service ensures that future PEC meetings address a wider range of issues relevant to dispersed primary health care placements.	The survey team noted some disparity of view between primary allocation centre and dispersed DCTs regarding the allocation process of PVDs to offsite terms. The survey team also received feedback s that the PEC meeting agendas were overly focused on secondary care placement issues and did not adequately consider rural and remote primary healthcare opportunities.
1.6 Reconsideration, review and appeals processes			
1.6.1 The prevocational training provider has reconsideration, review and appeals processes that provide for impartial and objective review of assessment and progression decisions related to prevocational training. It makes information about these processes readily available to all relevant stakeholders.	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.

Standard 2 - The prevocational training program – structure and content

2.1 Program structure and composition	PGY1/ PGY2	Rating	Condition/Recommendation/Commendation	Comments
2.1.1 The prevocational training program overall, and each term, is structured to reflect requirements described in the Medical Board of Australia's Registration standard – Granting general registration on completion of intern training and requirements described in these standards for PGY2.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
2.1.2 The prevocational training program is longitudinal in nature and structured to reflect and provide the following experiences, as described in 'Requirements for prevocational (PGY1 and PGY2) training programs and terms' (Section 3 of National standards and requirements for prevocational (PGY1 and PGY2) training programs and terms): • a program length of 47 weeks • a minimum of 4 terms in different specialties in PGY1 • a minimum of 3 terms in PGY2 • exposure to a breadth of clinical experiences • exposure to working outside standard hours, with appropriate supervision • working within a clinical team for at least half the year • a maximum time spent in service terms of 20% in PGY1 and 25% in PGY2.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
2.1.3 Prevocational training terms are structured to reflect and provide exposure to one or two of the required clinical experiences as described in 'Requirements for programs and terms' (Section 3 of National standards and requirements for programs and terms).	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
2.1.4 The prevocational training provider guides and supports supervisors and prevocational doctors in implementing and reviewing flexible training arrangements. Available arrangements for PGY1 are consistent with the Registration standard – Granting general registration on completion of intern training.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
2.1.5 The provider recognises that Aboriginal and Torres Strait Islander prevocational doctors may have additional cultural obligations required by the health sector or their community, and has policies that ensure flexible processes to enable those obligations to be met.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.

2.2 Training requirements				
2.2.1 The prevocational training program is underpinned by current evidence-informed medical education principles	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
2.2.2 For each term, the prevocational training provider has identified and documented the training requirements (see Training and assessment requirements for prevocational (PGY1 and PGY2) training programs: Section 2 – 'Prevocational training'), including the prevocational outcome statements that are relevant, the skills and procedures that can be achieved, and the nature and range of clinical experience available to meet these objectives.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
2.2.3 The prevocational program provides professional development and clinical opportunities in line with the prevocational outcome statements regarding Aboriginal and Torres Strait Islander peoples' health.	BOTH	PM	<u>RECOMMENDATION:</u> The health service to enhance the supports available to PVDs to promote culturally safe and effective communication with Aboriginal and Torres Strait Islander patients.	The survey team identifies the role of the health service's interpreter service as being integral to this Recommendation.
2.3 Assessment requirements				
2.3.1 Prevocational doctor assessment is consistent with the Training and assessment requirements and based on prevocational doctors achieving outcomes stated in the prevocational outcome statements.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
2.3.2 The prevocational PGY1 training program implements assessment consistent with the Medical Board of Australia's Registration standard – Granting general registration on completion of intern training.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
2.3.3 Prevocational doctors and supervisors understand all components of the assessment processes.	BOTH	PM	<u>CONDITION:</u> THAT The prevocational training provider ensures all supervisors receive appropriate training to understand and effectively implement the assessment processes for PVDs by QAP2.	Some feedback highlighted difficulties for PVDs in obtaining timely formal feedback, suggesting a need for greater consistency in supervisors' implementation of the assessment process.

			<u>CONDITION (Cardiology term only):</u> THAT The prevocational training provider ensures the formal assessment processes for PVDs undertaking the cardiology rotation are completed within the required timeframes. This requirement must be addressed by QAP2.	The survey team received specific feedback regarding the Cardiology term, with PVDs experiencing significant challenges in receiving timely formal assessments. This was identified as a particular concern and highlights the need for timely completion of the assessment process.
2.3.4 The prevocational training program has an established assessment review panel to review prevocational doctors' longitudinal assessment information and make decisions regarding progression in each year.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
2.4 Feedback and supporting continuous learning				
2.4.1 The prevocational training program provides regular, formal and documented feedback to prevocational doctors on their performance within each term.	PGY1	SM		The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
	PGY2	NM	<u>CONDITION:</u> THAT The prevocational training provider must provide evidence, by QAP2, of an implemented and documented system that ensures PGY2 doctors receive formal supervisor feedback that is timely and structured, supporting their learning and progression through the prevocational training program.	Whilst there is evidence of the program providing regular, formal and documented feedback to PGY1 doctors through the DCT meetings there is no evidence of the program providing the same (or equivalent) for PGY 2 doctors. The evidence suggested their feedback came from the level of the clinical supervisor only.
2.4.2 Prevocational doctors receive timely, progressive and informal feedback from term and clinical supervisors during every term.	BOTH	PM	<u>CONDITION:</u> THAT The prevocational training provider will ensure term and clinical supervisors receive appropriate training and support to provide timely, specific and constructive informal feedback to PVDs, supporting their learning and continuous improvement. Evidence for this condition is required by QAP 2.	The survey team received variable comments on the provision of informal feedback to PVDs, with some reporting limited opportunities to receive specific and constructive feedback. This highlights the need for continued supervisor training and support to ensure timely feedback that supports learning and continuous improvement.

2.4.3 The prevocational training program documents the assessment of the prevocational doctor's performance consistent with the Training and assessment requirements. Additionally in PGY1, the assessment documentation is consistent with the Registration standard – Granting general registration on completion of intern training.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
2.4.4 The prevocational training program implements a longitudinal approach to assessment in accordance with the Training and assessment requirements	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
2.4.5 Prevocational doctors are encouraged and supported to take responsibility for their own performance, and to seek their supervisor's feedback on their performance.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
2.5 Improving performance				
2.5.1 The prevocational training program identifies any prevocational doctors who are not performing to the expected level and provides them with support and remediation.	BOTH	PM	CONDITION: THAT The prevocational training provider ensures that all PVDs who are not performing to the expected level are identified in a timely manner and receive appropriate support and remediation. Evidence for this condition is required by QAP 2.	The survey team received supervisor feedback indicating challenges in identifying and initiating remediation for PVDs due to competing clinical demands, limited time and unfamiliarity with the formal remediation process. Enhanced supervisor education and support will assist in ensuring timely identification and management of PVDs performance concerns.
2.5.2 The assessment review panel is convened, as required, to assist with more complex remediation decisions for prevocational doctors who do not achieve satisfactory supervisor assessments.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.

Standard 3 - The prevocational training program – delivery

3.1 Work-based teaching and training	PGY1/ PGY2	Rating	Condition/Recommendation/Commendation	Comments
3.1.1 The prevocational training provider ensures opportunities for broad generalist clinical work-based teaching and training.	BOTH	SM	COMMENDATION: The health service is commended on the delivery of a PEPT that affords a large number of unique and highly valued opportunities for exposure to generalist roles outside of traditional prevocational training settings (i.e. acute and subacute hospitals).	Even within the acute environment, PVDs reflect breadth of exposure that has a clear focus on generalist learning. In the experience of the surveyors, the access to non-hospital settings (and, indeed, the rurality and complexity of these placements) is remarkable and should be recognised as a real strength of the TERHS PTP.
3.1.2 The prevocational training program provides clinical experience that is able to deliver the training and assessment requirements and for PGY1 doctors, is consistent with the registration standard – granting general registration on completion of intern training. The prevocational training program conforms to guidelines on opportunities to develop knowledge and skills, as outlined in 'Requirements for programs and terms' (Section 3 of National standards and requirements for programs and terms).	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
3.1.3 In identifying terms for training, the prevocational training program considers the following: • complexity and volume of the unit's workload • the prevocational doctor's workload • the clinical experience prevocational doctors can expect to gain • how the prevocational doctor will be supervised, and who will supervise them.	BOTH	SM	Nil	The survey team are cognisant of the desire to increase the NT Medical Workforce Pipeline. Careful consideration should be given in future submissions that the complexity and volume of a clinical unit's workload (and consequently PVD's workload) is assessed through multi-source feedback. PVD impressions of work intensity and quality clinical learning is imperative. Where requests are associated with new models of clinical service provision, this should be clearly identified in the submission. In addition, future submissions should consider the available supervisory capacity. To be reviewed at the scheduled Progress Report.

3.2 Supervisors and assessors – attributes, roles and responsibilities				
3.2.1 Prevocational doctors are supervised at all times at a level and with a model that is appropriate to their experience and responsibilities.	BOTH	SM		The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
		PM	<u>CONDITION (General Surgery only):</u> THAT The health service ensures the adequate supervision of all PVDs at all times, including after hours. Immediate clinical supervisors must be adequate in number and sufficiently resourced to provide prompt assistance to PVDs when requested. Evidence to be provided by QAP1.	PVDs raised on multiple occasion that access to adequate supervision by clinical supervisors out of hours was extremely challenging, and in some instances may have impacted patient care. It is an accreditation requirement that the quantity and quality of supervision be adequate at all times for accredited terms.
3.2.2 Prevocational supervisors understand their roles and responsibilities in assisting prevocational doctors to meet learning objectives and in conducting assessment processes.	BOTH	PM	<u>CONDITION:</u> THAT The prevocational training provider ensures all supervisors receive appropriate training to understand and effectively implement the assessment processes for PVDs by QAP2.	PVDs reflected difficulties with supervisors understanding the nature of a competency-based curriculum, and this presented barriers to the completion of learning tools. Whilst strength-based approaches may be effective, identifying and addressing supervisor underperformance is equally important.
3.2.3 Supervision is provided by qualified medical staff with appropriate competencies, skills, knowledge and a demonstrated commitment to prevocational training.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
3.2.4 The prevocational training program includes a director of clinical training or equivalent who is a qualified and senior medical practitioner with responsibility for longitudinal educational oversight of the prevocational doctors.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
3.2.5 The prevocational training program has processes for ensuring those assessing prevocational doctors (including registrars and assessment review panel members) have relevant capabilities and understand the required processes.	BOTH	PM	<u>CONDITION:</u> THAT That an effective process to evaluate the performance of supervisors and quality of supervision be implemented prior to QAP2.	The survey team did not feel that supervisors (including clinical supervisors) universally understood the requirements of supervision of PVDs, although quality supervision was present in many instances. Ensuring that all supervisors are adequately trained and understand the curricular requirements will require training and evaluation of supervisors.

3.3 Supervisor training and support				
3.3.1 Staff involved in prevocational training have access to professional development activities to support quality improvement in the prevocational training program.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
3.3.2 The prevocational training program ensures that supervisors have training in supervision, assessment and feedback, and cultural safety, including participating in regular professional development activities to support quality improvement in the prevocational training program.	BOTH	PM	CONDITION: THAT By QAP2 supervisor professional development related to supervision, assessment and feedback, and cultural safety are permitted to occur in the normal course of duties and are remunerated as such.	Supervisors reflected that professional development activities related to supervision were often accomplished outside of ordinary hours, and that this limited their ability to engage with and/or access professional development.
3.3.3 The prevocational training program regularly evaluates the adequacy and effectiveness of prevocational doctor supervision.	BOTH	PM	CONDITION: THAT By QAP2 the PTP regularly evaluates the adequacy and effectiveness of prevocational doctor supervision as part of continuous quality improvement.	Systematic evaluation of supervisor performance, ideally using multi-source feedback that is sensitive to existing medical power dynamics), is critical to ensuring quality supervision. The survey team did not observe an embedded process which ensured quality supervision and assessment.
3.3.4 The prevocational training program supports supervisors to fulfil their training roles and responsibilities.	BOTH	PM	CONDITION: THAT By QAP2 all supervisors are afforded sufficient paid, protected, non-clinical time to supervise and educate PVDs. CONDITION (Emergency Medical Care – RDH only) : THAT By QAP2 the PTP reviews the alignment between supervisor and PVD rostering, and mechanisms of workplace-based supervision, to ensure supervisors are able to fulfil their training roles and responsibilities.	Adequate time for supervision and education, as assessed by PVDs and supervisors varied between clinical units. Just as there were pockets of excellence, there were clinical units where provision of sufficient time for supervision and education were lacking. The PTP should ensure sufficient time across all clinical units. The multifactorial impacts of clinical load and system pressures on supervisors in particular in the ED were clear to the survey team. This should be a point of focus for the healthcare service. In particular supervisors being asked to complete PD feedback for doctors they have not had the opportunity to work with is a system, rostering issue to be rectified. Supervisors and PVDs reported that there were very limited clinical interactions between nominated term supervisors and PVDs to permit longitudinal assessment of performance, and this limited quality

				assessment and supervision. Additionally, PVDs and supervisors reflected that current practices made the completion of work based assessments very challenging.
3.4 Formal education program				
3.4.1 The training program provides PGY1 doctors with a quality formal education program that is relevant to their learning needs and supports them to meet the training outcomes that may not be available through completion of clinical activities.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
3.4.2 The training program monitors and provides PGY2 doctors with access to formal education programs that are flexible and relevant to their individual learning needs. This may include specific education sessions to support PGY2 doctors meeting the training outcomes that may not be available through completion of clinical activities.	BOTH	SM	Nil	The survey team note significant improvement in the quality of the HESP. Ensuring that these improvements are embedded into a culture of education over the accreditation cycle is imperative, to avoid key-person dependence. To be reviewed at the scheduled Progress Report.
3.4.3 The training program provides and enables for prevocational doctors to participate in formal program and term orientation programs, which are designed and evaluated to ensure relevant learning occurs.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
3.4.4 The health service ensures protected time for the formal education program, and ensures that prevocational medical doctors are supported by supervising medical staff to attend.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
3.5 Facilities				
3.5.1 The prevocational training program provides the educational facilities and infrastructure to deliver prevocational training, such as access to the internet, library facilities, quiet study spaces, journals, modern technologies of learning and other learning facilities, and continuing medical education sessions.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.

		PM	<u>RECOMMENDATION (Katherine Hospital only):</u> That there is robust access to wireless internet to support modern technologies of learning	PVDs and supervisors reflected that access to internet (in the form of wireless internet) was lacking in clinical and residential settings. Access to internet for educational, administrative, and personal reasons is imperative.
3.5.2 The prevocational training program provides a safe physical environment and amenities that support prevocational doctor learning and wellbeing.	BOTH		Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
		PM	<u>CONDITION (Katherine Hospital only):</u> THAT By QAP1 the PTP provides a safe physical environment through provision of secure accommodation, access to which is also safe.	PVDs and supervisors reflected instances in which PVDs felt unsafe returning to accommodations and instances in which responses from local police to concerns about unwelcome individuals were delayed and/or absent. This is especially the case in night-time hours after the completion of evening shifts. The provision of safe physical environments for placements within offsite units is imperative.
3.6 E-portfolio				
3.6.1 Once the e-portfolio system is confirmed, standards will be written, and will consider: • Systems to ensure prevocational doctors maintain their e-portfolio as an adequate record of learning and training. • Mechanisms to ensure the clinical supervisor and longitudinal supervisor review the record of learning.	BOTH	SM	Nil	The survey team recognises limitations related to the CLA Platform which are outside of the control of the PTP. Nonetheless, the impacts on quality supervision was noted. To be reviewed at the scheduled Progress Report.

Standard 4 - The prevocational training program – prevocational doctors

4.1 Appointment to program and allocation to terms	PGY1/ PGY2	Rating	Condition/Recommendation/Commendation	Comments
4.1.1 The processes for appointment of prevocational doctors to programs: • are based on the published criteria and the principles of the program concerned • are transparent, rigorous and fair • are free from racism, discrimination and bias • have clear processes where disputes arise.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
4.1.2 The processes for allocation of prevocational doctors to terms: • are based on the published criteria and the principles of the program concerned • are transparent, rigorous and fair • are free from racism, discrimination and bias • have clear processes where disputes arise.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
4.2 Wellbeing and support				
4.2.1 The prevocational training provider develops, implements and promotes strategies to enable a supportive training environment and optimise prevocational doctor wellbeing.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
4.2.2 The prevocational training provider develops, implements and promotes strategies to enable a supportive training environment and to optimise Aboriginal and Torres Strait Islander prevocational doctor wellbeing and workplace safety.	BOTH	PM	RECOMMENDATION: The health service develops a workforce plan that ensures a culturally safe environment for PVDs identifying as of Aboriginal or Torres Strait Islander origin.	It was identified to the survey team that PVDs who identified as Aboriginal or Torres Strait Islander were not known to formal supports within the Organisation, and that the Organisation did not have effective mechanisms to identify and support these PVDs. Identified limitations to this approach included hesitation on the part of PVDs to identify as Aboriginal or Torres Strait Islander, the reasons for which are beyond the scope of this report. These themes, however, were not unique to this setting or work environment.

4.2.3 The duties, rostering, working hours and supervision arrangements of prevocational doctors are consistent with the National standards and requirements for programs and terms and in line with principles of delivering safe and high-quality patient care.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
4.2.4 The prevocational training provider has and implements strategies, systems and safe reporting mechanisms to effectively identify, address and prevent bullying, harassment and discrimination (including racism). This includes policies and procedures that are publicised to prevocational doctors, their supervisors and other team members.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
4.2.5 The prevocational training provider makes available processes to identify and support prevocational doctors who are experiencing personal and professional difficulties that may affect their training, and confidential personal counselling. These services are publicised to prevocational doctors, their supervisors and other team members.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
4.2.6 The procedure for accessing appropriate professional development leave is published, reasonable and practical.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
4.2.7 The prevocational training provider makes available services to provide career advice to prevocational doctors.	BOTH	PM	RECOMMENDATION: That the PTP ensures PVDs, especially those in PGY2, are afforded career advice with a focus on the individual learner.	Current mechanisms for providing pastoral care for PGY1 PVDs were learner-centred and should continue to be strengthened, including career advice. Other mechanisms, including the careers fare, were commendable and should be fostered. PGY2 PVDs reflected limited pastoral care to assist them in making consequential decisions about career planning and trajectory, which are compounded by the unique nature of the health service.
4.3 Communication with prevocational doctors				
4.3.1 The prevocational training program provides clear and easily accessible information about the training program, including outcomes of evaluation, in a timely manner.	BOTH	PM	RECOMMENDATION: That the health service provides evidence of continued Quality Improvement Processes regarding communication strategies with PVDs.	The survey team note the health services self- identification as PM and support their intention to investigate alternative communication pathways to effectively communicate with PVDs.

4.3.2 The prevocational training program informs prevocational doctors about the activities of committees that deal with prevocational training in a timely manner.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
4.4 Resolution of training problems and conflicts				
4.4.1 The prevocational training provider has processes in place to respond to and support prevocational doctors in addressing problems with training supervision and training requirements, and other professional issues. The processes are transparent and timely, and safe and confidential for prevocational doctors.	BOTH	PM	RECOMMENDATION: That the health service conducts a review of the variants in procedures for claiming overtime across the service.	The survey team found adequate evidence that the service does have processes in place to respond to and support prevocational doctors in addressing problems with training supervision and training requirements, and other professional issues. A noted exception under this criterion as an “other professional issue” is the variation in process for PVDs to claim overtime throughout the service. The process is not transparent or consistent.
4.4.2 The prevocational training provider has clear, impartial pathways for timely resolution of professional and/or training-related disputes between prevocational doctors and supervisors, the healthcare team or the health service.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. The recent development/ implementation of the Dispute Resolution Policy was noted. Continued quality improvement cycles to evaluate its effectiveness is suggested. To be reviewed at the scheduled Progress Report.

Standard 5 - Monitoring, evaluation and continuous improvement

5.1 Program monitoring and evaluation	PGY1/ PGY2	Rating	Condition/Recommendation/Commendation	Comments
5.1.1 The prevocational training provider regularly evaluates and reviews its prevocational training program and terms to ensure standards are being maintained. Its processes check program content, quality of teaching and supervision, assessment, and prevocational doctors' progress.	BOTH	SM	Nil	The health services self-rating of PM is noted. The survey team were satisfied that there is clear evidence demonstrating that this standard has been addressed. To be reviewed at the scheduled Progress Report.
5.1.2 Those involved in prevocational training, including supervisors, contribute to monitoring and to program development. Their feedback is sought, analysed and used as part of the monitoring process.	BOTH	PM	CONDITION: THAT Evidence is provided of consistent sourcing and utilisation of supervisor feedback in the development of the PTP by QAP2.	The survey team noted high level engagement of supervisors within the health service and in the supervisor survey. Evidence of consistent sourcing, analysis and utilisation of supervisor feedback as a part of a quality improvement process needs to be provided.
5.1.3 Prevocational doctors have regular structured mechanisms for providing confidential feedback about their training, education experiences and the learning environment in the program overall, and in individual terms.	BOTH	SM	Nil	The survey team is satisfied that there is clear evidence demonstrating that this has been addressed. To be reviewed at the scheduled Progress Report.
5.1.4 The prevocational training program uses internal and external sources of data in its evaluation and monitoring activities, such as surveys and assessment data.	BOTH	PM	CONDITION: THAT External sources of data need to be sought and used to inform evaluation of the PTP by QAP2.	The survey team agree with the health services self-identified PM rating. There was evidence provided of acquiring and using internal sources of data to evaluate and monitor activities. There was inadequate evidence provided of acquisition or use of external sources of data.
5.2 Evaluation outcomes and communication				
5.2.1 The prevocational training program acts on feedback and modifies the program as necessary to improve the experience for prevocational doctors, supervisors and health care facility managers.	BOTH	SM	Nil	The survey team noted multiple examples during their visit of modification to the program based on PVD feedback. Changes

				had been initiated by the MEU and by specific terms. The presence of a culture responsive to feedback was noted. It is suggested that the health service aim to collate, record and review these changes as part of a quality improvement process. To be reviewed at the scheduled Progress Report.
5.2.2 Outcomes of evaluation activities are communicated to those involved in the prevocational training program, including prevocational doctors and supervisors.	BOTH	SM	Nil	The survey team notes the health services self-rating as PM. Whilst they would encourage the MEUs self-identified aim of increasing DIT response rate and support there listed strategies to achieve this goal the survey team was satisfied that, specifically throughout their visit, there was clear evidence demonstrating that this standard has been satisfactorily met. To be reviewed at the scheduled Progress Report.

Recommendation for accreditation

Based on the documentation provided to the survey team from the TERHS and the outcomes stated in this report, the survey team proposes to recommend that the Prevocational Accreditation Committee (PAC) grant the TERHS Prevocational Accreditation for 4 years for the terms listed below. For total numbers of positions accredited in each term see Table 'Terms Recommended for Accreditation' pg. 35 in this assessment report.

Current Terms Accredited

PGY1

- Emergency Medical Care - RDH
- General Medicine - RDH
- Cardiology
- Haematology
- Neurology
- IFD/HITH
- Urology
- Renal Medicine
- Palliative Care
- General Surgery
- SACU
- Vascular Surgery
- Head and Neck (Maxillofacial)
- ENT
- Neurosurgery
- Plastic Surgery
- Paediatrics
- Psychiatry/Alcohol and Other Drugs
- Emergency Medical Care - PRH
- Medicine - PRH
- Rehabilitation Medicine
- Geriatrics
- Emergency Medical Care -KH
- Medicine - KH
- General Rural Term - GDH

PGY2

- Emergency Medical Care - RDH
- General Medicine - RDH
- Cardiology
- Haematology
- Neurology
- IFD/HITH
- Dermatology
- Urology
- Renal Medicine
- Palliative Care
- Oncology
- General Surgery
- SACU
- Vascular Surgery
- Orthopaedics
- Head and Neck (Maxillofacial)
- ENT
- Neurosurgery
- Plastic Surgery
- Paediatrics
- Obstetrics & Gynaecology
- Psychiatry/Alcohol and Other Drugs
- Emergency Medical Care - PRH
- Medicine - PRH
- Rehabilitation Medicine
- Geriatrics
- General Surgery - PRH
- Emergency Medical Care - KH
- Medicine - KH
- Gove Peninsula Rotation - GDH
- Population & Primary Health Care Branch
- Danila Dilba Health Service
- Groote Eylandt
- Mala'la

New Terms accredited for a period of 1 year with a 6-month review after a prevocational doctor has completed a term

Mala'la - Population & Primary Health Care - Maningrida - PGY2 x 1

Modified Terms accredited for additional places:

Emergency Medical Care - RDH	- additional 4 x PGY2 positions
General Medicine – RDH	- additional 5 x PGY1 positions and 3 x PGY2 positions
Cardiology	- additional 1 x PGY1 position and 1 x PGY2 position
Haematology	- additional 1 x PGY1 position and 1 x PGY2 position
Neurology	- additional 1 x PGY1 position
IFD/HITH	- additional 1 x PGY1 position
Urology	- additional 1 x PGY1 position
Renal Medicine	- additional 3 x PGY1 positions and 3 x PGY2 positions
Palliative Care	- additional 1 x PGY1 position
General Surgery/SACU	- additional 3 x PGY1 positions and 2 x PGY2 positions
Orthopaedics	- additional 2 x PGY2 positions
ENT	- additional 1 x PGY1 position
Neurosurgery	- additional 1 x PGY1 position and 1 x PGY2 position
Plastic Surgery	- additional 1 x PGY1 position and 1 x PGY2 position
Psychiatry/Alcohol & Other Drugs	- additional 1 x PGY1 position
Emergency Medical Care -KH	- additional 1 x PGY1 position and 1 x PGY2 position

Modified Terms requested but not accredited for extra places:

Head and Neck (Maxillofacial)	- additional 1 x PGY2 position NOT APPROVED
ENT	- additional 1 x PGY2 position NOT APPROVED
Neurosurgery	- 1 x PGY1 position NOT APPROVED

Quality Action Plan due to NT Accrediting Authority by:

Stage 1	30 April 2027
Stage 2	30 April 2028

For all other accreditation cycle reports, see Prevocational Accreditation Cycle sent with this assessment report

Terms recommended for accreditation to continue

*****PLEASE NOTE:** This matrix indicates the maximum number of prevocational doctors for each term (not rostered shift within the term). As per the Prevocational Accreditation Policy 4.1 – “Interns **must not** be rostered to PGY1 **unaccredited** terms”.

PGY2 positions **are not** accredited for PGY1 prevocational doctors unless stated in writing by the NT Accrediting Authority. PGY1 accredited places are independent to PGY2 places. PGY1 and PGY2 places are **NOT** interchangeable.

ACCREDITED TERMS	PRIMARY SITE	AMC Category	ACCREDITED PLACES		
			PGY 1	PGY 2	TOTAL
EMERGENCY MEDICAL CARE					
Emergency Medical Care	RDH	A, C	10	20	30
MEDICINE					
General Medicine	RDH	B, C	17	15	32
Cardiology	RDH	B, C	3	4	7
Haematology	RDH	B, C	1	2	3
Neurology	RDH	B, C	1	1	2
IFD/HITH	RDH	B, C	1	2	3
Dermatology	RDH	B, C	0	1	1
INTEGRATED CARE					
Renal Medicine	RDH	B, C	5	5	10
Palliative Care	RDH	B	2	1	3
Oncology	RDH	B, C	0	2	2
SURGERY & CRITICAL CARE					
General Surgery	RDH	C, D - PGY1 B, C – PGY2	7	8	15
Surgical Acute Care Unit (SACU)	RDH	C, D	8	8	16
Urology	RDH	C, D	1	1	2
Vascular Surgery	RDH	C, D - PGY1 B, D – PGY2	1	1	2
Orthopaedics	RDH	C	0	6	6
Head and Neck (Maxillofacial)	RDH	C, D	2	1	3
ENT	RDH	C, D	1	1	2

Neurosurgery	RDH	C	1	2	3
Plastic Surgery	RDH	D	2	2	4
DIVISION OF WOMENS, CHILDREN & YOUTH					
Paediatrics	RDH	B, C	4	8	12
Obstetrics & Gynaecology	RDH	C	0	10	10
TOP END MENTAL HEALTH SERVICE					
Psychiatry/Alcohol and Other Drugs	RDH	B, C	1	5	6
OFFSITE UNITS					
Emergency Medical Care	PRH	A, C	4	15	19
Medicine	PRH	B, C	1	6	7
Rehabilitation Medicine	PRH	B	1	2	3
Geriatrics	PRH	B	1	2	3
General Surgery	PRH	D	0	6	6
Emergency Medical Care	KH	A, C	2	3	5
Medicine	KH	B, C	1	2	3
General Rural Term	GDH	A, C	3	0	3
<i>Gove Peninsula Rotation</i>	GDH	A, B	0	6	6
<i>Population & Primary Health Care Branch</i>	RDH	A, B	0	4	4
<i>Danila Dilba Health Service</i>	RDH	A, B	0	4	4
<i>Groote Eylandt</i>	GDH	A, C	0	1	1
<i>Mala'la - Population & Primary Health Care - Maningrida</i>	RDH	A, B	0	1	1
TOTALS			81	158	239

Survey team members

All surveyors have accepted and endorsed this report via email.

Dr Nigel Gray (Team Lead)

Dr Kristof Wing (Team Member)

Dr Jerida Keane (Team Member)

Ms Silvia Bretta (Team Member)

Accrediting authority support team members

Support Team:

Ms Cherie Hamill

Ms Nancy Ioannou

Report Sighted by: NT Accrediting Authority's Accreditation Director

Name: Ms Maria Halkitis

Date:

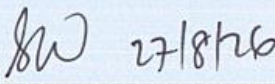
Health service/facility report received

The Prevocational Accreditation Committee requests that the Director of Medical Services (or equivalent), Director of Clinical Training and Prevocational Medical Education and Training Committee Chair upon receipt of this report sign and notify the NT Accrediting Authority Director that the assessment report has been received.

*****Please Note** that receipt of the report does **not** mean that the health service agrees with the content of the report.

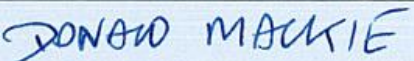
NT Accrediting Authority will update the latest health service accreditation status and accredited terms on the NT Accrediting Authority's website.

Receipt of the survey report outcomes for TERHS reaccreditation report is acknowledged by -

General Manager (or equivalent)	
Name: Sara Watson	Signature: 
Date: Highlight here to enter text	

Director of Medical Services (or equivalent)	
Name: Donald mackie	Signature: 
Date: Highlight here to enter text 28/8/26.	

Director of Clinical Training	
Name: Dennis Bonney	Signature: 
Date: Highlight here to enter text 28/8/26	

Prevocational Clinical Training Committee Chair	
 Name: Danika Thiemt	Signature: 
Date: Highlight here to enter text 28/8/26	

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