Regional Traning Hubs Evaluation: A Place-Based Approach in Rural Medical Education

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Acknowledgement of Country

We acknowledge the traditional owners of the land we are meeting on today and pay our respects to their elders past present and emerging.

Acknowledgements

Evaluation Working Group

- David Atkinson,
- Deb Russell,
- Matthew McGrail,
- Denese Playford,
- Sally Hall

- Thank you to all participants

Presenter Disclosure

- have no conflict/s of interest
- am employed by the University of Western Australia
- was Chair of FRAME 2016-2019
- am on the Board for Essential Skills in Medical Education, AMEE

Objectives

1. To outline the RTH evaluation findings
2. To introduce a place-based approach as applied to rural medical education
3. To discuss recommendations for RTH future development

What are RTHs?

- 26 Hubs funded April 2017 - Integrated Rural Training Pipeline for Medicine (IRTP)
- Embedded in the Rural Health Multidisciplinary Training (RHMT) Program
- Role of RTHs in postgraduate training is less clear and more complex than Rural Clinical Schools
- RTHs aim to facilitate streamlined pathways for doctors into rural postgraduate vocational training.
- Collaborate with multiple organisations (Colleges, State/Territory Gov, RTOs, workforce agencies, health services)
- Local variation in what needs to be addressed in different rural regions.

"Who are you*?" said the Caterpillar.*
This was not an encouraging opening for a conversation. Alice replied, rather shyly, "I—I hardly know, Sir, just at present—at least I know who I was *when I got up this morning, but I think I must have been changed several times since then."*
"What do you mean by that?" said the Caterpillar, sternly. "Explain yourself!"
"I can't explain myself*, I'm afraid, Sir," said Alice, "because I am not myself, you see."*

Regional Training Hubs

Jurisdiction	Region	University
NSW	Mid North Coast	University of New South Wales
	Border (Albury – Wodonga)	University of New South Wales
	Murrumbidgee	University of New South Wales
	Riverina	University of Notre Dame Australia
	South East NSW	Australian National University
	Far Western NSW	University of Sydney
	Western NSW	University of Sydney
	Northern NSW	University of Sydney University of Wollongong
	North West NSW	University of Newcastle
NT	Northern Territory	Flinders University
Queensland	Southern Queensland	University of Queensland
	Wide Bay	University of Queensland
	Central Queensland	University of Queensland
	North Queensland	James Cook University
	Western Queensland	James Cook University
	Far North Queensland	James Cook University
SA	Limestone Coast	Flinders University
	Eyre Peninsula and Spencer Gulf	University of Adelaide
Tasmania	North West Tasmania	University of Tasmania
Victoria	North West Victoria	Monash University
	Gippsland	Monash University
	Western Victoria	Deakin University
	Goulburn Valley	Melbourne University
WA	Midwest/Goldfields	University of Western Australia
	Kimberley/Pilbara	University of Western Australia
	Great Southern and Wheatbelt	University of Western Australia

Methodology

A mixed methods study

Data collected, analysed, and interpreted in 2 phases

1. A document review phase involving analysis of the annual workplans and activity reports 2018-2020
2. In depth, semi-structured interviews using a series of interview questions

- Quantitative data were collated and compared using MS Excel.
- Narrative comments in reports (Phase 1) and interview data (Phase 2) were collated and analysed using content analysis

"But I don't want to go among mad people," Alice remarked.
"Oh, you can't help that," said the Cat: "we're all mad here. I'm mad. You're mad."
"How do you know I'm mad?" said Alice.
"You must be," said the Cat, "or you wouldn't have come here."

Lewis Carroll

Phase 1

- RTHs report on specific core requirements in funding agreement.
- Received 15 reports representing 20 of 26 hubs.
- Some Hubs have multiple sites but only required to produce one report.
- Reports contained numbers of students, trainees, and training places but were inconsistent.
- Reports contained descriptive text activities.

Phase 2

- Aim of interviews - to describe types and diversity of RTHs.
- 19 in-depth interviews with RTH leaders

  (clinical directors or senior administrators),
- Via telephone, Zoom/Teams in July -August 2020
- 20-90 minutes duration

NB: Interviews were held when programs were significantly affected by the COVID-19 pandemic. RTHs adapted to on-line support, education, and meetings. However, hindered relationship building, identifying new training positions and workforce planning.

Some universities initially withdrew student placements, but most reversed these decisions so students could continue to learn.

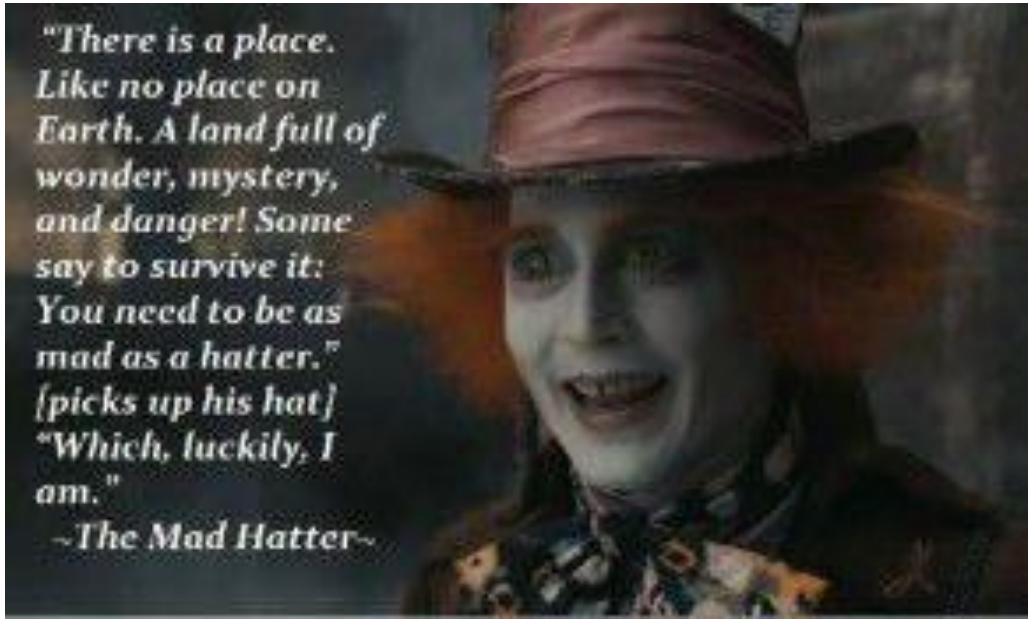
Theoretical Framework

Place-based Theory

"*Place-based initiatives are programs designed and delivered with the intention of targeting a specific geographical location and particular population group in order to respond to complex social problems. Typically, they focus on areas and communities with entrenched disadvantage or deprivation.*" (https://aifs.gov.au/publications/commonwealth-place-based-service-delivery-initiatives).

Local knowledge is valued:

1) find solutions, and build strong connections,
2) tap into local knowledge,
3) know how to navigate cultural sensitivities,
4) balance social and economic priorities,
5) combine health, education and community services,
6) achieve governance through collaboration, and
7) recognise the role of various levels of government (Bradford 2005)



Place Based Learning Theory is new in medical education research

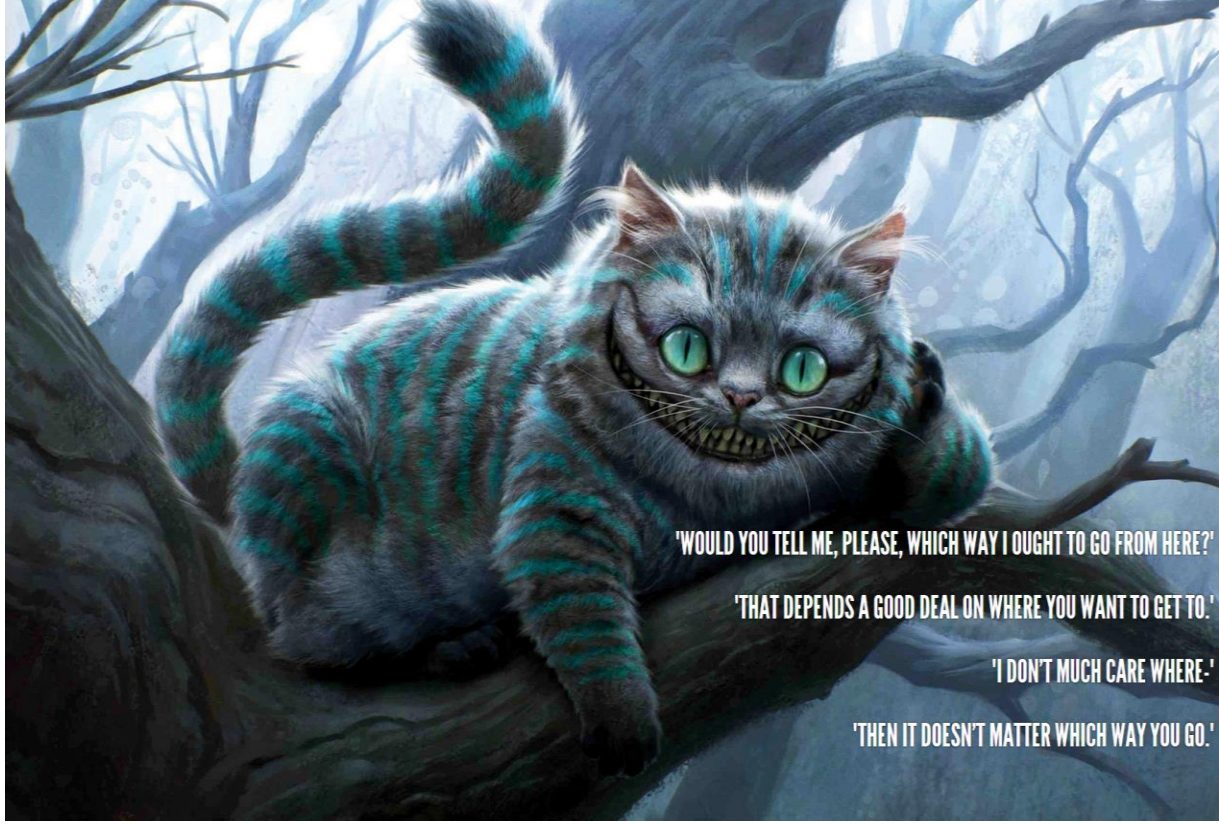
Key Themes

3 themes derived from report data

1. Collaboration,
2. Expanding Training
3. Sustainability

6 themes derived from interviews

1. Building a leadership team
2. Planning medical workforce
3. Expanding training capacity
4. Creating an educational culture
5. Generating novel training pathways
6. Identifying and supporting students and Junior Medical Officers



Phase 1 Summary Reports

Achievements	Challenges
Strong relationships with health services, hospitals, clinics GPs	Health service restructuring HR practices create barriers to employ rural doctors
Collaboration with peak bodies, PHNs, workforce agencies, colleges and communities	Long lead times for changes in training
Workforce planning	Workforce planning is generally decided by Departments of Health in urban settings, with variable input from the regions.
Hub sites are aligned with rural clinical school sites, medical student placements and GP training sites	Challenges with providing high quality accommodation in a timely fashion.
Participation in selection of rural origin students	Timeframes out of sync for recruitment of graduates due to funding and expectations of timing of recruitment.
Aboriginal and Torres Strait Islander recruitment, training, knowledge development	Not formally included in RTH
Clarifying and promoting training pathways and flowcharts in some States/Territory	Several college training programs remain metrocentric and discount rural experience, recognition of rural experience is largely ignored at specialty selection
University support for postgraduate training	Limited ability to manage or influence budget. Additional rural research capacity is required
Accrediting training posts via colleges	Some difficulties in obtaining accreditation
IRTP Emergency med, Anaesthetics, GP academic, Public Health training posts created	Some training posts remain vacant
Advanced skills training in internal medicine, O&G, surgery, emergency medicine, critical care, psych, paeds, public health	Continuing reliance on locums and FIFOs
Teaching on the run, junior doctors as supervisor workshops	Limited capacity for supervision
Increased rural internships and mentoring interns, rural rotations for urban interns	Limited redistribution to create more rural internships
Orientation resources developed, RMO training and assessment, supporting Junior Doctors to attend conferences, seminars etc.	low numbers of Junior Doctor positions in rural areas

Phase 1 Findings

1) **Collaboration** - Improved collaboration and relationships with key partners, including through formal advisory groups and state-wide approaches, resulted from closely located or co-located sites, with more planning and training opportunities.

2) **Expanding training** – New training pathways, greater range and number of training for specialty training posts to meet local needs in rural areas. However, most have been in the absence of comprehensive and transparent rural workforce planning, which needs to be addressed.

3) **Sustainability** – Depends on establishing a stable RTH team with engaged and clinical academic leadership; engaging partners who are invested in the agenda; identifying where there is additional capacity for new junior doctor positions, specialist training posts or rotations; co-planning investment (e.g. time to achieve new accreditation, build skilled supervision) with limited budgets, access to workforce data and research

Phase 2 Findings:
1. Building a leadership team

- Took a while to establish various staffing profiles and structures.
- Many are co-located with RCS and health services.
- Experienced Managers/administrators, terrific at organising activities to attract graduates into rural pathways and they understand college training and accreditation.
- Clinical leaders form good linkages with health services and colleges. They have become integral in medical workforce decision making through formal forums and alliances.
- Clinical leadership is vital as they are "*influencers*"
- "*For the hubs to [be] successful they had to be locally credible with senior clinicians on each site who had credibility and influence in their local medical community". (P14)*
- Rural academic leaders need an ongoing support network, would benefit from a national rural leadership development program.

Phase 2 Findings
2. Planning medical workforce

- All involved in consultations re National Medical Workforce strategy
- "*there is a huge need for GPs and certain specialities*"(P16).
- Very difficult to fill GP registrar posts. "*We are hoping that rural JMO posts will lead to an increase in rural GP registrars, this is the biggest need*"(P6). NB Menzies Institute research
- Preparing for Rural Generalist training positions but "*the rural generalist training model is a bit too black and white. They have seven posts but only one is filled*."(P3)
- Remote RTHs - A program for rural generalists with remote practice skills and advanced training in remote Indigenous health (? Funding)
- Rural medical workforce is ageing and decline in doctors with procedural skills
- Tele-health helps with access to specialist appointments but not a solution to workforce shortages
- Workforce data are an asset, "*When we came on board none of the hospitals had workforce data, now they come to us frequently for information*." (P10)
- Workforce plans are good, but may be out of date and therefore don't replace "*having people on the ground, they know who is retiring or leaving and what's happening*." (P18)
- Need national-scale research to inform the development of rural postgraduate medical work/training and its outcomes

Phase 2 Findings:
3. Expanding training capacity

- Prioritised local opportunities for advanced trainee positions - to submit a large number of advanced training applications (we need to evaluate what proportion have been successful and if not why)
- Understand health needs in their community including where, how and why there is a reliance on locums, fly in fly out (FIFO) or other visiting services.
- Know the majority of requirements for advanced trainees can be achieved through a networked model (depending on core and non-core rotations)
- Leverage the influence of senior clinicians "*The hubs are collaborative... I've got a lot of relationships across the district with all the various agencies in [the State] and ad hock groups nationwide that work on increasing training time and supervisor support in rural areas". (P8)*
- Need supervisors to be able to meet the specialist college training requirements or to adjust these requirements where the "*rules are metrocentric*"(P7).
- New employment conditions have been negotiated that will facilitate rural generalist training posts. *"And now the advantage is that rural generalist trainees have parity with specialty trainees in their terms and conditions*
- Focus on improving teaching through supervisor training - need to increase remote supervision
- Need high level support through MDANZ *"We had to get political to get it approved, the Dean contacted the College President*"(P1).

Phase 2 Findings
4. Creating an educational culture

- RTHs have been a catalyst for developing formal committees or collaborative working groups.
- One RTH has taken on Grand Rounds for the LHD and another has streamlined the intern orientation program.
- "*no education culture in corporatized general practices*" (P5).
- "*challenging to get buy in*" (P12) from health service executives.
- Junior doctor training and internships are managed by the State health departments.
- A strong educational culture across northern QLD - 1200 training positions across 31 hospitals in 54 specialties. "*The creation of our website touches on the strategic priorities with clear pathways mapped for education and training*" (P10).
- Several communities no longer have a reliance on locums!

Phase 2 Findings
5. Generating novel training pathways

- Extensive knowledge of different clinical training pathways, information that is often not written down anywhere in easily digestible form and is constantly moving.
- Postgraduate medical training is "*like a game of snakes and ladders,"*(P7) meaning navigating training pathways is unpredictable with numerous traps that can prevent trainees from completing and successfully passing exams and attaining their Fellowship.
- Low based -"*Prior to the RTH there was no full year of hospital specialist training in any hospital [in the State] there are a number of 6 month placements particularly in surgery and there were only 5 intern positions…and no prevocational training. … [our State] currently doesn't have an award for recognising the skills of specialist rural generalists so the salaried models of payment are inadequate and we can't attract a rural generalist workforce in those environments.* (P 20)
- On the other hand "*In the physician space, we are working closely with the RACP to become a trial exam site and then to become a … clinical exam site …and we worked to get two additional basic physician training terms accredited so we could become a level 2 for a 2 year rural training post … (P7)*
- Comments like "*I have learnt to speak fluent College*" (P3).
- "*All of the colleges are different to work with and have a variable understanding of the role of hubs" (P9).*
- *A key concern is: "there is scepticism regarding the role of hubs." (P2)*

Phase 2 Findings
6. Identifying and supporting students and JMOs

- RTHs have prioritised providing rural career advice and support for students and junior doctors. Junior doctors are often graduates from the RCS so several RTHs have integrated these functions.
- Bespoke career advice is offered, Intern application sessions, how to apply for a job and mentoring sessions.
- Apps, podcasts and mentoring platforms developed – evaluation is needed
- Very strong relationships with rural health clubs and the NRHSN
- ANU RTH has novel internships with rotations across the Bega Hospital Emergency Department and rural general practices. "*There is research on how the GP internship career pathways can be developed.*" (P4)
- In the NT research about preparedness for internships. "*We are about 30 GP registrars short fall this region…"*

CHALLENGES

- Limited influence and don't feel well integrated either in the medical school or health services
- No input on their budget - central control by their university hampers flexibility and are unable to respond to opportunities.
- A clear role has been a challenge. *"there is a lot of overlap and uncertainty, the Hub doesn't have teeth we can only encourage collaboration (P2)*
- Challenges of supervision and developing training
- Complex and different workforce issues in regional areas compared with remote areas.
- 50% of rural GPs are international graduates
- Turnover of senior managers and clinical leaders in health departments and health services
- General Practice locum services in hospitals are a source of tension

So, what's changed?

"The best way to explain it is to do it"

- RCS increased knowledge and understanding of medical training beyond the intern year. "*RTHs are a well-travelled bridge across the health services at all levels*". (P1)
- Building networks and having a vision for regional training capacity.
- Adelaide Uni - Remote Medicine Academy collaboration with the Royal Flying Doctor Service (RFDS).
- RTHs are collaborative and place-based with students from several universities. "*it's not just geographical or just one Uni, it's better to collaborate across all*." (P4)
- Alignment and consolidation of calendars - maximise access to training.
- NT RTH established advanced training in remote and Indigenous health accredited by several colleges.
- Student engagement - very good especially final year students who are interested in career paths.
- Rural specialist networks have been established in WA and NSW eg a physician and a paediatrics network meet regularly to discuss training opportunities.
- Engaging with Medical Education Officers
- Being flexible and understanding all the different pathways.
- NSW networked model for training no longer rely on a single hospital and they have a new Medical Workforce Plan that is consistent with the Clinical Services Plan to 2022. They said: "*The plan helps everyone understand with the RTH does and the future direction*." (P3)

A Place-based Approach

Originally from public policy, successfully applied in underprivileged communities to improve early childhood education and transitions to primary and secondary school education and employment and to **disrupt cycles of disadvantage**.

A place based approach

a) taps into local knowledge,

b) balances social and economic priorities,

c) combines health, education and community services,

d) governance is through collaboration

e) recognises the role of various levels of government

(Bradford 2005).

- Innovation develops from an emphasis on the local milieu and reveals barriers to social inclusion.
- A highly contextualised, place-based approach takes account of the local knowledge about different workforce needs of communities to co-design various ways to overcome challenges

Elements of a Place-based Approach

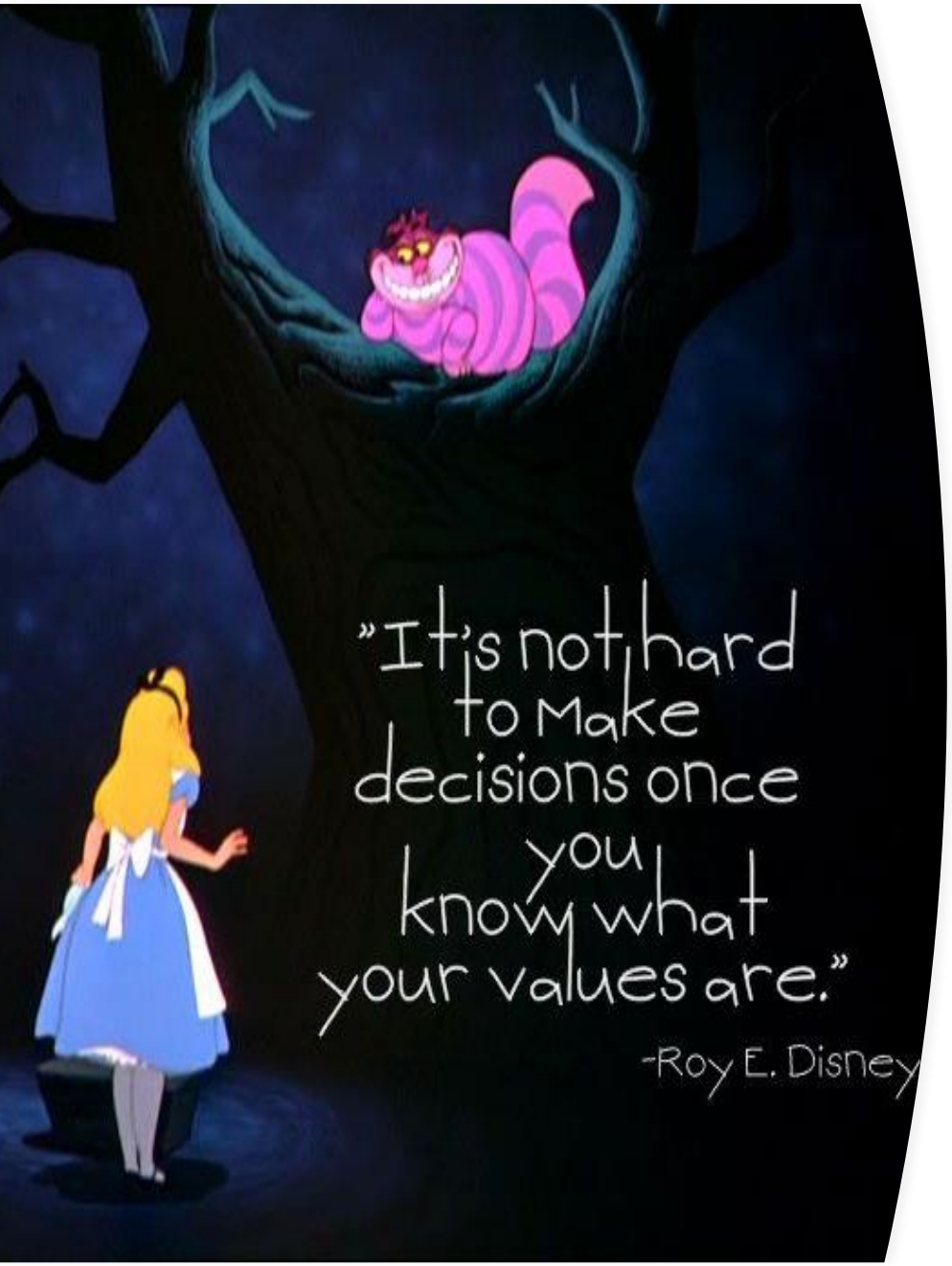
- Appropriate governance and leadership to support local action
- Meaningful engagement with community stakeholders
- A strengths-based approach
- Collaborative ways of working with a systems perspective
- Building the readiness of community stakeholders
- Local decision-making and flexibility
- Use of quality data to guide decisions
- Monitoring and measuring impacts
- A long-term focus.

Trust and Uniqueness

- "Change happens at the speed of trust…Working, trusting relationships at every level is key to these initiatives…Trust is built through principled action that demonstrates people do what they say and through people seeing outcomes."

Australian Centre for Social Innovation (2019).

- A place-based approach not only recognises that regions are not homogenous but also is able to capitalise of the uniqueness of the community.



RTHs are Place-based

We found that RTHs have:

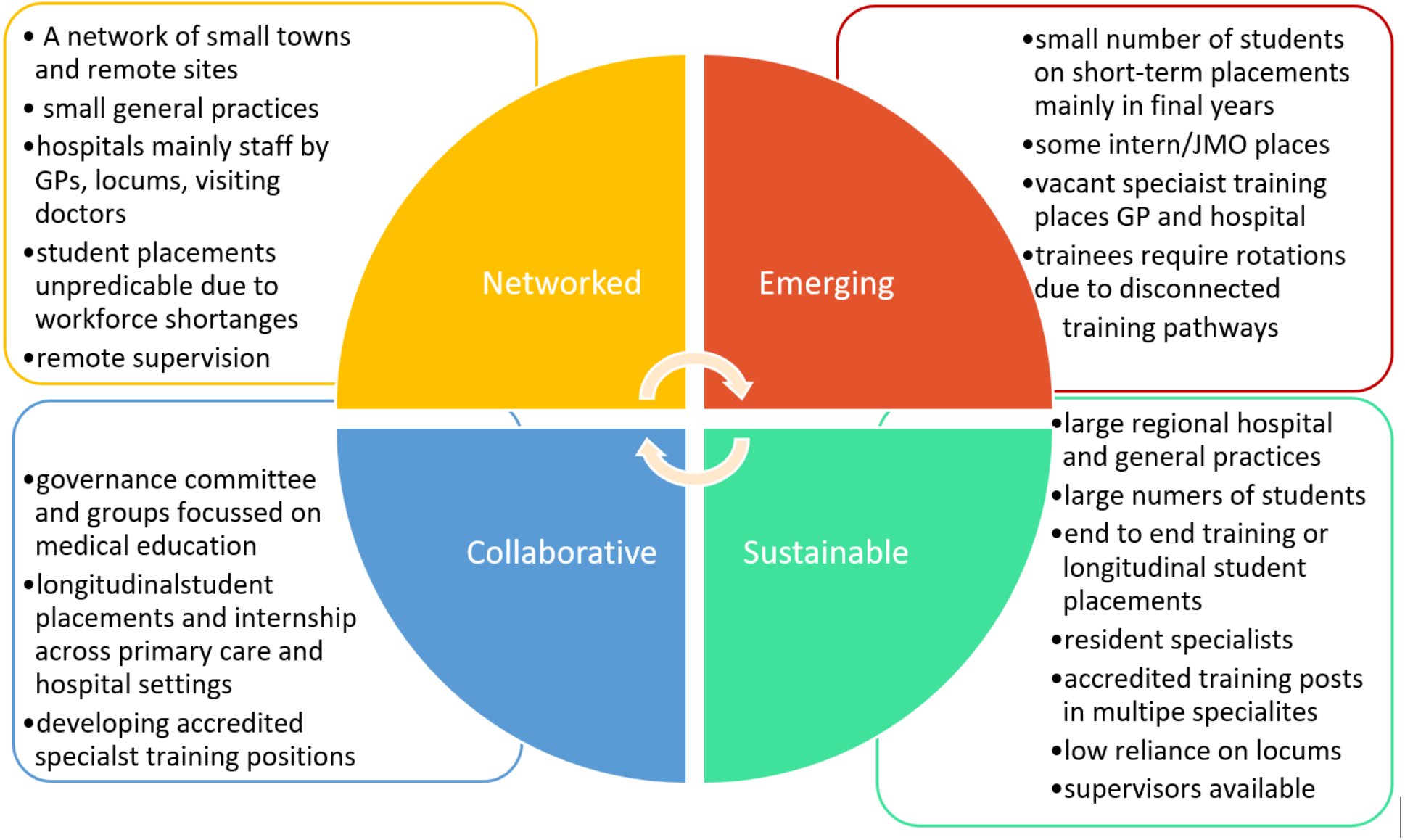
A) Knowledge *of* communities – RTHs have an in-depth understanding of current rural medical training, know about local opportunities to increase training capacity. E.G. mentoring individual students who may be interested in a novel, tailored training program.

B) Knowledge *about* communities: RTHs have access to workforce data, trends in the local health services, many have developed a local profile of students, junior doctors, advanced training posts and supervisors.

C) Knowledge for change in communities: Understanding accreditation processes and college training requirements, clarify options for solutions and training rotations. Marketing of training pathways to deliver flexible training pathways.

A Place-based Model for Rural Medical Training

study of 26 Regional Training Hubs 2020



Recommendations

1. The Commonwealth Government and jurisdictions should **clarify and promote the role of the Regional Training Hubs** as an integrated component of the RHMT program.
2. Each RTH should **establish a formal regional medical workforce governance structure** to maximise partnership opportunities and increase influence in medical education decision making in their regions.
3. **FRAME should support collaboration across RTHs** through an annual forum to share resources and information and increase understand of jurisdictional differences in rural junior doctor and postgraduate medical training.
4. RTHs need to be included in the Commonwealth Government development of databases and **workforce planning tools**, to improve access to timely and accurate data.
5. RTHs should strengthen partnerships with jurisdictional health departments to develop long-term plans for **maximising rural intern and junior doctor** capacity.
6. Commonwealth Government should **increase funding for rural Specialist Training Posts** and require that applications be partnerships between colleges and RTHs.
7. RTHs and Rural Clinical Schools co-design a national rural and regional **leadership development program** to address succession planning and attract and support emerging rural managers and clinical leaders.
8. RTHs and Colleges should collaboratively develop and support appropriate models for **remote supervision of trainees** that are relevant to their local needs.
9. The Commonwealth should develop a program for **ongoing evaluation** of the RTHs that includes a return on investment.
10. The Commonwealth should increase support for **rural workforce research** through a collaborative research strategy that encourages longitudinal studies, rural generalist and rural specialist training program evaluation.

Our research highlights the need for a **sustainable system of training** with

- local leadership,
- deep local knowledge and
- collaboration to create a sustainable rural and remote workforce.

Summary, reflections and feedback

What did you learn?