FRAME

Wednesday 4th and Thursday 5th May 2016

Throsby Room, Peppers Manor House, Kater Road, Sutton Forest, NSW

MEETING NOTES

Represented at the meeting were:

University of Adelaide
Deakin University
Flinders NT
Monash University
University of Newcastle
University of Notre Dame
University of Sydney
University of Western Australia
University of Wollongong
National Rural Health Student Network
ARHEN National Director, Ms Janine Ramsay
Australian National University
Flinders University
James Cook University
University of Melbourne
University of New South Wales
University of Queensland
University of Tasmania
University of Western Sydney
Commonwealth Department of Health
Australian Medical Students' Network
MDANZ CEO, Ms Carmel Tebutt

Day 1: Wednesday 13th May 2015

Welcome to Country

Aunty Val Mulcahy, on behalf of the Dharawal people, welcomed the participants.

Welcome to FRAME Meeting

Associate Professor David Garne welcomed participants to the FRAME Meeting at Peppers Manor House, Sutton Forest.

Welcome on behalf University of Wollongong

Professor Alison Jones, Executive Dean, Graduate School of Medicine, University of Wollongong, introduced herself and welcomed all participants.

Welcome to FRAME

As the current Chair of FRAME, Professor Amanda Barnard also welcomed everyone and introduced herself to those who were new to the FRAME meeting and outlined the Day 1 agenda.

Update from RCS/RMS

Representatives from all rural clinical schools gave a three minute presentation on the 'Implementation of the RHMT.

(See attached Powerpoint Presentations in Attachment 1)

DoH update on RHMT and IRTP Funding

David Meredyth, Assistant Secretary (A/g), from Health Training Branch/ Health Workforce Division, Department of Health

David advised the following:

- Conversation with Govt on how to bring together the different issues that have been successfully funded over a number of years to get better outcomes and address some of the gaps in the rural training system
- Generous allocation of funding in a tight fiscal environment - $93.8 million over 4 years and 3 different components of that measure:
  (i) Up to 30 **Regional Training Hubs** to be supported and rolled out from 2017
  (ii) **New Rural Junior Doctor** innovation fund – trying to address what the department sees as a priority area
  (iii) 100 new training posts in the **Specialist training program** – rurally focused and really different to the standard STP positions
- From a student perspective, navigating the system is difficult and confusing and at many points in the pathway, encourages students to head back towards the cities in their informative years
- Limited opportunities for postgraduate training rurally
- Endeavour to try and remove the disincentives towards keeping a connection with rural communities and a rural focus in the development of graduate careers

(i) Regional Training Hubs

- A lot of interest in what a regional training hub is
- Hubs will be based around existing physical and educational infrastructure of the current regional/rural training network of rural clinical schools and university departments of rural health
- They will be focused on developing postgraduate training to complement existing rural training networks
- Up to $14.7 million per year from 2017 onwards to establish the Hubs
- There will be a process to allocate the funds
- Department will not pick the sites - Universities to identify where they think the best sites will be
- Current RHMT programs will be asked to submit proposals to manage hubs
- Proposals assessed against the criteria to ensure best outcomes and a good national distribution

- Regional Training Hub vision is around building partnerships and collaboration and working with professional groups and employers to focus on building capacity
- Criteria will encourage you to demonstrate the partnerships that RCS & UDRHs have in place and how those relationships can be built on
- Provide core requirements that will fund the successful organisations to put on additional academic and administrative staff to undertake the building and maintaining of existing relationships, facilitate the development of new training capacity and identifying medical students with an interest in rural practice, and provide them with support.

(ii) Rural Junior Doctor Innovations Fund

- Specific and targeted investment to address the gap in Junior doctor training around general practice rotations for junior doctors undertaking their internship in a rural area
- $10 million over 30 years
- Targeted at rural based interns to foster community based junior doctor training
- Builds on rural training networks for Junior doctors funded by states
- Approx 60 FTE places comprising 240 rotations of 10-12 weeks roughly in GP settings
- Foster community based Junior doctor training
- Designed to enable rurally based interns to gain experience in general practice as an additional elective
- Support general practice placements for new doctors

(iii) Specialist Training Program

- Specialist training program expansion of up to 100 new training posts in rural areas
- Address the gap in the specialist training program
- Two intakes of 50 posts in 2017 and 2018
- College led program
- Department has been liaising with specialist colleges about proposed models of training
- Colleges should show a clear and organised training pathway and link up with Rural Training Hubs to try and identify the relevant students who are interested in the specialist training places
- Designed to enable a trainee to complete the majority of their fellowship course living, training and working in a rural region
- Focus to be just not on educational experience but include student's background & intern training, which will hopefully indicate that these students are more likely to be rural doctors
- Trainees selected for funded posts must show a commitment

- Second round in 2018 – opportunity to build on the program further
- Targeting of more ATSI students as part of this expansion, linked to university enrolment and graduation of more ATSI medical students
- $15 million per year to support the extra 100 places
- Commonwealth is trying to support an innovative, well structured and vibrant environments that produces rural specialists, produces good high quality rural GP's and have the ability to support rural generalist models
- Invest in the broader educational space and have lots of regional flexibility to determine what the best pathway is and have good resources on the ground and in place to enable interested and well qualified doctors at the end of the training pathway
- Not about conscripting people but having different entrance and exit points to produce a good environment which will work in partnership with regionally led collaboration and good integration between the different levels of government, health services and the training facilities.

(iv) <u>RH Multidisciplinary Training update</u>

- Doubling of support through UDRHs – $83.1 million to support additional capacity for nursing, midwifery, allied health and dentistry
- Universities have been asked to increase /renegotiate targets
- Establishment of 3 new UDRH's – targeting Kimberley/Broome region in WA, Southern & Central NSW and SE Queensland
- No specific locations identified as yet
- Open to all Universities offering commonwealth support places in those disciplines
- Hopefully start up by January 2017

<u>Contractual commitments</u>

- Pretty well placed moving into the caretaker period
- $487 million over next 3 years including UDHR expansion funds
- All variations will be in place pre-election
- Next step is to run the Regional Training Hubs round
- Substantial increase in the RHMT placement training weeks to just under 40,000 by 2018 up from 21,000 now

Q & A Session

'Jen Lang (Uni of Newcastle) asked whether RCSs & UDRHs had to apply for all 3 components of the RHMT & ITRP or if we understand all of what we can do in our own area, can we apply for one component.'

David's response

- Department will ask for applications for a 'fund holding role'
- RCS's and UDRH's will play a role in assisting local partners as they bid for resources under that fund.
- Most likely to be local hospital networks and possibly organisations like regional training and primary health networks
- Must be attached to those health care settings in that region.
- Don't envisage that universities would play a 'fund holding' role in that space
- Bring stakeholders together and the idea of the RTH is that RCSs & UDRH's will certainly be one of a group that help develop the application

Mark Yeates (from Ballarat RCS)

'I see a fairly major hole in the pathway which is the PGY2. Do you see any particular roles going forward for the PGY2? Most of the Colleges don't start until PGY3.'

David's response:

- Still some gaps in the pre vocation training space
- Targeted investment in one part
- Have some investments in private sector training beyond just PGY1
- How this links in with the jurisdictional and junior doctor employment system
- The Comonwealth can't by itself create a rural training pathway but what it can do is contribute, invest and try and provide leadership in that space

David Campbell (Monash University)

'Specifically with the STP – will there be an expectation from the funding that flows through the Colleges to the Health service that there will be a clinical academic role for those specialist trainees? Sometimes discussions with Health services, when looking for clinical academics to supervise students, has been problematic. Will there be a component of the funding to support clinical academic work?'

David's response:

- Suggestions have been made to look at funding specific posts for clinical academics and the department will look at that

- Department is investing in more regionally based clinical academics through the regional hubs and through what we are already doing in the STP
- As we look at new STP agreements, department will be saying to Colleges that part of their job is engagement at the local and regional level with people who are already there on the ground
- Funding model is more based around contributing to salary costs and contributing to costs of supervision and looking at rural loadings for trainee support
- Must be careful to keep the program cost effective

Deb Wilson - (University of Tasmania)

'Couple of questions relating to the STP funding, - we are very keen to engage with the colleges and keen to get those posts out into the rural areas, but we sometimes find that the Colleges are not so keen to engage with us. It would be quite helpful if the department could let us know exactly where these 50 places have been allocated and which colleges are going to get them and where they are going to be located, so that then we can engage for those positions for 2017 and work in a more strategic way when we have our rural training hubs up and running.'

David's response:

- More visibility of where the rural standard STP positions are
- Information systems are very important and need to be better developed
- Happy to share once the decisions are made

Emily McLeod – AMSA

'AMSA's concern is about the length of the program and whether students will be supported for the entire specialist training program or for only 6-12 months.'

David's response:

- Support is for the entire specialist training program
- Designed to have standard STP posts and then the integrated rural pathway posts
- Open up the students support to enable students to have better support if they need to undertake specialist training in the city although based rurally
- Rotations out are still important but will be linked in with the first of these rural posts

Panel Discussion & Q & A on 'Perspectives on the Issues and Challenges in Rural Training

Amanda Barnard introduced the panel members –

Dr Susan Wearne (Medical Adviser, Health Workforce Division, DoH

- Urban girl from Manchester who lived and worked in Alice Springs and now working as a bureaucrat in Canberra
- Whilst we are good at talking about the opportunities of rural life, we sometimes forget to talk about the challenges
- We need to build resilience in our students and talk about the realities of the toughness of rural life, eg. Being on call for long periods of time
- What is it about our health system that means that there is still one person for one specialty covering a huge area
- As a Rural GP you create your own ghost town – you see an address and you think that person is dead but then you realise that somebody else has moved into that place now
- You get those flooding rains which is just the best but you also get those long periods of drought which is tough
- What are we doing about our health professional education to ensure that our students can cope with that toughness and what are we doing about models of care which mean that each of us work in ways that is sustainable
- There are specific educational advantages and opportunities to rural and remote teaching
- But we need to think about patterns of care when looking after our students and supervisors

Ms Carmel Tebutt, (CEO MDANZ)

- Relatively new to some of these issues as started in this position in October 2015
- Why does it matter that we address the challenges of workforce issues in regional and remote Australia?
- Worth stating that as a society and a community we shouldn't and don't accept that people's access to health services is determined by where they live and yet for people in regional and rural Australia, that is still very much the case
- Access to health care for those in regional and rural Australia is not that available nor forthcoming as for those who live in metropolitan areas
- Pleasing to see the initiatives that David Meredyth has just outlined in the previous segment
- Investment in the capacity building is very important and a pleasing development
- RCSs and UDRH's are a success story. They have changed the landscape of rural health delivery and rural health services
- MDANZ are keen to see in the role out of the integrated rural pipeline initiatives, that the knowledge and experience that has been developed within the RCSs and UDRHs, is drawn upon to inform the pipeline.
- MTRP figures so that there has been an increase in the number of students from rural backgrounds undertaking medicine from 20% in 2003 to 26% in 2014

- Outcomes also show a significant increase in the number of students who are identifying that they want to undertake regional and rural practice, however the real challenge becomes the lack of opportunities for them to undertake their post graduate specialist training in the way that they should be
- MDANZ is linking their data sets with those of the National Health data sets to identify where students are actually ending up and what is happening to those students who are identifying that regional practice is something they are interested in - are they actually being able to realise those aspirations
- Although there are huge challenges ahead with addressing the maldistribution of the medical workforce, there are some very real opportunities as well that can be taken advantage of
- Real political will on both sides of politics
- Will take teamwork, commitment, really good project management skills and a level of pragmatism as we work towards those goals and work out what is possible to achieve

Dr Tony Hobbs, (Principal Medical Adviser, Strategic Policy & Innovation, DoH)

- Here on behalf of Chris Baggoley, who will be retiring in mid July after a great contribution to medicine in this country
- Worked in southern NSW for about 20 years, with strong collaboration between general practice, primary care and specialists either remotely and in person when they came to visit the community
- Great to hear that the department has actually put in place an enabling policy environment that really enables you to get on and do stuff that you are already doing well.
- Important that the department is collaborating, communicating and working towards common outcomes
- Good to see the acknowledgement, support and investment of the PGY1 to develop good outcomes
- Registrar training is very important as well, as is vertical integration
- Also good to hear that STP rurally based positions rotating back to the metropolitan areas
- Clearly it is not just about the importance of doctors, but also nurses and allied health. The multidisciplinary approach is needed to meet the demand of our cohort of patients with chronic and complex diseases.

Q & A

Jennene Greenhill – Flinders University

'What are the challenges now going forward and what are the top 3 priorities of research to be identified? What would you like to see from our research programs?'

Susan Wearne – a priority would be that I would love to see specialist training accreditation undertaken where one or two local rural/regional specialists are supported remotely by

specialists in Melbourne or Sydney. Research into different models of 'on call' would be ideal. Currently we have a model of care where the GP or the nurse does everything. Would like to see the everyone who works rurally is able to have a life as well as being a good clinician.

Carmel Tebutt – The key priority for MDANZ is that we are particularly interested in looking at where students who identify with working in rural settings actually end up, and if not why not. We have a very rich data base and need to link up with the National Health workforce data to do the research effectively and efficiently. We are currently talking with AHPRA and the department and FRAME about ways to make this happen.

Tony Hobbs – Health care home model about to be implemented. Voluntary registration and bundle package of care. Very important to make sure that the workforce is looked after.
Another issue is the primary health networks and evaluating their performance over time.

John Wakerman – Flinders NT
'There are 3 national gaps that have come up in the conversation today
First is around resourcing of primary care in this country, especially in rural and remote areas.
Second gap is that we have been struggling with no electronic records for decades unlike Canada which has good communication and good electronic records with electronic discharge summaries being made available within 24 hours in remote areas.
The third is related to the IT infrastructure to support primary care information that is available at a national level.'

Tony Hobbs - Capacity for numbers in the workforce is really important and distribution and mix is critical as well.
There have been lots of incentives and programs over time which have not resolved the situation
Maldistribution needs to be addressed
Not able to put anything on the table today but clearly will take that message back to the department.
Challenges for FRAME as a group, how does FRAME think it would best be served?

There have been stops and starts with the electronic health records. Enabling infrastructure that sits behind it is also really important
Having access to good download speeds - NBN roll out is a critical issue, having access to wireless is another issue which is currently being debated,
Tele health and tele medicine are both underutilised at this time
In the Primary care advisory group discussions had recently, the use of e-health and tele medicine were key enablers and one of the requirements of health care home will be to use what is actually there at the moment. One of the problems is that in primary care we don't actually use the available infrastructure as best we should for not only the individual patients but making better utilisation of the practice held data for making us better informed about the local population.
The other conversation was remote access to care both into and out of the practice

David Kandiah - Monash Rural Health Bendigo
'Interested in the panel's thoughts that State rural stakeholders should be engaged in this type of discussion that we are having here today. They after all fund the training in the community and the hospitals
State governments need to be fully aware that they are a crucial part of the bridge between the funding and the delivery.'

Tony Hobbs - There is a National medical training advisory network with a broad representation including state and territory representatives. Carmel Tebutt is the MDANZ rep on that committee and Tony is the commonwealth rep. They are very happy to take suggestions from today's forum back to that committee. Communication, inspiration and working towards common outcomes for training the workforce of the future, is very important.

Andrew Bonny – University of Wollongong
'Interested to see responses from the panel regarding that as rural educators, academics and practitioners, we very readily see rurality as being equivalent of disadvantage. Hence we see the need for training of doctors and provision of medical services, allied health services and multidisciplinary teams across rural areas. Chronic diseases are very much a marker of disadvantage underlying rurality as such and all rural areas are not equal as we know.
My concern is that perhaps we need to be dealing in measures of geographic disadvantage as well as remoteness.'

'What are your thoughts about rurality and levels of disadvantage within rurality and the possibility of placing these training hubs in areas of more disadvantage so that we can leverage more for the money being put into policy at the moment.'

Susan Wearne - Great idea and it is something that is being considered to be looked at in more detail

Tony Hobbs - From a Policy perspective this is the bread and butter of the PHN
Within a public health care network environment, there are going to be areas of very significant disadvantage
This is a role that Medicare locals are taking on, then trying to target those resources to the most in need
Part of that discussion is workforce, all of the these things need to be joined up
Role of the PHN in working with the local health district is crucial
Shouldn't under estimate the power of the local community – local communities do support the drive for redistribution of funds to more disadvantaged areas.

Amanda on behalf of FRAME thanked the panel for attending today and for their time and contributions to the discussions.

NRHSN and AMSA update

NRHSN Chair – Ms Rebecca Irwin

Summary:

- Thanked FRAME Chair for invitation to attend the FRAME meeting
- Advised the NRHSN was a multidisciplinary team from Universities across Australia representing the members nationally.
- There are 28 Rural Health clubs at Universities throughout Australia and they provide Social Events; Clinical Skills; Mental Health, first aid and cultural training; Rural experiences, Career information; Indigenous community engagement and Networking opportunities.
- Rural Health Clubs link with local stakeholders such as Rural Workforce Agencies, Universities, Primary Health Networks and training providers etc. to ensure that the members are engaged with the rural health workforce sector.
- 2016 priorities include:
  - Positive, clear and supported rural training pathways
  - Aboriginal and Torres Strait Islander Health
  - Mental Health training and awareness for all university health students
  - Innovative future healthcare models that empower communities
- 2016 key activities include:
  - 21st Birthday Celebration on 17th March at Parliament House, Canberra
  - Future of Rural Health care
  - International future of rural workforce initiatives research
  - Rural Placement experience research project
  - Advocacy – Mental Health; Indigenous Health; Emerging Health Professions
  - Sector Development
- NRHSN website at www.nrhsn.org.au for further information

AMSA Rural Health student representative – Ms Emily McLeod

Summary:

- AMSA Committee established on 13th April 2015
- 6 member student committee formed, now expanded to an 11 member committee with 2 subcomittees: Rural Health Colloquium (RHC) event subcommittee and Publications sub committee
- AMSA's key priorities are:
  - Promotion
  - Representation
  - National events
  - Connections
  - Advocacy
- Common requests include:
  - Increased presence within social media channels
  - Greater rural focus at AMSA national events
  - Greater publicity of rural events and opportunities
  - Connections with RHCs

- Future plans included:
  - Develop an AMSA Rural Health page and a social media prescence
  - Promote existing opportunities in Rural Health (e.g. conferences, placements, scholarships careers)
  - Addressing myths and misconceptions around rural health
  - Connecting with Rural health clubs and Stakeholder engagement
- National Events
  - Global Health Conference
  - National Leadership Development Seminar
  - Rural Health Colloquium from 10-11th September in Melbourne
- AMSA Contact details:
  Emily.mcleod@amsa.org.au or website www.amsa.org.au

Regional Training Hubs and Rural Pipeline presentations (see attached presentations in Attachment 2)

1. Dr Jenny May (University of Newcastle)
   'Rural and urban – an exploration of medical workforce in regional centres'

2. Prof Brendan Crotty (Deakin University)
   'The Victorian Regional Medical Training Networks'

3. Prof Jennene Greenhill (Flinders University) & A/P David Mills (University of Adelaide)
   'SA collaborative proposal for Rural Hubs'

4. A/P Ruth Stewart (James Cook University
   'Developments with Northern Clinical Training Network'

ARHEN – Update, Structure and Strategic direction – Janine Ramsay, National Director

Janine thanked Amanda and the Frame Policy group for the invitation to address the meeting.

ARHEN Structure

- The old hands in the organization are emphatic – the pronunciation is 'ARHEN' – not 'AAHEN' or 'AHREN'
- ARHEN was established to link and support the UDRHs not long after the UDRH program was established in the late 1990s.
- It was incorporated in November 2001, and formally launched in 2002
- At times ARHEN has had direct Commonwealth funding, the membership has always supported it through fees
- However from the 1st July, the organisation will be funded by its membership
- ARHEN National Office – shortly to be 1.6FTE staff – is based in Canberra and engages with key stakeholders and provides policy and secretariat support to the organisation

- As a public company limited by guarantee, ARHEN needs to meet certain ASIC requirements such as in relation to registration of its membership, financial audits and a company secretary
- There are currently 11 members with one UDRH in the process of transitioning into two. They are in all States and the NT
- ALL UDRHs are represented on the Board, but not always by the UDRH director.
- A constitution underpins the Board's operation and it meets at least 4 times per year – 2 x f2f meetings including a regional meeting plus 2 teleconferences

ARHEN Strategic Direction

- In terms of ARHEN's strategic direction, it is business as usual
- Changing political and policy landscapes over the past few years have led to the emergence of a new era in relation to RCSs and UDRHs
- Directors see that the organisation will have a role in supporting the 3 new UDRHs when they roll out next year
- ARHEN is committed to working with FRAME into the future
- Functional reality is that already the membership of the 2 organisations have crossover in various parts of Australia, and this is strengthened through RHMTP

ARHEN and FRAME

- ARHEN and FRAME working together is not new
- What form should working together take
- ARHEN/FRAME past joint activities include
    - The publication in 2006 of the photojournal *Opportunities as Vast as the Landscape*. This aimed to highlight the diversity, rewards and opportunities available to health professionals in country Australia
    - Joint involvement in the RRH e-journal when ARHEN had administrative responsibility for a time
- Recently the new ARHEN executive met the FRAME policy group in the context of the new RHMTP
- ARHEN Board in its March meeting this year, highlighted the importance of ARHEN and FRAME working together. Options cavcassed included:
    - Joint scheduling of ARHEN and FRAME meetings on a regular basis
    - Sharing events such as a 'think tank' on health workforce issues
    - A joint ARHEN and FRAME rural research stream at the next National Rural Health Conference in 2017
    - Exploring the possibility of a new ARHEN network dedicated to medical education issues
- As the Government's investment in supporting high quality multidisciplinary rural health training is continuing, it will be vital for both networks to liaise closely and work together.

Workshop - Collaborations and Strategies for RCSs

Attendees broke into state based groups to discuss recommendations on how Regional Hubs would work and to give feedback on the DoH paper. This information will be consolidated and sent to Jennie Della, DoH.

(Note: Feedback has now been distributed to all Directors and forwarded on to DoH)

Amanda thanked everyone for the day's contributions and hoped that all those attending the dinner at 6.30pm would enjoy the evening.

Day 2: Thursday 5th May 2016 – FRAME Business Meeting

FRAME & AHREN relationship – Judi Walker

Judi distributed a briefing paper and briefed on the FRAME and AHREN relationship after which discussion took place.

Discussion points of interest:

- Current set up not sustainable, time for change
- Definite need for something new but doesn't mean we lose what we have
- Both organisations have real strengths so we need to build on what we both do well
- Appears that FRAME is more keen for collaboration than AHREN – possibly due to medical health v's allied health or put simply 'Medicine shouldn't be running everything'
- Need to reinforce the need for interdisciplinary collaboration
- Joint scheduling of ARHEN and FRAME meetings but both organisations to keep their separate business meetings
- Workforce and Research is the common ground
- Workforce has not always strictly been on the AHREN agenda
- Suggestion of a Workforce Think Tank
- How do we recognise the inherent expectations of the groups and move forward into the future

Amanda then summarised the outcomes from the Discussions

- Need to start to do something with AHREN now, in terms of the thrust of Rural Medical Education
- Judi to draft a response which will be sent to all directors which includes:
  - Need to be looking towards one organisation, but perhaps in the interim, have an umbrella structure which might include some separate business meetings - need to look at possible options?
  - We need to be explicit in our discussions and include the 'elephant on the table'
  - Explore options and conditions for potential organisational structure and the first is mapping out the areas of interest
  - Over the next 3 years, as everyone is moving at varying some speeds, joint activities would be useful and like their idea on a 'think tank on health workforce issues' and suggest scheduling one at the same time as the FRAME meeting in October
  - FRAME had already planned to request a day of specifically medical education at the WONCA conference in Cairns in 2017
  - FRAME looks forward to other research collaborations and possibly the National Rural Health research meeting in September
  - FRAME and ARHEN continue in the business sense as per current arrangements, but we look at pursuing the 'big picture' things with them

- Mapping process – helped by having an independent/impartial facilitator

Issues from Day 1

Accommodation

- ARHEN has been very affective in lobbying and has completed a survey of all the accommodation needs of the UDRHs. This was a comprehensive canvassing of available accommodation and estimation of accommodation needs required to meet the new target of the UDRHs. This is currently sitting in Minister Nash's office for consideration.
- Suggestion that FRAME requests accommodation information from ARHEN as there may be capacity within Medical School RCS's that could be utilised
- Suggestion that Judi is to add into her letter to ARHEN that one of the issues that came up during the FRAME meeting was the huge issue of accommodation and that perhaps this is one of the issues that could be worked on together in an integrated way.
- Suggested at the Directors meeting this morning – the possibility of having a FRAME day, where we showcase what we do in rural medicine in Australia, on the first or second day of the 2017 WONCA Rural Health conference in Cairns next year. (The National Rural Health conference is running from the 26-29th April 2017 in Cairns with WONCA Rural Health following on from the 30th October to 3rd May)
- Judi to draft a response to AHREN which will be send around to all Directors

National Rural Health Alliance update – Joe McGir

- Joe is the FRAME rep on NRHA council and has been asked to sit on the Board which he has just accepted
- NRHA is one of the co-sponsors with ACCRM of the World Rural Health conference in Cairns in 2017
- Suggestion of having a FRAME day, where we showcase what RCSs do and have achieved in in rural medicine in Australia as part of this conference in Cairns
- NRHA has their 5th Rural and Remote scientific symposium in Canberra the on the 6-7th September with focus on national data and research organisations and tools available to access data in remote and rural areas
- Good opportunity for RCSs to send their research staff to engage and to be updated
- The NRHA has also negotiated access to the journal of rural health for its members. Please see Joe if you need access.
- There will be a farewell to Gordon Gregory, the CEO and founder of the NRHA on the 9th June
- NRHA is going through a period of change and the Board now has the opportunity to rethink its direction and strategy as it moves forward. Kim Webber is now acting in the CEO role for the next 6 months.

- NRHA has been reliant on funding by the government and has now been re-funded for the next 3 years as a peak representative organisation and is now facing a number of challenges:
  - Can the Alliance continue to function without looking at other opportunities?
  - NRHA is now made up of 35 organisations and how the Govt structure around that will enable them to function?

Research and FRAME Outcomes and the Exit Survey update – Jennene Greenhill

Research update

- Not a lot on the research agenda at this time
- Asked to put forward a proposal as to whether FRAME would be willing to support either in kind or financially, the second part of a project which was done in 1996/97 when the first national GP survey was published by. Another round of interviews and data collection on GP workforce has been proposed and will be called National GPS2. Last survey was of 1400 hundred GP's, this time it would include a comprehensive study of the entire rural GP workforce hopefully completed by 2019. Whole focus will be on critical issues for the future of GP workforce.

FRAME members like the idea but need to have more information. Amanda suggested that Jenenne distribute more information to FRAME members and that she also contact Ayman Shenouda, RACGP Chair.

Frame 2016 Survey update

- Acknowledgement and thank you to Sharon Liu whose diligence has made the FRAME survey possible
- Several questions were deleted to reduce length
- More interest than ever before in adding new questions and altering questions
  - changed definition of rural origin to match new parameters
  - factors important in choosing location of practice and speciality discipline of preference
- Improved timelines so surveys now printed and ready to do for students leaving RCSs midyear
- Several new publications for 2015-2016
- Current projects are:
  - Clinical Epistemology
  - Patient-practitioner orientation scale
  - Longitudinal integrated Clerkships
- New projects underway:
  - 2016 survey includes new research questions on
    - Self efficacy in remote practice added by Craig McLachlan from UNSW
    - Factors important in choosing location of practice and speciality discipline submitted by Riitta Partanen from UQ

- Next Steps
  - Look out for an email from Sharon Liu calling for numbers of surveys required in 2016 and dates they are required.
  - Please be aware that the new survey questions will be to be emailed to lucie.walters@flinders.edu.au by 4th Feb 2017 to ensure inclusion in next year's survey
  - Ethics expires 31/10/2017

RRH Update – Amanda Barnard (Australasian co-editor)

- Turnaround is now quicker but still far from ideal
- Journal now has a South American section – lots of international articles now received
- Articles received now are 4-5 times more than received 6 years ago
- Hold ups and delays are being reviewed

FRAME Leadership Program update – Judi Walker

- Thank you to everyone who participated in the Harvey Bay leadership course, especially Riitta, Jennene, and Georgia who were the co-facilitators.
- Feedback was very positive
- Suggestions for improvement – challenge to obtain a better gender balance
- Attendance capped at around 20
- Cost is approximately $700
- Check FRAME website for information on future programs. Proposal for another program to be arranged for July next year possibly in Darwin

Further information on the program, can be found on the powerpoint presentation (see Attachment 3)

Housekeeping

- General Discussion was had on when the next Canberra meeting should be held. It was decided that an email will be sent around asking for other dates.
  Note: It has now been decided to hold the FRAME Canberra meeting on 5-7th October 2016.

- Amanda asked for volunteers for the FRAME 2018 meeting – Uni of Newcastle (Tamworth) volunteered.

- Amanda reminded the meeting that at the October FRAME meeting, the members will be electing a new chair and new policy group for the next two years. Need to think about whether we want to go to a structure of having a chair and chair elect.

- Next Frame meeting to be held at JCU in May 2017. It is proposed for FRAME to hold a full day of presentations and a half day business meeting, to coincide with the WONCA scientific program.

Amanda advised the meeting that Justine Brindle and Graham Allardice were attending their last's FRAME meeting as they were 'retiring'. Amanda, on behalf of Frame, thanked them for their input over the years and wished them well in their future endeavours.

David Garne, on behalf of Wollongong Uni, thanked Amanda for her leadership and the Policy Group for their input into making FRAME Bowral a very successful and enjoyable meeting.

He also thanked, Jade Thomas, Kerry Pert, Tracey Dugald and Belinda Smith for all their hard work in making the FRAME meeting successful and presented them all with lovely flower bouquets.

The meeting then closed.