FRAME Meeting Minutes Canberra 2018
ANU Common Room – University House
Monday 9th & Tuesday 10th April 2018

Rural Clinical Schools, Regional Medical Schools and Regional Hubs from the following Australian Universities were represented at the meeting

University of Melbourne	Australian National University
University of Wollongong	University of Newcastle
University of Tasmania	University of Queensland
University of Sydney	Griffith University
University of Western Sydney	University of Western Australia
University of Notre Dame (NSW)	Flinders University
University of Adelaide	Flinders University NT
Monash University	Deakin University
University of New South Wales	James Cook University

The Commonwealth Department of Health was represented by:

Fay Holden, Assistant Secretary, Health Training Branch
Dr Susan Wearne Senior Medical Adviser
Jennie Della, Director, Professional Entry and Rural Training Section
Katy Roberts, Assistant Director, Professional Entry and Rural Training Section
Josie Dichiera, Professional Entry and Rural Training Section
Molly Kenny, Professional Entry and Rural Training Section
Mel Pietsch, Assistant Director, Postgraduate Training Section

Rural Health Commissioner – Professor Paul Worley

FRAME meeting Monday 9th April

Apologies:
John Wakerman Flinders University NT, Ruth Stewart JCU, Angela McLeod Melbourne University, Lizzi Shires, University of Tasmania, Tony Jordan and Lesley Forster from the University of New South Wales.

Acknowledgement to Country given by Stuart Sutherland from ANU.

Professor Jennene Greenhill, FRAME Chair, opened the meeting, welcoming FRAME members, DoH representatives' Professor Paul Worley (the Inaugural Rural Health Commissioner) and Helen Craig, the new CEO of MDANZ .

Jennene thanked Stuart and also acknowledged elders, past, present and future and invited Amanda Barnard, Director of ANU RCS and host for the meeting to speak.

- On behalf of ANU and Imogen Mitchell, acting Dean of ANU Medical school, Amanda welcomed all the delegates to University House. She said it would be her last FRAME meeting as she leaves ANU in June and has been working with FRAME and the people involved for the last thirteen years. It gave her time to reflect on what FRAME has achieved through the hard work of all involved and is now at the next phase with the Hubs.

Jennene highlighted the considerable work of the FRAME Policy Group:

- In February Jennene attended the Ministers Rural Health Roundtable with other rural health stakeholders. The highlights of that meeting were:
    - The focus on Aboriginal health workers and their professional training pathways.
    - The announcement that RACGP and ACCRM will be working together on rural generalism.
    - Push for rural generalism and the pathway beyond medical graduate training as well as allied health and nursing.
- In March, the Policy Group gathered in Canberra to meet with:
    - Ruby Cameron, senior rural health policy advisor to Minister Bridget McKenzie, where they introduced FRAME, its agenda and work.
    - Tony Zappia, Shadow Assistant Minister for Health who showed great interest in rural generalism, the role of FRAME and the shaping of medical training for the future.
    - Paul Worley to discuss how RCS can facilitate the vision for rural generalism
- Also in March the Policy Group met Professor Ian Frazer in Brisbane, chair of MRFF (Medical Research Future Fund) which was enlightening.
    - Federal Health Minister wants key priorities for research to include health services and not be focussed entirely on "laboratory-based" research
    - He would welcome research submissions from groups like FRAME
    - There will soon be an announcement about "grass roots" development for research that will make a difference at community level will receive:
        - Seed funding for 1 year with a 5 year program for the successful researchers
        - Projects will be required to be focussed on making a difference to the health of communities
    - Working hand in glove with the NRHMRC and they will have an influence in setting some of the research priorities in the future
    - Need to make the case that rural health research is really important and make a pitch for a program that will last 5 years and positively affect rural communities
- After correspondence from MDANZ (Richard Murray is the Chair) regarding AGPT changes to training in 2020
    - MDANZ have indicated that rural should be consulted on the policy direction and asked if FRAME would like to be included in the consultation as time frame was quick.
    - Held a Directors teleconference at short notice and it was decided that rural health is a stakeholder and FRAME would put together a briefing letter to the Department regarding future training
    - Jennene thanked Medical Deans for their support in this important debate for the future and said that it is important that FRAME is seen to be a collaborative group to assist in driving forward policy and directions for the future
- Jennene thanked the Policy Group for both the time they give away from their families and their work and commitment
- The next meeting will be in Mount Gambier, October 2018
- Tomorrow we will outline the election process for Chair, Deputy Chair, Policy Group and other positions and consider the nominations and positions
- Jennene acknowledged Amanda Barnard, mentioning that ANU is the richer for her leadership, she has been a great mentor to Jennene as chair and director, has been a great role model for women and has been an amazing woman in her leadership role for both FRAME and ANU
- Jennene thanked Amanda and then presented her with a gift from FRAME to thank her for her support and hard work as both a member, host for annual meetings and past chair.

- Amanda responded and said that the RCS have profoundly changed medical education in Australia and played an important role in changing the agenda for medical school training and potentially for post graduate training. The changes are huge and what binds us all (FRAME) together is the underlying strong sense of purpose. One of the strengths of the group (FRAME) is commitment to the best health outcomes for all Australians living in rural areas. Amanda thanked everyone.
- Jennene also presented Fiona Jorgensen and Kerry Pert with a gift from FRAME members to thank them for their hard work and support in hosting meetings.

RCS Roundup with focus on hubs (Presentations Attachment1**)**

University	Presenting
University of Melbourne	Julian Wright
University of Wollongong	David Garne
University of Tasmania	Sarah Jordan
University of Sydney	Linda Cutler & Jennifer Rodwell
University of Notre Dame (NSW)	Joe McGirr
University of Adelaide	Lawrie McArthur
Monash University	Robyn Langham
ANU	Amanda Barnard & Katherine Stonestreet
University of Newcastle	Jenny May
University of Queensland	Tom Doolan & Steve Flecknoe-Brown
Griffith University	Scott Kitchener
University of Western Australia	David Atkinson
Flinders University	Meredith Peters
Flinders University NT	Monica Barolitz
Deakin University	Lara Fuller
University of New South Wales	Apology
James Cook University	Marcel Crawford
University of Western Sydney	Jane Thompson

Key messages from presentations:

- Issue of alignment with selection, medical school, junior doctor, vocational training, RMO etc. – difficult to find a way to track.
- Need to tailor posts and experiences to the very different regional communities.
- Opportunity with integrated regional training hubs for local indigenous students to go through medical school without spending excessive time out of country.
- Need for communication between hubs as students may train in one geographic area and then want careers elsewhere – network of sharing information flow important.
- Long term vision to create partnerships that count (services, training providers etc) – understand challenges.
- Catalyst for state-wide collaboration
- Initiatives developed for different approaches to technology, supervision etc
- Some smaller regional areas present challenges for change.
- Struggle with new MD's and curriculum redesign
- Need to build links with specialty colleges will be important for the health workers of the future
- Accreditation – the importance of receiving and then maintaining it

Update on FRAME presentation for WONCA 2018 – Amanda Barnard ANU

Amanda Barnard is presenting at WONCA (World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians) in India soon.

- There is International rural medical education interest in what happens in Australia and FRAME.
- Will also speak about the background of FRAME, Commonwealth parameters and give an overview of the Hubs current status and future challenges and opportunities.
- The Rural and Remote Health Journal is developing a new website, to be launched at WONCA. The journal is managed by JCU and supported by the RCS. (Amanda Barnard - Australasian Regional Editor, Denese Playford and Nikki Hudson – Associate Editors). Tomorrow, ANU will film a group of FRAME researchers discussing rural research and the RRH journal and its special place in supporting rural research. The film will be used at the launch of the website.

Hubs Evaluation tool update - Deb Russell, Flinders NT (for John Wakerman)

(Presentation Attachment 2)

National Hub Evaluation is led by John Wakerman from the Northern Territory.

- Steering committee meets every 1 – 2 months and their role is to advise a smaller working group.
- Core aims of the evaluation:
    - Determine the effectiveness of the Regional Training Hub (RTH) program in addressing the inequitable geographic distribution of the medical workforce in Australia
    - Quantify the economic benefit to regional Australia of the RTP program
- Study design and contexts:
    - The extent to which RTH resources are able to improve the distribution and increase the size of a well-prepared rural and remote medical workforce will vary
    - The work will identify factors associated with variation in outcomes using a program logic evaluation framework, linking inputs, outputs and outcomes for trainees
- Study Methods:
    - Questionnaire & spreadsheet (repeated annually) to obtain data including information on training posts: number, type (vocational, student, GP etc), duration, vacancy rate; where possible before and after RTH work; and
    - Qualitative interviews (hub staff, key stakeholders, junior doctors) will examine functions and activities of hub staff, number and nature of existing and new connections with stakeholders, processes involved in creating newly accredited training positions and the barriers and enablers to their creation

Will need help

- Have sent information to UDRH/RCS via FRAME
- Have FRAME endorsement but need active support from all UDRH/RCS
- Have quantitative skills but would like assistance with qualitative

Rural Health Commissioner Presentation and Q & A (Prof Paul Worley)

Jennene Introduced Paul Worley, the inaugural Rural Health Commissioner for Australia as someone who has been a rural doctor, is passionate, still practices as a rural clinician and cares about rural practice. He is an educator, teacher, musician, father, an all-round Renaissance man and a good friend and colleague.
Paul thanked FRAME for the invitation to speak and also thanked Stuart for his welcome to country.

- The work he does and the work FRAME is doing has not come out of nowhere, but has been building on centuries and millennia of health education in traditional indigenous lands , which still has a great deal to teach us
- The presentations from RCS around the country highlighted the contribution being made to meeting community need
- The paradox is a room of people that represent rooms full of people around our country funded in millions if not billions of dollars each year to address problems that don't go away
- Everyone is working passionately and doing good work and if it weren't for the RCS and Commonwealth initiatives, where would we be?
- If it weren't for the overseas trained doctors coming to rural Australia, where would we be?
- Country Australia has to say a big thank you to the overseas trained doctors and DoH.
- One of the joys of taking the RHC position has been to get to know the people within the Commonwealth Public Service who share the same aspirations as FRAME members and are just as frustrated when community needs are not being met
- Over the last decade or so, a great body of corporate knowledge has been built
- Paul thanked the Commonwealth for being part of this (FRAME) and for not just being a purchaser provider or funder but actually a sharing partner.
- In the majority of rural health services the service capability is decreasing despite funding and the work of people such as those in FRAME

If we look at the data available, despite changes, there remains:

- Maldistribution of workforce
- Lack of funding to rural health services compared to the per patient funding in cities
- Rural phobia for potential future practitioners
- Problems with mental health despite advances in tele-psychiatry
- Issues of cultural safety for health practitioners

Despite all the work we still have the problems.

So – in the way of the good clinician, when you are essentially dealing with symptomatic diagnoses, for example hypertension, you need to ask: What is the underlying disease process?
What is the pathological process that has not changed, despite decades of investment, research and changes addressing the "symptoms"? The underlying process hasn't changed and is controlled by the city
The underlying process needs to be changed. There is an argument, well-intentioned but wrong, that "In terms of the educational strategy, you need to have time in the city as that's where the knowledge is, where the people who hold the knowledge are." or

- If you didn't make it in the city, you went to the country.
- If you didn't make it as a specialist, you became a GP.
- If you didn't make it as a city GP, you became a rural GP.

That is what I (RHC) have heard again and again.
What has also changed over the last 20 years is that through your work (FRAME) have shown that this is not true and that rural clinicians are "wise". Students who study in rural clinical schools can have supervision that is equivalent to if not better than students studying in tertiary hospitals (which are also good).

In terms of health outcomes for the world, Australia looks very good, but it is not evenly distributed and we are advocates for the people who are missing out (rural) and not empowered to make the changes required

There is evidence that good people have made policies that have ended up perpetuating inequity. The French saying "The more things change, the more they stay the same" has been part of our problem over the last 20 years. The reason is that the underlying pathology hasn't been addressed.

There are some examples of where that has been addressed (not promoting Queensland or advocating it should be followed but there are some good things happening there):

- What JCU are doing in a program based in MMM 2 to 7 – the evidence of where their graduates are practicing shows that approach works.
- You don't have to convince a person from the country to come to the country and you don't have to convince the spouse of that person to come to the country.
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One of the biggest reasons for the doctors from rural programs in RCS who express interest in rural and never go, because they marry someone from the city.

- Why – because that's where they are when they are marrying age (end of university to fellowship).
- If they make decisions about life partners while in the city; if they meet their partner it is highly likely the partner will have a job linked to the city.
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No matter how much we look at providing the inputs, we are always going to be battling against where that person's land is. An appreciation of country is a human aspect. Our indigenous brothers and sisters articulate it really well; it is applies to all of us. Our attachment to land is like citizenship, we are given it. It is something that is intrinsic in us and it draws, pulls and pushes. Aboriginal and Torres Strait Islanders articulate it well and we cannot deny it, a memory or connection to a place.

What does a rural generalist pathway look like (that addresses the pathological process rather than just the symptoms)?

- Join a medical program at the end of high school in regional areas
- Link up:
    - Junior doctor training in those areas
    - Fellowship program based in those areas
- 12 or 13 year pathway for rural generalism
- Does that mean the people who take up those opportunities are bonded to that – no
- They need to be able to move like those in city are not bonded to the city
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If there were a rurally based pathway and program there would be more of an exchange as opposed to a paternalistic "We'll see what we can do to help out the country" approach.
What would this mean in terms of the health services?

- It would mean they would stop being underfunded as opposed to city
- Per patient LHN's in regional areas are currently funded less than those LHN's in cities

Funding that goes to the city is about more than patient care, it is also about education, registrar, intern and RMO positions, and clinician research. Also academic health science centres that are our city hospitals.
Why can't we:

- Have academic health science networks across rural Australia?
- See our rural health services with research as a core function that is funded?
- See our rural health services train their own as a core function and are funded to do it?

Current system is delivering what it is designed to do.

- Creating a system where the majority of graduates become city sub-specialists.
- That is where the majority come from, are trained and where the funding is.

We have an opportunity to change that. Doing more of the same will make the problem worse – not better.

What could that look like for Rural Clinical Schools?

- RCS's have been part of helping to treat some of the symptoms of the underlying problem.
- Almost solving the problem is a problem.
- We need to consign the problem to history.
- We need to think we do not have to put up with a system of rural health care delivery and rural health workforce that is less than the city.
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If we stay the same there is potential for health services to close and towns to shrivel.
Do we accept second best as being our natural place or has the world moved on so small can compete with and do better than big?
Rural health services have felt like underdogs for a long time.
Underdogs can achieve more than those who appear to have privilege.
There is now opportunity:

- State jurisdictions and the Commonwealth Government realise that they do want to make a substantial change
- We need to realise how big a change that should be.
- Could be incremental and lower cost (looking at symptoms with more symptomatic treatment)
- Or – get to "underlying pathology" and change once and for all.
- Rural communities are sick and tired (of current health service delivery) and believe they can take control of their destinies but it needs to be regions and networks

The Rural Health Commissioner took a variety of questions from an appreciative audience.
Jennene thanked him on behalf of the group for an excellent presentation that outlined his thoughts for directions for change.

FRAME Dinner – The Deck at Regatta Point

FRAME meeting Day 2 – Tuesday April 10th

Jennene Greenhill (FRAME Chair) welcomed everyone and shared highlights of Day 1.

- Rural Clinical School and Hub roundups and challenges
- Meeting old and new friends
- Listening to the extraordinary work being done around Australia
- Thought provoking session with Paul Worley RHC
    - Challenge presented
    - Strong foundation and principles to establish rural generalism
    - Shared ideas of how it could work from around Australia
    - Up to us (FRAME) to work collaboratively which we do well
    - Build partnerships to make rural generalism "come to life"

Supporting Aboriginal and Torres Strait Islander students – (Presentation Attachment 3**)**
(David Atkinson UWA RCS, David Paul Notre Dame & Andrea McKivitt)

David Paul acknowledged the traditional owners and Aboriginal and Torres Strait Islander colleagues.

- Aboriginal recruitment and retention cannot be spoken about in isolation and to address the matter there are a range of issues that must be considered
- A range of support systems need to be in place to ensure that those selected can progress through the course
- There is a need to acknowledge the history, listen and work together to address health disparities
- In recruitment there is a long and a short story
    - First Aboriginal doctor to graduate was 1983 in WA
    - In New Zealand, the first Maori graduate was in the early 1900's
    - In the US 1885
    - We are a long way behind in this journey
- Some schools do it reasonably well, but reasonably well is not always consistent
- Experience of some schools:
    - Newcastle started 1984-5 with specific agenda to recruit Aboriginal students
        - Recruitment was successful
        - A few years ago – realised that although recruitment was successful, they were not doing so well in the system
        - Visited a few other schools then put together a program to better prepare, select and support Aboriginal students
        - A couple of years ago had 66 studying Medicine and in the same year offered 20 places and got 19 students
        - Possible to change
    - University of Western Australia
        - Strong commitment in the mid 90's
        - After about 10 years started to get some traction and strong numbers
        - Now there are challenges again which can be tackled by addressing structural issues
    - Auckland and Otago
        - 15 – 20% of population is Maori compared to our 3 – 3.5% (Aboriginal)
        - They deal with a different situation
        - With a structured funding program (for Maori & Pacific students), able to put the resources in to enable a different support process than we can offer our distributed multiple schools
        - It is very different though with 100 – 150 Maori students per school as opposed to our 3, 10 or 15

        - If you do things well, you can go from 0 students in 2013 (ND) to 10 students with first graduates in a very short time
- Overall Australian retention rate is not good
    - Some schools >90%
    - Changes year to year (leave, sick or fail)
    - Need a long term view
    - If we do it right, can lift to 80 – 90% for all schools
- AIDA Healthy Futures 2005
    - Need alternate entry pathways with preparation and support
    - Select on capability, capacity and preparation
    - Not UMAT or GAMSAT
        - Good for filtering the 1,000's of non-indigenous places
        - Not a good measure for capacity and capability
        - It is expensive
        - Not culturally sound
    - Need support processes
        - Fremantle have 6 indigenous health academics
        - Many colleagues have fractional appointments and many do all recruitment, teaching and support in big schools and that does not work so well
        - Need off the top funding for this – not from RCS – need strong support
    - Need safe place to both work and learn
    - CDAMS framework 2004
        - All students learn about Aboriginal health
- What are the drivers for Aboriginal health outcomes?
    - Supportive process
        - Need somewhere people can retreat to, get support and learn
        - Need to know communities, build bridges, bring elders and wise people into the teaching environment as not always academics with the strong messages
        - Academics need to drive the process and make sure that it is not the same people and stories every year
        - Need holistic approach
- AMC Standards – 2012
    - Aboriginal health and health related content
    - Recruitment and graduation
    - Aboriginal staff
    - Engagement and partnership with Aboriginal communities
- RHMT requirements
    - Targets related to funding
- Some schools have specific employment strategies re indigenous staff etc, but it is not uniform across the sector

- Need for:
    - Entry and recruitment pathway
    - Take people on a learning journey
    - Range of meaningful supports
    - Ongoing scholarships
    - Ongoing staff
    - Meaningful curriculum
    - Deans and executive support
    - Whole of school approach

- To be resilient, sustainable, ongoing and part of the school's normal business

Andrea McKivitt, who grew up in the Kimberley, gave a presentation about her experience as an Aboriginal student, covering encouragement, recruitment, support and graduation as a doctor.

- Growing up in the Kimberley, a career in medicine did not cross her mind
- School discouraged
- Supportive family is key
- Did not do UMAT – anxious about capacity
- After year 12, contacted by university to try out medical program in the city
    - For medical and dental students
    - Peer support and mentors
    - Offered options, scholarships
    - Good staff support both indigenous and non-indigenous
- Entered course with a couple of others; thought themselves "imposters", vulnerable
- There was a strong support network
- House support structure was helpful
    - Support at Stenlin House with house Mum to approximately 200 Aboriginal students
- Support for formal help by both Aboriginal and non-Aboriginal doctors
- Students social needs were different, but catered for
- Good networking
- The house was a refuge for students and all taken care of by the staff
- Good Aboriginal health curriculum was a driver to finish university
- Had a placement in Derby and another in Canberra
- Now working in Adelaide
- Has had inspiration from others at conferences interstate and overseas
- Long term vision that helped get her through medical school:
    - Support
    - Mentorship and collegiate support
    - A clear vision of where she was going
- Has since done Masters in Aboriginal health in WA
- Enabling Aboriginals through education is a strong driver

David Atkinson and David Paul conducted a workshop and group discussion

David Paul asked the audience to think participants to reflect their approach might and the actions they would take to achieve; David Atkinson facilitated and comments and ideas were shared:

- School support needed to assist students achieve and enter their chosen field of study
- Engage students in early high school and "talent spot"
- Concept of studying medicine should be made "normal"
- Consider encouraging study of science in schools
- Ensure university is on students radar
    - Eg; year 7 science prize
    - Award year 12 scholarship for student contemplating health or medicine and if they enter the course, further 2 years of financial support
- Community engagement officer to work with families, school principal, teachers and students
- Medical students run information sessions with aboriginal high school students (year 11 and 12) – successful model is small
- Having good relationships with the students is important
- Success requires courageous leadership

- Extend learning beyond Aboriginal students eg; walk on country available to all students and staff
    - Takes shackles off “normal” way of teaching
- Need supportive Deans and Vice Chancellors
- Students require diversity of support personnel
    - Both Aboriginal and non-Aboriginal staff and academics
    - Need to find a way to support and keep a conduit back to advisors
    - Aboriginal student support council – formal council to give advice to schools
- Support is easier on main campus than in RCS as often one or very few Aboriginal students in regional campus
- Need to focus on where the students have come from and tailor the support (many from disadvantaged families)
- Success is possible with cultural differences and graduates have been successful but need support

DoH Update and Q & A – Fay Holden - Assistant Secretary, Health Training Branch (Attachment 4)

Health Workforce Strategy

- 2018-19 Budget
- Will include a range of measures to:
    - Improve the supply and quality of medical workforce
    - Better target the distribution of the health and medical workforce
    - Support the development of multidisciplinary and team-based models of primary care.
- Provides a framework for investment over the coming years.
- PM announced additional $84 million over 4 years to RFDS for dental, mental health and ambulance services.

Distribution Working Group

- Distribution Working Group (DWG) established in September 2016 to address the maldistribution of the health workforce.
- The DWG last met in February 2018. Outcomes:
    - Agreed which programs should transition to the Modified Monash Model (MMM) classification system.
    - A set of principles to be created to determine when exceptional circumstances of a town should be taken into account.
    - Discussions regarding DWS methodology are progressing.

Changes to the Australian General Practice Training program

- To be transitioned to the GP Colleges from 2022, following a transition period from 2019
- The transition will be an extension of the current arrangements in place for the program
- Opportunities to reform elements of the program may be considered in the transition process, in consultation with impacted parties
- Maintaining stability and continuity in the sector is critical
- Continued focus on: quality of the GP workforce, number & distribution of GP trainees/the GP workforce, regionalised training delivery including priority for rural, regional and remote Australia

Rural Health Multidisciplinary Training Program

- First cut of data from 2017 reports show:
    - Rural origin enrolment of medical students – 31.1% across universities, up from 30.7% in 2016.
    - 977 graduating medical students - or 34.6% - completed at least a year of rural training, marginally higher than the 34.3% achieved in 2016.
    - Of these, 310 completed over a year of rural training, and a further 118 completed over two years of rural training.
- More universities increasing the length of medical student placements beyond one year (2- and 3- year placements).
- Innovative Service Learning approaches being implemented to increase multidisciplinary rural training capacity.
- Universities revisiting financial incentives to support students on rural placements especially multidisciplinary students.

- Rural origin students given preference to rural streams.
- More engagement with rural primary and secondary school students to promote rural health and medical careers.
- Universities engaging with Aboriginal and Torres Strait Islander peak bodies and organisations towards development and implementation of strategies to enrol and support Aboriginal and Torres Strait Islander students through to graduation.
- Current RHMT funding agreements end on 31 December 2018

Integrated Rural Training Pipeline for Medicine:

Regional Training Hubs

- Regional Training Hubs – one of three components of the Integrated Rural Training Pipeline for Medicine (IRTP) measure.
- Regional Training Hub teams appointed.
- Progress with key stakeholders within Regional Training Hub catchments.
- Identifying areas of regional workforce need and priority specialty areas.
- Collaboration across Regional Training Hubs to maximise training opportunities.
- Challenges/Concerns
    - Role of the Regional Training Hub

Rural Junior Doctor Innovation Fund

- A second grant round was opened on 27 October 2017.
- Seven applications were received
- Applications have been assessed, with contract negotiations underway.
- Outcome will improve the program's national distribution.

Expansion of the Specialist Training Program

IRTP - Specialist Training Program (STP)

- Creating new rural training opportunities – expansion of the STP with 100 IRTP STP rural places across Australia (50 allocated in 2017 and 50 in 2018).
- Additional requirement for IRTP STP posts – "flipped model" where trainees spend at least 66% of their fellowship pathway in rural areas.

Specialist Training Program (STP)

- Aims to improve the quality of the future of the specialist workforce by providing registrars with exposure to a broader range of healthcare settings.

- Aims to have a positive influence on future workforce distribution.

- Up to 1077 STP positions being funded in 2018 – includes Emergency Medicine Program posts and 100 dedicated rural training positions under the Integrated Rural Training Pipeline (IRTP) initiative.

- STP funds between 5 and 7 per cent of all specialist training.

NRHSN Presentation - Ashley Brown - NRHSN Community & Advocacy Officer - **Medical Student University of Tasmania (**Attachment 5)

Ashley acknowledged the traditional owners and thanked FRAME for the invitation to attend and present.

- NRHSN provides a voice for students interested in improving health outcomes for rural and remote Australians
- Promotes rural health careers to students, with the aim of addressing the workforce shortage in rural Australia
- Clubs in all states and territories
- Broad representation of students studying health related degrees amongst office bearers
- Current priorities
    - Committed to encouraging Indigenous students (priority area)
    - Positive pathways
    - Aboriginal and Torres Strait Islander health
    - Mental health especially in rural areas
- Plan to publish a position paper on student placement
- Work with all health students (across disciplines)
- Clubs believe they are functioning well with support
- New funding arrangement through Rural Workforce Agencies - NSW RDN
    - Clubs have difficulty if there is no rolling over of funds; if not spent, returns to Government
    - If funds are held through university finance departments and if a function is run, students use own funds and often have to wait up to 3 weeks for reimbursement
    - If they could roll over funds would have more continuity and be able to plan bigger events
    - Need options for payments and reimbursements or funds in advance and greater flexibility with allocation of funds
- Need support from RCS and communication

Richard Colbran CEO RDN NSW

Richard thanked FRAME for their invitation and commended Ashley on his presentation.

- Rural Workforce Agency (NSW RDN) administer the student network and represent all 7 agencies
- Support the NRHSN executive and make sure they function well and manage risk and business appropriately
- Advocate for future health workforce
- Workforce agencies aim to bring executives together with RWAC CEO's in a workshop before the end of the year to discuss the functioning of the workforce agencies, workforce issues, and bonded scholars
- Support leadership development for students
- In CEO role, travels around NSW and sees great work being done and acknowledges that. It is important to say thank you and congratulations.
- 1st July 2017, Workforce Agencies contract changed
    - What was RRGP with 9 funding buckets became 1 and now called the Rural Health Workforce Support Program (RHWSP)
- RHWSP – three critical outcomes or guidelines:
    - Access to services in rural communities
    - Quality of services in rural communities
    - Sustainability of services in rural communities

- Cohort goes beyond the Medical Workforce to Primary Health Workforce as well
    - Currently working on defining the need to ensure that access, quality and sustainability is addressed.
- The NSW RDN is defining it as Medical GP Workforce, Nursing, Allied Health, Practice Managers, Practice Owners, Administrators, Aboriginal Health Workers (it is broad)
    - Critical mechanisms to be put in place as Workforce Agencies
        - Annual primary health workforce needs assessment (due annually in February) articulating the need in terms of workforce in each jurisdiction
        - Next year will include allied health
        - Following year will add nursing
    - Need to work well in partnership for national consistency to ensure those that need to can tap into the workforce needs assessment and develop ongoing plans
    - Activity Work Plan – in response to needs assessment demonstrates outputs and outcomes against needs assessment and partnerships
- Workforce agencies have been asked by Department to consider looking at and supporting bonded scholar placements and have commenced that work and within six months would like to be able to demonstrate a good program plan to access, engage and connect with bonded scholars.
- There is a grey area in the role of the relationships between the Hubs and Workforce Agencies which may require further conversations.

Jennene thanked Richard for his presentation, Ashley and UWA team who led the morning discussion as well as visitors and representatives from the Department for attending.

FRAME Business Meeting

Issues and key learnings raised on day 1 and morning of day 2

- Potential announcement re Health Workforce Policy in the Budget
- There is uncertainty around funding
- Strong bi-partisan support for the program – positive messages
- Some schools are not meeting rural origin targets (Aboriginal and Torres Strait Islander students)
- May be too soon to expect Rural Generalism program in the Budget
- Comments re which RCS receive funds from their university CSP and RHMT funding
- Jurisdictions are different re rules for funding agreements with teaching hospitals
- There is variability around the country and no standard or uniform payment model for placements
- Grant funding section of the Department (currently in WA) may change to another Department
- Some confusion regarding what is being evaluated (by Department)
    - Should FRAME set a small number of things to be evaluated that could influence policy
- DoH are using trend data on RCS from reporting and improving capability around big data and trend analysis
- Money should be spent on developing workforce as opposed to lots of evaluation
- RCS program is to be evaluated at some stage in the next 2-3 years
- Hub evaluation and potential Hub workshop/planning day
    - RTH workshop under FRAME banner
    - Common approaches and sharing information
    - Hubs fit into core business of RCS
- Unanimous agreement to hold workshop with 1 – 2 universities partnering to help develop it within next 3 – 4 months
    - Potential venue Sydney
    - Need facilitators
    - Small group identified to take this forward
- Potential FRAME leadership development program
    - Material available from previous one
    - Suggested that Jennene could run after she finishes as Chair
- Potential large shakeup of rural medical education in Budget
    - To include redistribution of CSP's, end to end training, Murray Darling proposal, targeted specific programs

Jennene thanked everyone for their participation and sharing of information and ideas.

Future meetings in Canberra – Administration and organisation

Jennene thanked ANU who have been gracious hosts for the Canberra meetings, but with Amanda leaving at the end of June, they would like the hosting and management of the event shared.

- Idea to have rolling hosts in Canberra and the next meeting due to be November 2019.
- Idea to have Department host and FRAME supply resources
- Do FRAME need two meetings per year?

FRAME Survey Study – Lucie Walters (Attachment 8)

- Results from 2016 in the data
- Over the last 5 years, 60% of RCS students are female, 42% of rural origin and 31% bonded
- Career intentions have been consistent
- Quite a number of working groups apply to get the data and collaborate to publish
- Some projects doing well (eg Patient Practitioner Orientation Scale)
- There are studies looking at burnout in rural placement and features that attract graduates to rural locations
- New questions (survey) around student wellbeing activities and cultural safety
- No changes to the survey this year as some universities have asked for it in May
- Lucie said that she has enjoyed doing the survey and would be happy to continue but believes it may need new blood, so is keeping it so it can be transitioned.
- If anyone would like to contribute new questions, need by August 30th in order to go for ethics approval for a new round of surveys in 2019-2020
- Next one to run for 18 months until June 2019
- On the ethics application, there needs to be a contact person who is the primary researcher for the FRAME survey
    - If changes to the FRAME survey principal contact person
- Leadership of the survey going forward:
    - Need 2 more members on the FRAME working party (business mostly done via email with 2 teleconferences per year)
    - Lucie would like to know if FRAME would like her to continue to be the research Chair for the survey and Sharon to continue to manage the survey or is there another school keen to take over the FRAME Survey management

Jennene confirmed that the management of the FRAME Survey will be part of the voting process at the FRAME meeting in Mt Gambier

RCS Publications – Denese Playford (Attachment 6)

Denese Playford: We report so much about our education and workforce outcomes and so little on the academic components

- Heads of RCS were asked to forward publications and the RCS of WA's librarian has been entering a large number of them onto a library
    - Intention to both hand back to the Commonwealth and share amongst FRAME via the website to show the length, breadth and depth of clinical research of RCS around Australia
- Of the 18 RCS, have data from ½ so the presentation is hardly representative, but is a snapshot of the outputs until something available from every RCS
    - Look forward to those who have not yet sent publications in doing so
- In going through the publications, looked at & identified (from 1,118 publications):
    - What are the general areas rural clinicians are publishing in?
    - What is the evidence suggesting is the rural workforce agenda?
    - Journal most published in is the RRH Journal
    - Biggest number were about education and medical workforce and decreasing number in Aboriginal health, mental health etc:
- Of all the authors, 1 has published 177 papers, but is in an urban location
    - How do we allow for those publishing beyond rural boundaries (urban)

Snapshot Study – Joe McGirr

Draft paper has been circulated to a representative from each university and in some cases it is the Director of RCS or a person nominated by the Director. Joe asked that if any Director present has not received the paper, to please contact him for it to be re-sent. Nothing has been published but the paper is close to its final draft and good positive comments in feedback. It has been a collaborative effort of 12 universities. Data was 2011 graduates and where they were in 2017.

Joe said he would see value in repeating the process again in 2 years and again 2 years after that and would like everyone comfortable with the data prior to publishing

NRHA – Joe McGirr

Going from strength to strength

- New CEO – Mark Diamond
- Have moved to becoming a company limited by guarantee with a new constitution
- In the last month have recruited a Communications Director (Di Martin) and policy Director (Joanne Walker) – means now a full secretariat
- Has been a significant transition
    - Financial position moved from projected deficit to positive balance
    - Doing work on a range of access standards for rural health
    - Begun work on a reconciliation action plan

2019 meeting – Tamworth - Jenny May

FRAME meeting next year in Tamworth hosted by University of Newcastle

- May be an idea to also focus on something of policy significance to ensure there is value for those attending
    - Ideas could include AMC, a Forum, Hubs, engaging with colleges nationally
    - Are there burning issues – there is an opportunity to deliver something of quality
    - If anyone has ideas please contact Jenny
- Dates – May 7 - 9 2019

Jenny said she looks forward to welcoming FRAME members in Tamworth

RRH Journal Update – Amanda Barnard and Richard Murray

Amanda Barnard

Thanked everyone who responded and who volunteered as reviewers

- It is still the limiting step in getting reviews back
    - Needs automating (still manual)
    - Editorial team still have to scan through everything and occasionally papers are missed
- New website is a step towards automation
- Some reviewing is challenging for reviewers (eg; Aboriginal health)
- How the process works:
    - Amanda, Denese and Mike meet monthly via Zoom
        - Go through all new papers, read, discuss, make preliminary decision (eg; not suitable for the journal)
        - May suggest change of format etc. prior to sending out for review, and this process can take a long time – next step is to get that process automated

Richard Murray

Commented about the business end of the journal

- It is free to access and publish
- JCU on behalf of FRAME agreed to take on the employment of staff, management of legal processes and governance
    - Richard chairs the Journal Management Team (David Garne is the FRAME representative on that team)
- Have sought to make as impactful as possible (with money from FRAME members)
    - Website and total journal management system including fully automated processes for review of the publication pipeline
    - Now launched and international launch to be at WONCA in India
- Still need financial and reviewing support (FRAME members)
    - Need those contributing from other countries to also contribute financially
    - Would appreciate ideas on how this could be done effectively

Amanda will stay on as Australasian Editor

Paul Worley is Editor

Election process – Jennene Greenhill

The FRAME elections will be held at the next FRAME meeting in Mt Gambier

- Chair & Deputy Chair (Academics with the title of Associate Professor or above)
- Policy Group to include 4 Rural Clinical School heads and 1 representative from both the management group and Hubs
    - Would like everyone to start thinking about nominations
- Other representatives
    - Survey Working Party – Longitudinal Survey
    - RRH Journal representative
    - NRHA representative
- Gives opportunities for leadership development and succession planning for the future as Jennene will be stepping down as Chair
- Process is on the FRAME website and was developed by Judi Walker

Mount Gambier FRAME meeting logistics and plan

Jennene reminded everyone that the next FRAME meeting will be in Mt Gambier following The Muster on Friday 19th October – full day at a separate venue

Administrators will inform if they wish to have a meeting then as well

Jennene also stepped the group through a brief overview of The Muster, jointly hosted by Flinders University and The Northern Ontario School of Medicine, run every second year and alternating host country. It includes the conference and an optional conference on the move (Kangaroo Island or Broken Hill). There is also an active student group involved.

Leesa Walker informed the group that abstracts are open and registrations will be open soon

FRAME website – Elspeth Radford

Elspeth showed the group a snapshot of the current website and said that it was originally developed by Kumara Mindes and Helen Peacocke in 2011 (Sydney University).

They did a great job as does Helen still who is still managing the site.

At the FRAME meeting last November it was decided that the site needed re-vamping.

We have a volunteer group to put the new site together that includes Helen Peacocke (Sydney University), Breeanna Stubbs (JCU) and Mimi Zilliacus (University of Melbourne) and Elspeth Radford.

Aim to build the site cost effectively using an out of the box program.

Policy Group have agreed that the Chair at the time could cover costs (website approximately $500, domain name $129 every 2 years).

In future uploads to be by the Chair's Project Officer with approval by Chair or Deputy Chair.

Elspeth showed the audience a mock-up of a new logo for FRAME

- It was accepted with no changes

The website update is under way and Elspeth went through the process of how people can be included on the broadcast list for FRAME mail.

Other Business

There was no other business

15:00 Meeting Closed

Wrap up - Jennene Greenhill

Jennene thanked ANU for hosting and said that their work has been appreciated and also thanked everyone for attending.

She looks forward to seeing everyone at The Muster and next FRAME meeting in Mt Gambier.