SETTING THE SCENE

David Atkinson, RTH Representative
FRAME Policy Group

Regional Training Hubs
Setting the scene:

- Intro to RHMT, RCS, RTH, UDRH & Rural Dental training
- Medical workforce – numbers
- Rural Geographical Classifications
- Current distribution of GPs, specialists and trainees
- Future directions

Regional Training Hubs (June 2018)

Regional training hubs

Medical

Medical training sites

Combined

Combined training sites

Multidisciplinary

Multidisciplinary training sites

Dental (previously DTERP)

Dental training sites

Regional Training Hubs (June 2018)

Regional training hubs

Medical

Medical training sites

Combined

Combined training sites

EMPLOYED MEDICAL PRACTITIONERS 2013-2016

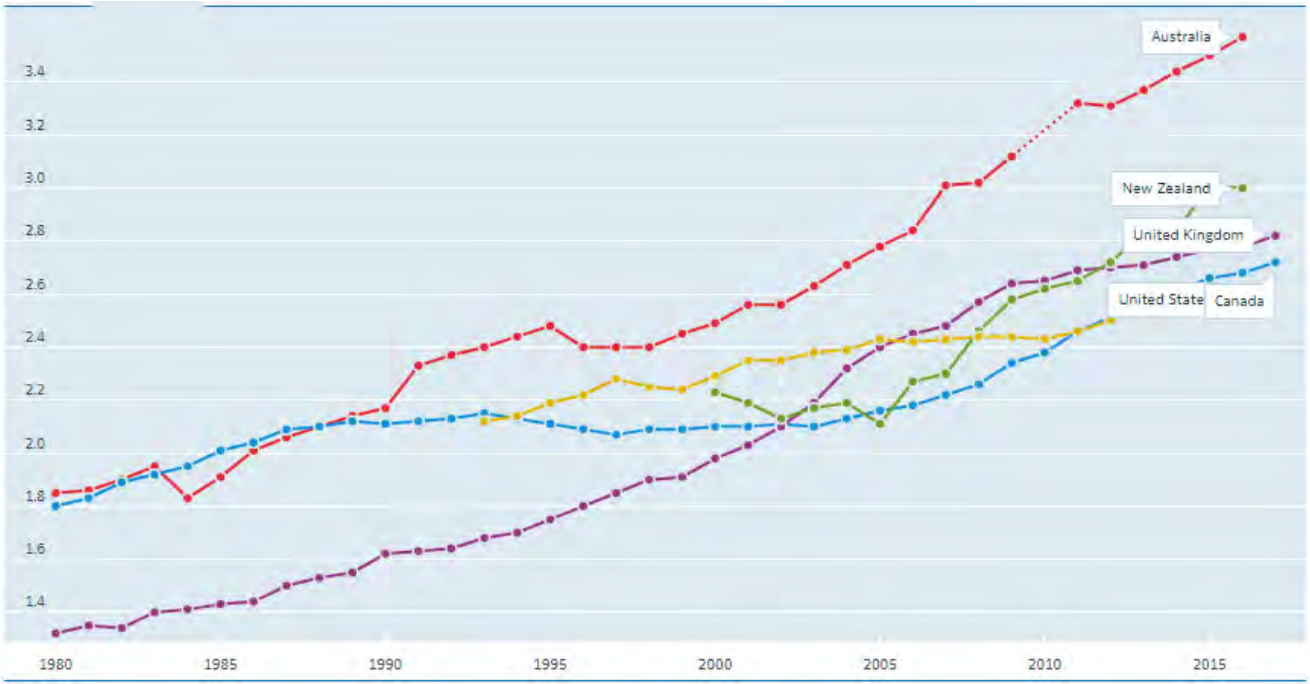
	2008	2009	2011	2012	2013	2014	2015	2016
Medical practitioners	68,455	72,739	78,960	79,653	82,408	85,491	87,999	91,341
Workforce growth (%)	-	6.3%	8.6%	0.9%	3.5%	3.70%	2.90%	3.80%
Australian Population	21,249,199	21,691,653	22,340,024	22,742,475	23,145,901	23,504,138	23,850,784	24,210,809
Population growth (%)	-	2.1%	3.0%	1.8%	1.8%	1.50%	1.50%	1.50%

Source: NHWDS: Medical Practitioners, 2013-2016. AIHW Medical labour force 2008, 2009. NHWDS (AIHW version): Medical practitioners 2011, 2012

Source: ABS 3218.0 – Regional Population Growth, Australia, 2016-17 (at 24/04/2018)

FRAME

Selected OECD Doctors per 1,000 (1980:2017) 1980 to 2017 (or latest available).



Source: OECD (data.oecd.org/healthres/doctors.htm)

FRAME

AUSTRALIAN STATISTICAL GEOGRAPHICAL STANDARD (ASGS) REMOTE AREA (RA) ,

Remoteness Area Category	Remoteness Area Name	SA1 Average ARIA+ Value Ranges
0	Major Cities of Australia	0 to 0.2
1	Inner Regional Australia	greater than 0.2 and less than or equal to 2.4
2	Outer Regional Australia	greater than 2.4 and less than or equal to 5.92
3	Remote Australia	greater than 5.92 and less than or equal to 10.53
4	Very Remote Australia	greater than 10.53

1270.0.55.005 - Australian Statistical Geography Standard (ASGS): Volume 5 - Remoteness Structure, July 2016

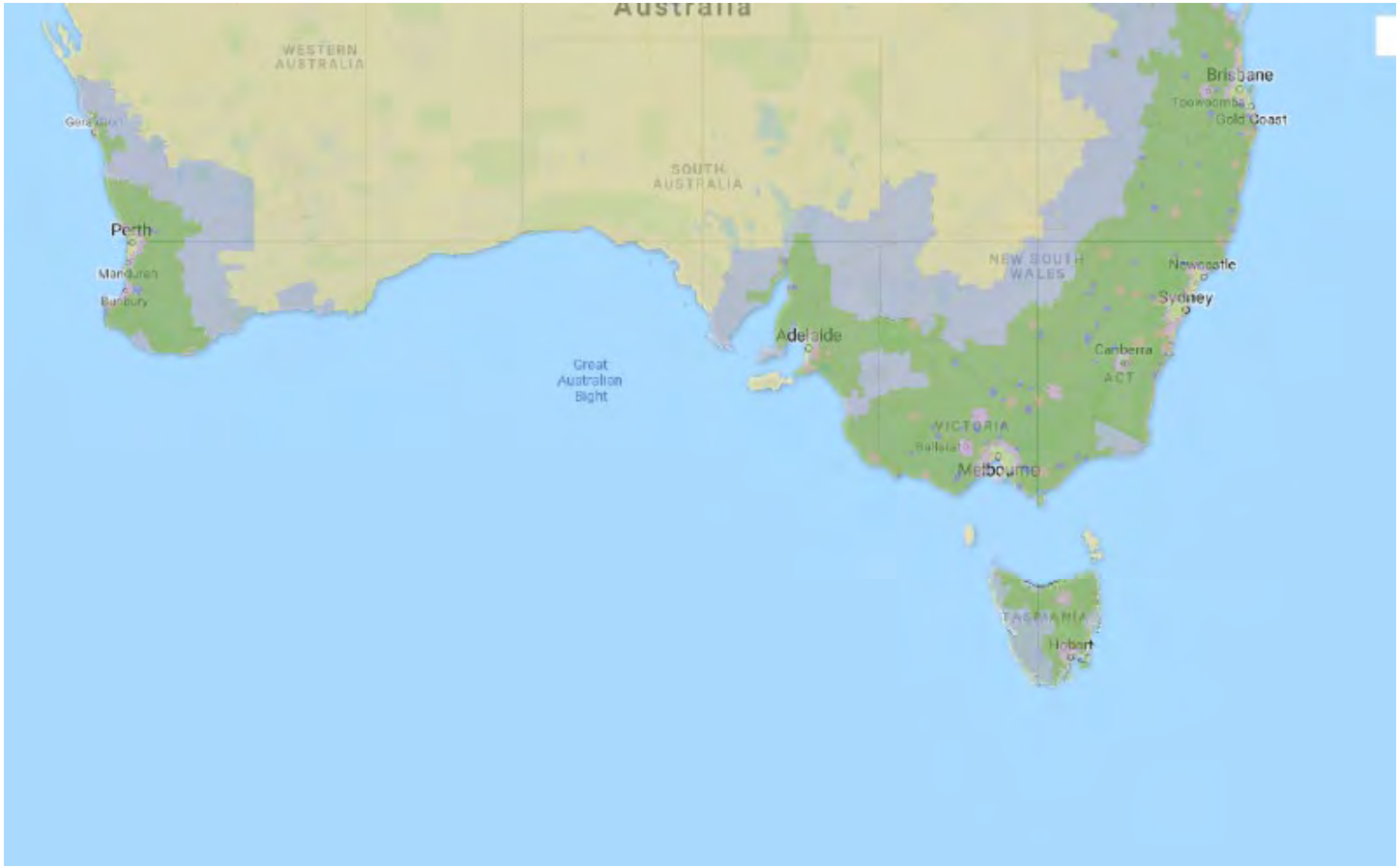
FRAME

Modified Monash Category	Inclusions
MM 1	All areas categorised ASGS-RA1.
MM 2	Areas categorised ASGS-RA 2 and ASGS-RA 3 that are in, or within 20km road distance, of a town with population >50,000.
MM 3	Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM 2 and are in, or within 15km road distance, of a town with population between 15,000 and 50,000.
MM 4	Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM 2 or MM 3, and are in, or within 10km road distance, of a town with population between 5,000 and 15,000.
MM 5	All other areas in ASGS-RA 2 and 3.
MM 6	All areas categorised ASGS-RA 4 that are not on a populated island that is separated from the mainland in the ABS geography and is more than 5km offshore.
MM 7	All other areas – that being ASGS-RA 5 and areas on a populated island that is separated from the mainland in the ABS geography and is more than 5km offshore.

FRAME


Indonesia
Java Sea
Makassar
Banda Sea
PAPUA
Papua New Guinea
Lae
EAST JAVA
BALI
WEST NUSA TENGGARA
EAST NUSA TENGGARA
Timor-Leste
Arafura Sea
Port Moresby
Solomon Sea
Timor Sea
Darwin
Cairns
NORTHERN TERRITORY
Townsville
Coral Sea
Mackay
QUEENSLAND
Alice Springs
Australia
WESTERN AUSTRALIA
Brisbane
Gold Coast

FRAME


Australia
WESTERN AUSTRALIA
SOUTH AUSTRALIA
NEW SOUTH WALES
VICTORIA
TASMANIA
Perth
Mandurah
Bunbury
Adelaide
Great Australian Bight
Brisbane
Toowoomba
Gold Coast
Newcastle
Sydney
Canberra
ACT
Melbourne
Hobart

FRAME


KALIMANTAN
SOUTH SULAWESI
Indonesia
Makassar
Bandā Sea
PAPUA
Bismarck Sea
Papua New Guinea
Lae
Manokwari
Arafura Sea
Port Moresby
Solomon Sea
BALI
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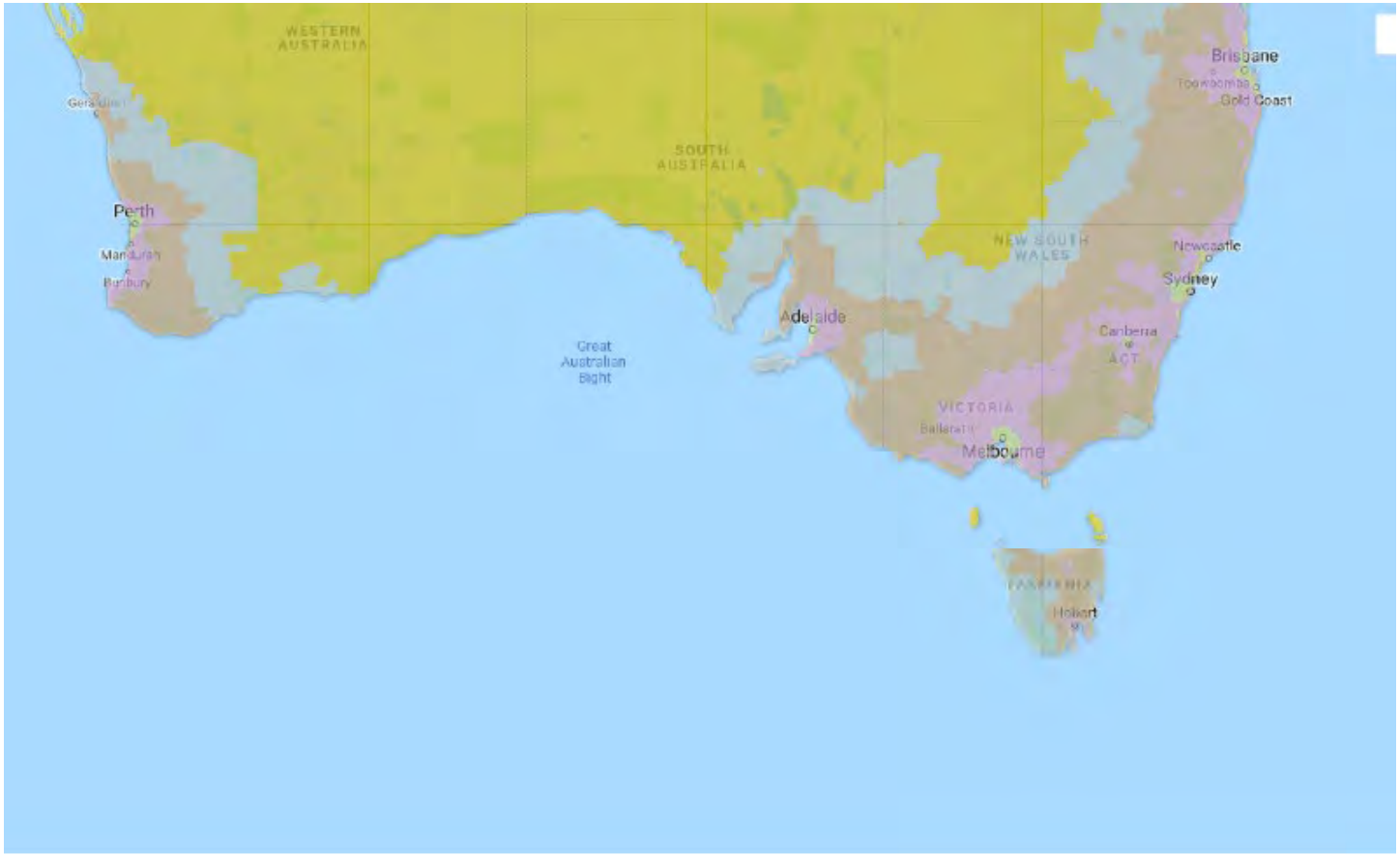
Brisbane

FRAME


WESTERN AUSTRALIA
SOUTH AUSTRALIA
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Toowoomba
Gold Coast
Newcastle
Sydney
Canberra
ACT
Melbourne
Hobart

FRAME

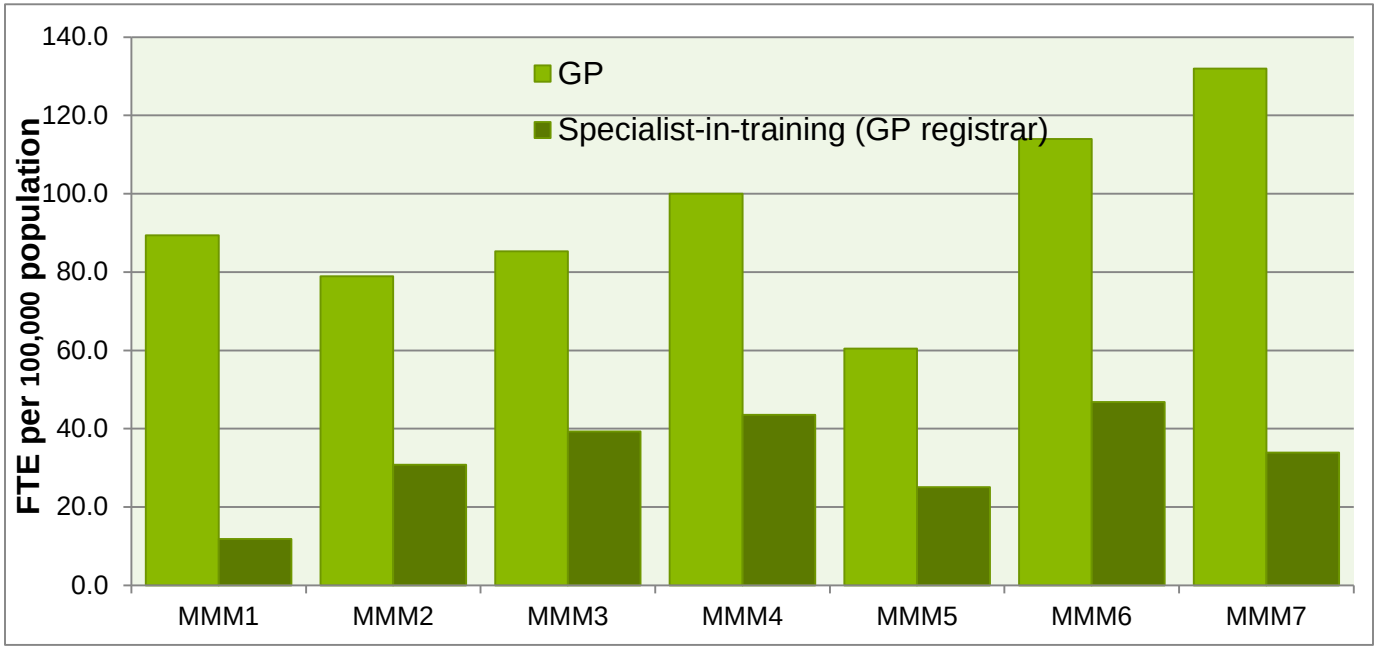
Australian Population estimates by RA (ABS 2019)

	2008	2008 RA %	2018	2018 RA%	Change 2008-2018 Number	%
Major Cities of Australia (RA1)	14,895,703	71.3	18,003,544	72	3,107,841	20.9
Inner Regional Australia (RA2)	3,935,140	18	4,445,356	17.8	510,216	13
Outer Regional Australia (RA3)	1,926,433	8.5	2,052,366	8.2	125,933	6.5
Remote Australia (RA4)	293,621	1.2	291,213	1.2	-2,408	-0.8
Very Remote Australia (RA5)	198,302	0.9	200,381	0.8	2,079	1
TOTAL AUSTRALIA	21,249,199	100	24,992,860	100	3,743,661	17.6

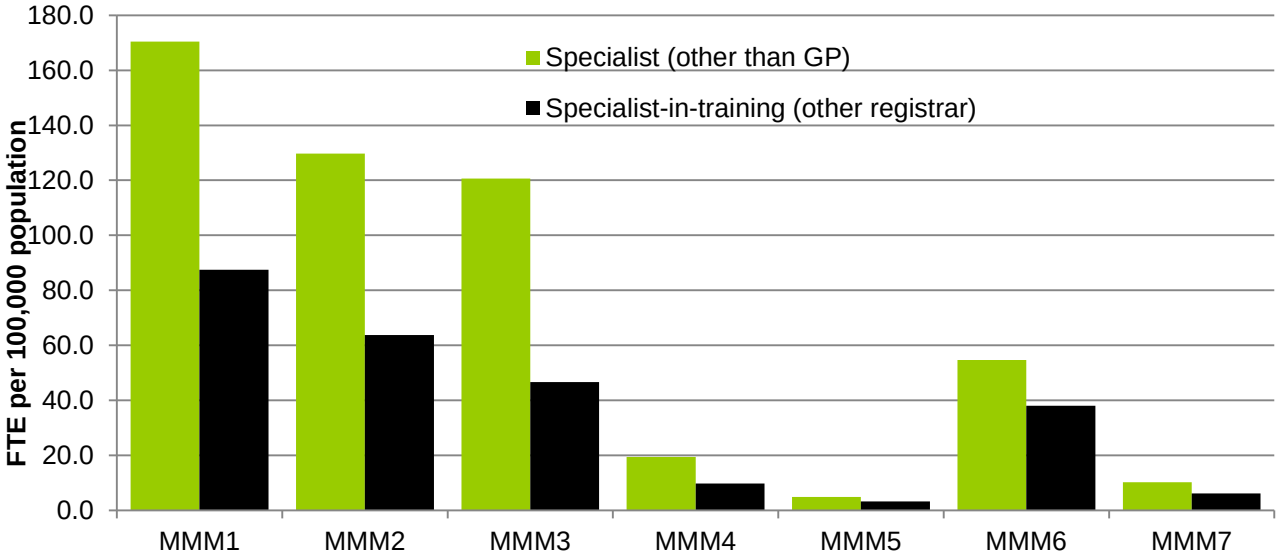
Australian Bureau of Statistics www.abs.gov.au
3218.0 - Regional Population Growth, Australia, 2017-18

FRAME

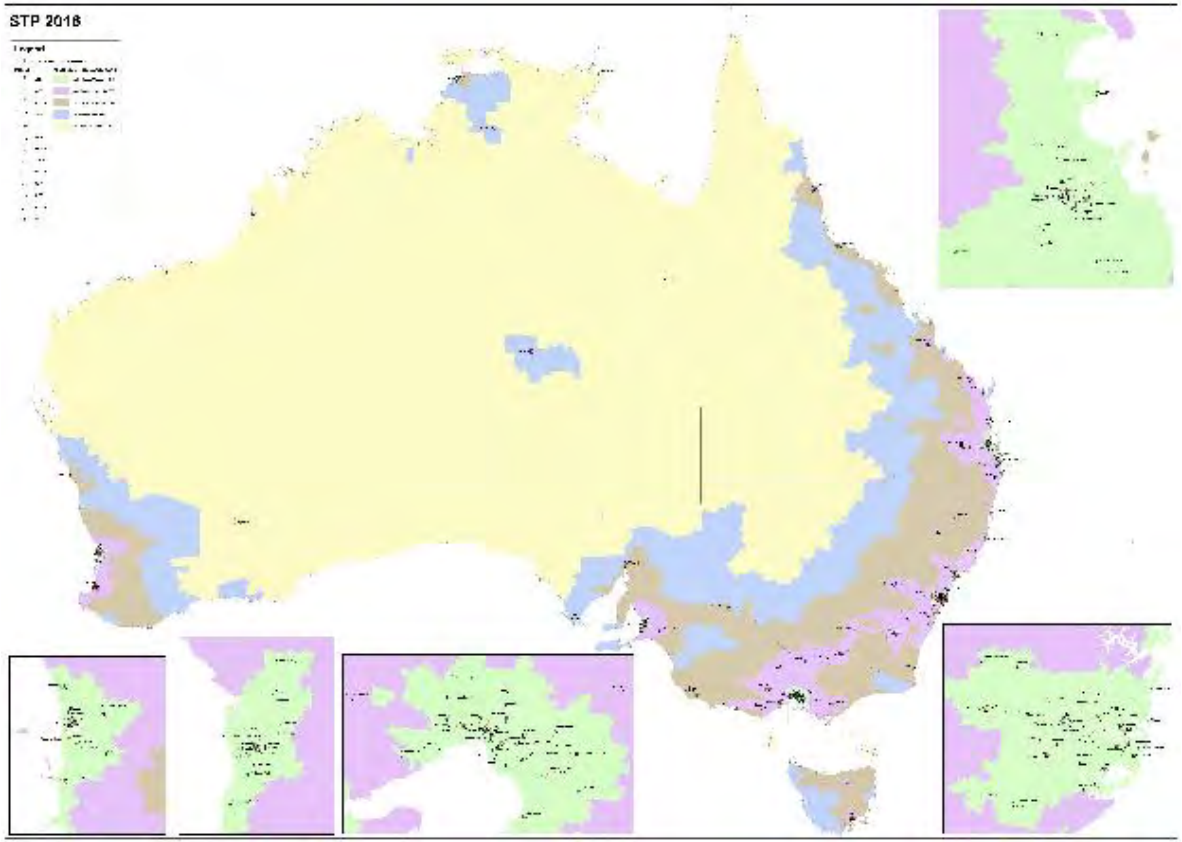
FTE RATE: GPS & GP REGISTRARS



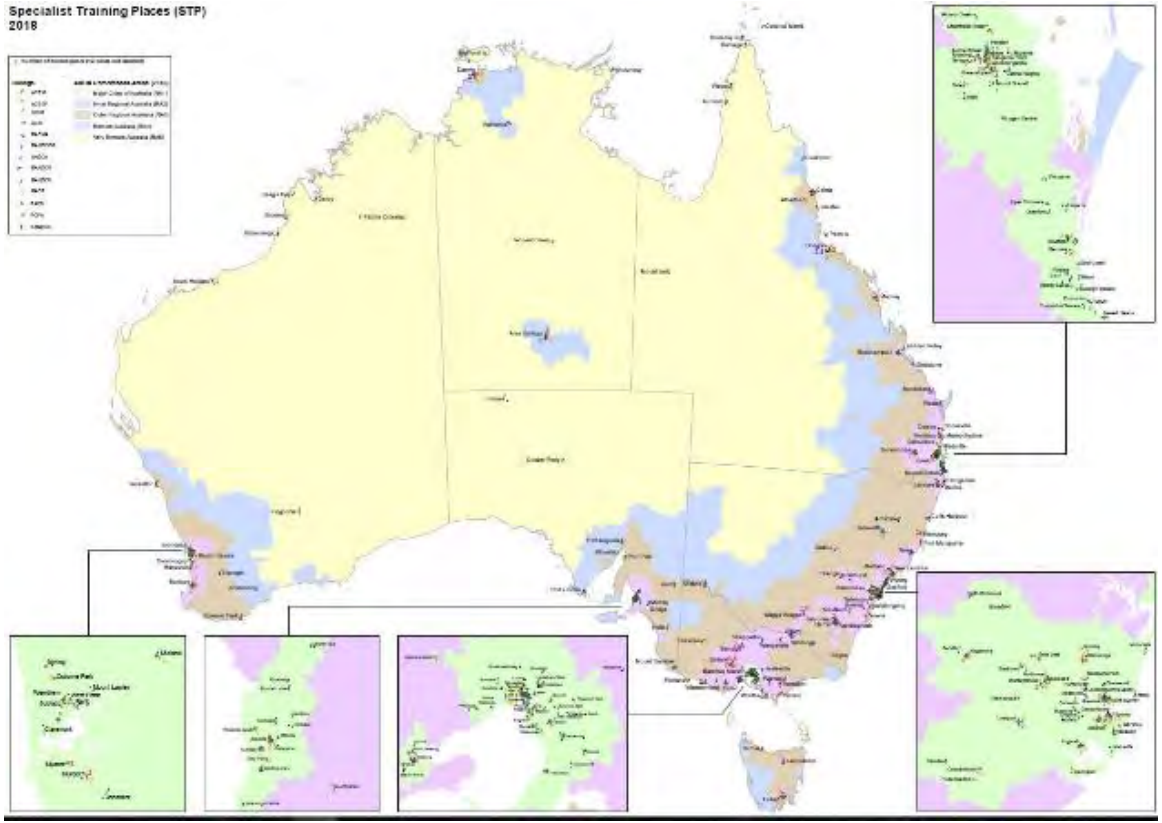
FTE RATE: SPECIALISTS & SPECIALISTS IN TRAINING



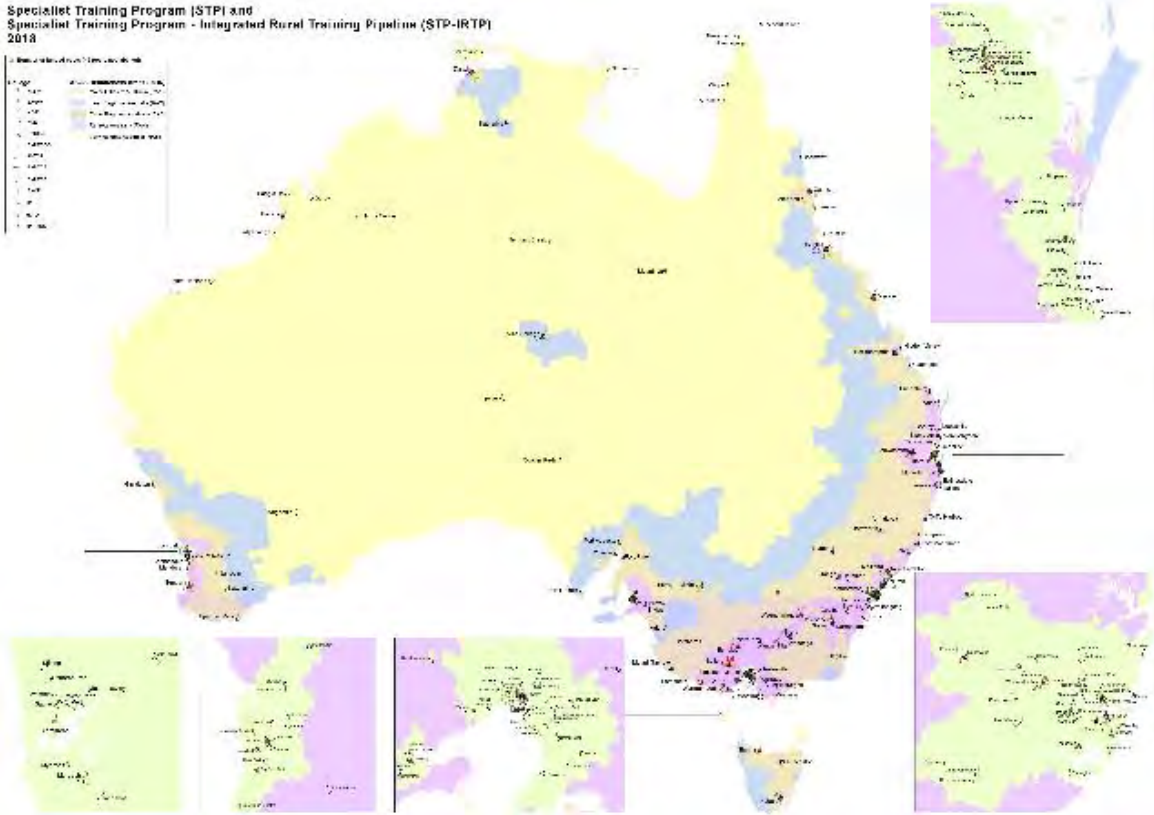
Distribution of Specialist Training Posts 2016 (pre rural targets)



Distribution of Specialist Training Posts: Standard STP positions 2018



Distribution of STP (including IRTP-STP and Tasmanian Program)



MDANZ – Medical Schools Outcomes Database, National Data Report 2018
Career intentions on graduation (58% response rate for 2017)

Table 21. First preference of specialty for future practice

First preference specialty of future practice	2013			2014			2015			2016			2017		
	Number	Per cent	Rank (in year)	Number	Per cent	Rank (in year)	Number	Per cent	Rank (in year)	Number	Per cent	Rank (in year)	Number	Per cent	Rank (in year)
Adult Medicine/ Internal Medicine/ Physician	456	17.6	2	474	19.5	1	391	19.8	1	428	19.3	1	390	18.5	1
General Practice	469	18.1	1	392	16.1	3	351	17.8	2	356	16.0	2	349	16.5	2
Surgery	440	16.9	3	393	16.2	2	303	15.3	3	342	15.4	3	317	15.0	3
Anaesthesia	193	7.4	6	183	7.5	6	160	8.1	6	221	10.0	4	226	10.7	4
Paediatrics and Child Health	264	10.2	4	249	10.2	4	189	9.6	4	219	9.9	5	189	9.0	5
Emergency Medicine	229	8.8	5	185	7.6	5	168	8.5	5	206	9.3	6	181	8.6	6
Obstetrics and Gynaecology	167	6.4	7	181	7.4	7	122	6.2	7	148	6.7	7	138	6.5	7
Psychiatry	82	3.2	8	74	3.0	8	74	3.7	8	74	3.3	8	84	4.0	8
Intensive Care Medicine	59	2.3	9	64	2.6	10	39	2.0	10	53	2.4	9	54	2.6	9
Ophthalmology	55	2.1	10	69	2.8	9	29	1.5	11	41	1.8	10	45	2.1	10
Radiology	51	2.0	11	54	2.2	11	53	2.7	9	39	1.8	11	43	2.0	11
Dermatology	44	1.7	12	42	1.7	12	22	1.1	12	24	1.1	12	25	1.2	12

https://medicaldeans.org.au/data/medical-schools-outcomes-database-reports/

FRAME

Table 16. Career intention: first preference of region of future practice for students preferring to practice in Australia

First preference region of future practice	2013		2014		2015		2016		2017	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Capital city	1,819	66.2	1,693	69.9	1,240	63.3	1,408	65.1	1,342	64.2
Major urban centre	427	15.5	352	14.5	367	18.7	361	16.7	365	17.5
Regional city or large town	335	12.2	266	11.0	231	11.8	266	12.3	262	12.5
Smaller town	111	4.0	78	3.2	84	4.3	97	4.5	87	4.2
Small community	54	2.0	33	1.4	36	1.8	32	1.5	35	1.7
Total	2,746	100.0	2,422	100.0	1,958	100.0	2,164	100.0	2,091	100.0

https://medicaldeans.org.au/data/medical-schools-outcomes-database-reports/

FRAME

Table 7. Respondent considers themself to come from a rural background

Rural Background	2014		2015		2016		2017	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Yes	474	19.5	467	23.3	539	23.9	508	23.7
No	1,961	80.5	1,538	76.7	1,719	76.1	1,638	76.3
Total	2,435	100.0	2,005	100.0	2,258	100.0	2,146	100.0

https://medicaldeans.org.au/data/medical-schools-outcomes-database-reports/

FRAME

Plan for a National Medical Workforce Strategy

A National Medical Workforce Strategy is necessary to guide long-term, collaborative medical workforce planning across Australia. The Strategy will match the supply of general practitioners, medical specialists and consultant physicians to predicted medical service needs and will involve consultation with a range of stakeholders. Health Ministers will fund the development of a National Medical Workforce Strategy. This will include sharing of data across Commonwealth and other jurisdictions to support the strategy.

It is expected that the Strategy will address several system-level issues including:

- **the number and distribution of specialist training positions and how these might be better aligned to community needs**
- **access to the full range of medical services, including maternity services, in regional, rural and remote areas**
- **the current reliance on overseas trained doctors to fill specific workforce shortages and how Australia can improve self-sufficiency in medical workforce development**
- **integration of medical care between settings and professions**
- **improving workplace culture and doctor wellbeing**
- **the under-representation of Aboriginal and Torres Strait Islander doctors in the medical workforce.**

A Steering Committee has been established under the National Medical Training Advisory Network to guide this work.

COAG Health Council Communique 8 March 2019
https://www.coaghealthcouncil.gov.au/Portals/0/Final%20CHC%20Communique_080319.pdf

FRAME

AMA response to proposal for National Medical Workforce Strategy

The AMA congratulates COAG Health Ministers who today agreed to work collaboratively to fund, develop, and implement a new strategy for a national medical workforce to meet Australia's future healthcare needs.

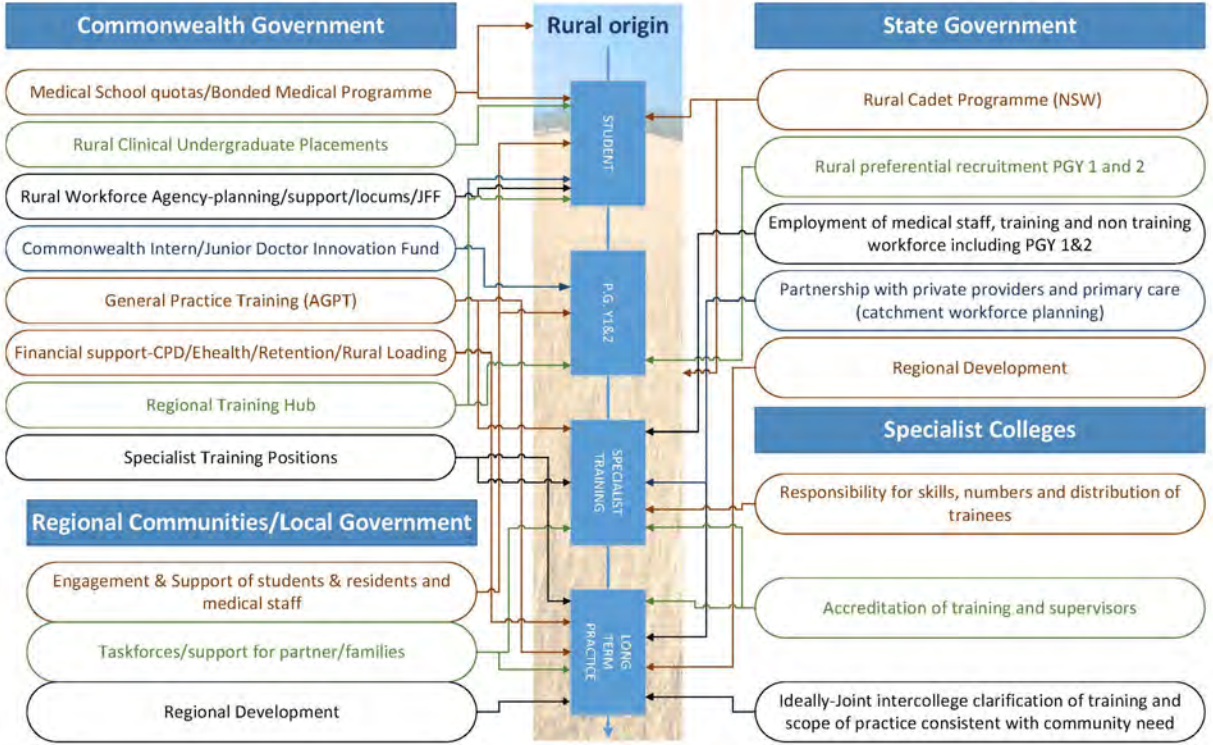
The AMA Summit also called for:

- better support for generalism;
- a focus on matching training with community need;
- more opportunities for specialist training in rural areas;
- the development of a strong rural training pathway; and
- supporting careers in undersupplied specialties.

Extracts from AMA response to COAG Health Council announcement
https://ama.com.au/media/new-national-medical-workforce-strategy-welcome-long-overdue

FRAME

Stakeholders & their levers in the rural training pathway



May J, Walker J, McGrail M, Rolley F. It's more than money: policy options to secure medical specialist workforce for regional centres. *Australian Health Review* 41(6) 698-706
https://doi.org/10.1071/AH16159

FRAME

SHARED POSITIONS UWA

Tracey Isidori & June Foulds

FRAME

Collaborations addressing workforce challenges – RCSWA

The Kalgoorlie Intervention

Tracey Isidori - Project Officer

WESTERN AUSTRALIAN REGIONAL TRAINING HUBS

WA Regional Training Hubs
hubs@rcswa.edu.au

The Rural Clinical School of Western Australia

THE UNIVERSITY OF WESTERN AUSTRALIA

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

Kalgoorlie and surrounding regions at risk

WA Regional Training Hubs
hubs@rcswa.edu.au

BACKGROUND:

- Kalgoorlie and surrounding areas was identified as a high risk area after the loss of many General Practitioners in the region and the breakdown of communication between various health professional networks.

- Kalgoorlie, is a city in the Goldfields-Esperance region of Western Australia

- Located 595 km east-northeast of Perth
  Population: 30,059

Regional Services Program Officer

RESPONSE:

- August 2018 a meeting was convened between five WA based health agencies to develop a strategy that would help support the local medical services
- Aim being to rebuild social capital amongst the medical and wider clinical community.
- Five agencies involved:
  - ❖ Rural Health West (RHW)
  - ❖ Rural Clinical School of WA (RCSWA)
  - ❖ WA Primary Health Alliance (WAPHA)
  - ❖ Western Australian General Practice Education & Training (WAGPET)
  - ❖ Western Australian Country Health Service (WACHS)

Regional Services Program Officer

WA Regional Training Hubs
hubs@rcswa.edu.au

OUTCOME:

- Establish a Kalgoorlie based Health Professional Network with a locally employed Project Officer (funded by all parties and employed by all parties involved)
- Focus would be to provide many of the key functions previously undertaken by the GP Network
- This role would be responsible for:

  - ❖ Establishment and management of the health professional network
  - ❖ Preparation of strategic action plans led by the steering group.
  - ❖ To build collegiality across health professions
  - ❖ To support networking & build cohesive workforce across clinical professions.
  - ❖ Promote communication & interaction across hospital & primary health sectors.
  - ❖ Coordinate education and social events to facilitate communication, discussion and interaction on key medical & health issues facing the region

Regional Services Program Officer

WA Regional Training Hubs
hubs@rcswa.edu.au

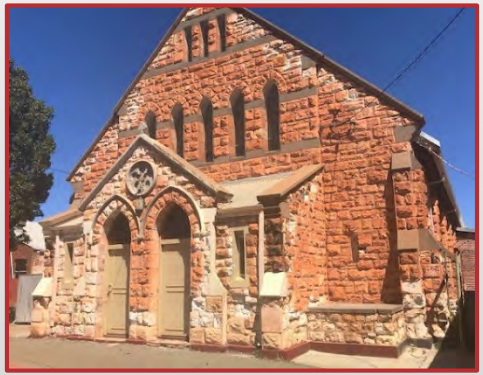
PROGRESSION TO DATE:

- Project Officer Job Description document drafted and endorsed
- Position advertised in April 2019
- Eleven applicants applied for the position
- Interviews to be conducted early May
- Position to commence in June 2019

Regional Services Program Officer

WA Regional Training Hubs
hubs@rcswa.edu.au

Thank you



Australian College of Rural & Remote Medicine

WORLD LEADERS IN RURAL PRACTICE

ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the traditional owners of lands across Australia in which our members and staff work and live, and pay respect to their elders past present and future.

Collaborations addressing workforce challenges – RCSWA

June Foulds

Rural Generalist Co-ordinator WA

WA Regional Training Hubs
hubs@rcswa.edu.au

The Rural Clinical School of Western Australia

THE UNIVERSITY OF WESTERN AUSTRALIA

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

TWO ORGANISATIONS

Australian College of Rural and Remote Medicine (ACRRM)

The Rural Clinical School of WA (RCSWA) Regional Training Hubs (HUBS)

WA Regional Training Hubs
hubs@rcswa.edu.au

The Rural Clinical School of Western Australia

THE UNIVERSITY OF WESTERN AUSTRALIA

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

With One Mantra

We think regional, we think rural, we think remote!

WA Regional Training Hubs
hubs@rcswa.edu.au

The Rural Clinical School of Western Australia

THE UNIVERSITY OF WESTERN AUSTRALIA

THE UNIVERSITY OF NOTRE DAME AUSTRALIA

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

We do this by

Supporting Medical Students, Rural Health Clubs, Practices, Hospital based Junior Doctors, GP Registrars and GP Supervisors

Actively engaging with Colleges, Agencies and individuals who work within the medical training space in WA, including AMA and WA Primary Health Alliance.

Raising the profile of both ACRRM and HUBS locally

WA Regional Training Hubs
hubs@rcswa.edu.au

The Rural Clinical School of Western Australia
THE UNIVERSITY OF WESTERN AUSTRALIA
THE UNIVERSITY OF NOTRE DAME AUSTRALIA

Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

Our Cross Collaborations

Rural Vocational Training Scheme , HUBS, ACRRM, Rural Health West, WA Country Health Service, Regional Aboriginal Medical Services, – working together to attract Doctors to some of the most remote, medically disadvantaged communities in WA

WAGPET, HUBS, ACRRM, WA Country Health Service – working together to identify training posts for the future medical workforce

HUBS, ACRRM, WAGPET, RACGP, Rural Health West, WA Country Health Service, Post Graduate Medical Council of WA – working together at local Career Expos, Junior Doctor events, Medical Student events, to promote rural medicine as a preferred career choice.

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Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

PROGRESSING TOWARDS A RURAL BASIC TRAINING PATHWAY IN VICTORIA

Michael Nowotny

FRAME

MONASH University

MONASH RURAL HEALTH

BUILDING A REGIONAL PAEDIATRIC TRAINING PROGRAM IN VICTORIA

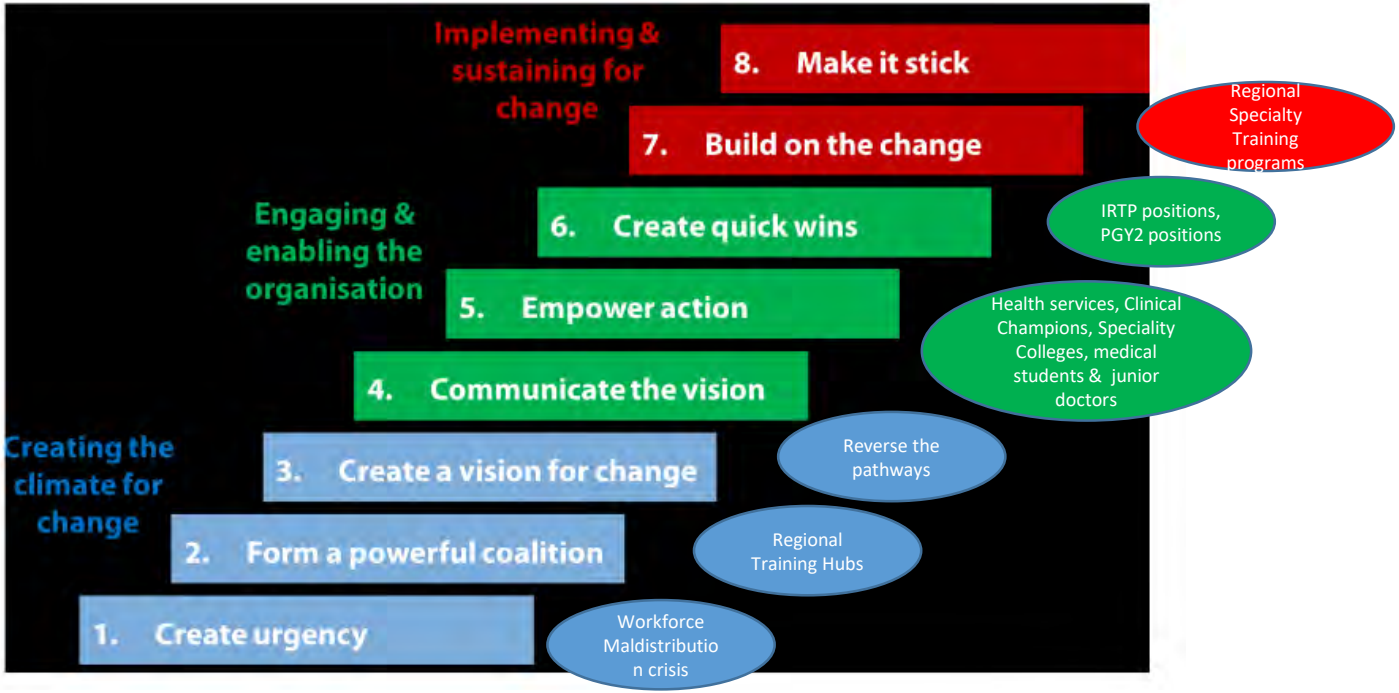
ASSOC PROF MICHAEL NOWOTNY

DIRECTOR GIPPSLAND REGIONAL TRAINING HUB

KOTTER'S EIGHT STAGES

Where are we on the journey?

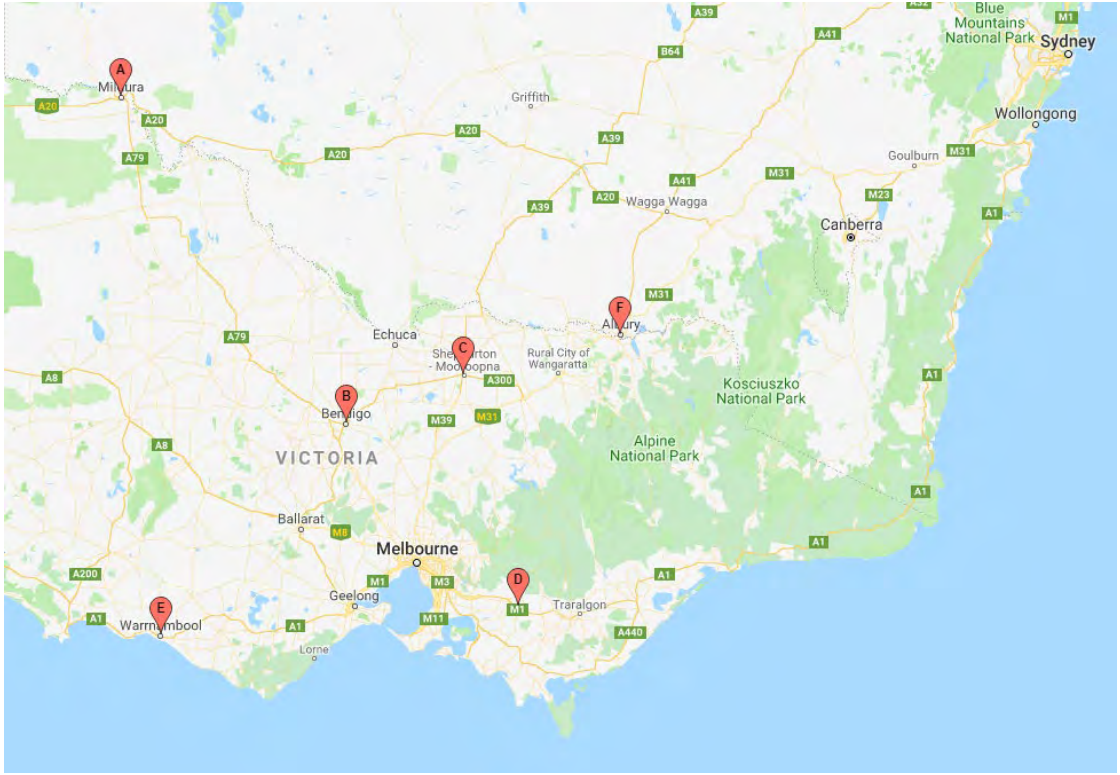
Leading Change: Why Transformation Efforts Fail



STEPS TO BUILDING A REGIONAL TRAINING NETWORK

1. Audit existing training positions ✓
2. Establish dialogue with key stakeholders ✓
    - Rural Health Services
    - Metro Health Services
    - DHHS
    - DOH
    - Speciality Colleges
    - Trainees
3. Identify and engage clinical champions ✓
4. Expand PGY2 positions✓
5. Excellent supervision and mentorship ✓
6. Attract and retain junior medical staff from Internship ✓

SOUTHERN REGIONAL TRAINING HUBS ALLIANCE



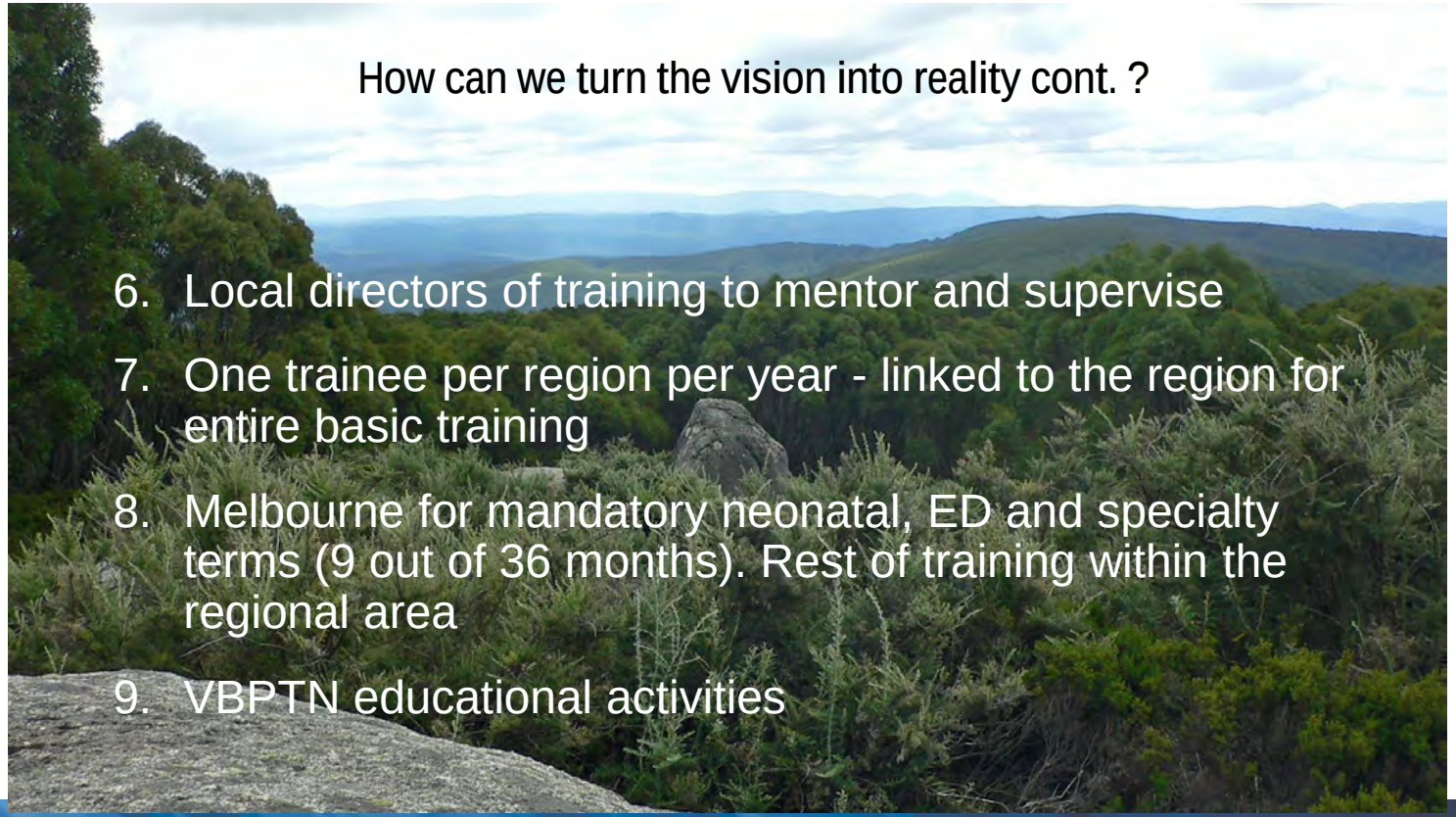
A. Monash University's North West Victoria Regional Training Hub (**Mildura**)
B. Monash University's North West Victoria Regional Training Hub (**Bendigo**)
C. University of Melbourne's Goulburn Valley Regional Training Hub (**Shepparton**)
D. Monash University's Gippsland Regional Training Hub (**Warragul**)
E. Deakin University's Western Victoria Regional Training Hub (**Warrnambool**)
F. UNSW (Sydney) Border Regional Training Hub (**Albury**)

REGIONAL PAEDIATRIC TRAINING IN VICTORIA

How can we turn the vision into reality?

1. Maintain Rural Secondment rotations
2. Additional FTE funding that follow trainees
3. Fund administration of the VBPTN process at an independent site
4. Rural subcommittee of VBPTN in charge of selection
5. Divide Victoria up based on regional opportunity and hub locations
   - West(Ballarat/ Warrnambool)
   - Northwest(Bendigo/Mildura)
   - North(Shepparton/Echuca)
   - Border(Albury/Wodonga/Wangaratta)in cooperation with NSW health
   - Gippsland(Warragul/Traralgon/Sale)

REGIONAL PAEDIATRICS TRAINING IN VICTORIA

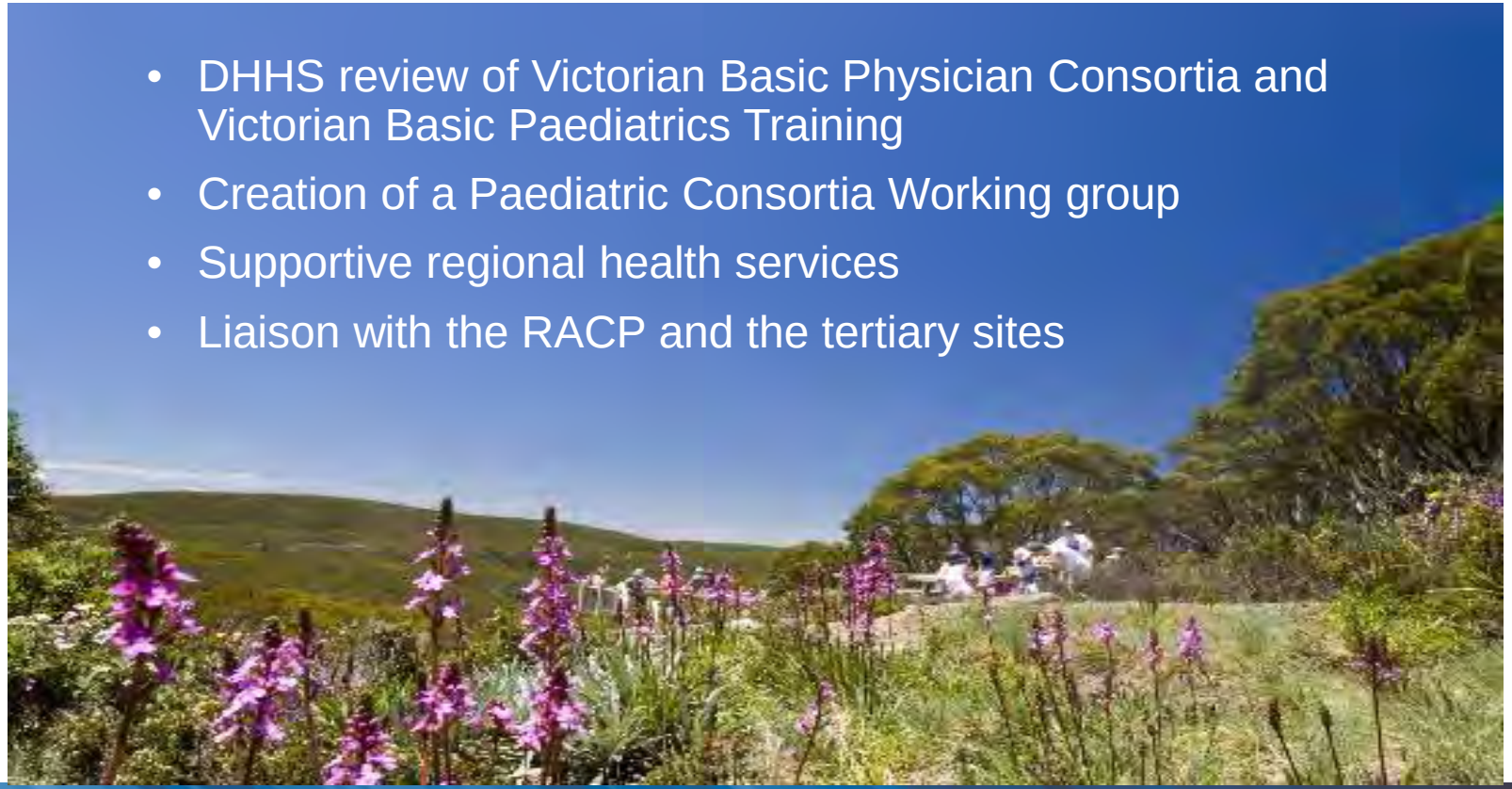


How can we turn the vision into reality cont. ?

6. Local directors of training to mentor and supervise
7. One trainee per region per year - linked to the region for entire basic training
8. Melbourne for mandatory neonatal, ED and specialty terms (9 out of 36 months). Rest of training within the regional area
9. VBPTN educational activities

WHERE TO FROM HERE?

- DHHS review of Victorian Basic Physician Consortia and Victorian Basic Paediatrics Training
- Creation of a Paediatric Consortia Working group
- Supportive regional health services
- Liaison with the RACP and the tertiary sites



DR PATHWAY: A SOUTHERN REGIONAL TRAINING HUBS COLLABORATION

Mimi Zilliacus & Amy Swart

FRAME

DR PATHWAY

VISION

ABOUT US

BETA RELEASE

Dr Pathway

ABOUT US

Southern Regional Training Hubs Alliance

SHORT BIO

MEMBERS

- Border Regional Training Hub, UNSW Sydney, Albury
- Gippsland Regional Training Hub, Monash University Waragul
- Goulburn Valley Regional Training Hub, University of Melbourne, Shepparton
- North West Victorian Regional Training Hub, Monash University, Bendigo
- Western Victorian Regional Training Hub, Deakin University, Warrnambool
- Tasmanian Regional Training Hub, University of Tasmania, Burnie

WHY, WHAT, HOW

- The alliance started with the Victorian Universities who have a long history of working together, which has always been important because we have towns where our students all learn together
- Came to include UNSW and UTAS because Albury is a Victorian health service and several College training regions include VIC and TAS
- We meet officially 3-4 times a year with all Clinical Directors, Managers, DoH, DHHS, RWAV, MCCC and AMA Vic
- We collaborate, coordinate and share ideas

DR PATHWAY

VISION

ABOUT US

BETA RELEASE

Dr Pathway

DR PATHWAY

- A web-based app designed to help users explore rural training opportunities
- Freely available

LIVE DEMO

THE PROJECT

http://staging.drpathway.org.au/

THE PROJECT

- Fantastic engagement with DHHS
- Students and junior doctors very excited
- Biggest challenges have been content because it's a new format

DR PATHWAY

VISION

ABOUT US

BETA RELEASE

Dr Pathway

BETA RELEASE

11th May 2019

BETA VERSION

BETA VERSION

- Currently covers most of rural and regional Victoria and Tasmania
- Allows us to demonstrate a viable product and get feedback for future development and content
- Content is being entered in phases which will continue after the release

DR PATHWAY

VISION

ABOUT US

BETA RELEASE

Dr Pathway

VISION

Dr Pathway covers the whole of Australia

NEXT STEPS

NEXT STEPS

- Dr Pathway has already been designed to be future proof and scalable but some additional building would make it even better at mapping the complexities of Commonwealth and State programs, particularly for GP training
- Develop appropriate partnerships and future governance structures for a national roll out. This should include the PMCs and state departments of health in some way
- Monitor, evaluate and adapt

A STATE WIDE COLLABORATION SUPPORTING MEDICAL TRAINING ACROSS REGIONAL AND RURAL QLD

Marcelle Crawford & Debbie Croyden

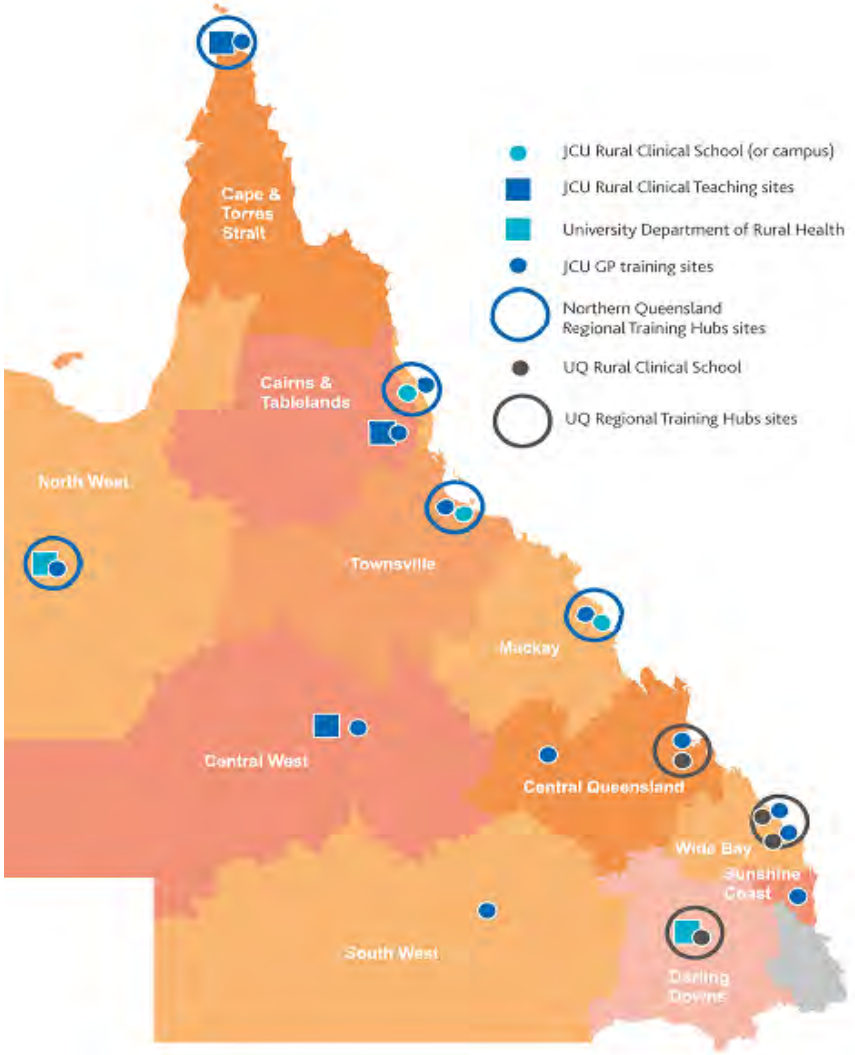
FRAME

JAMES COOK UNIVERSITY AUSTRALIA

THE UNIVERSITY OF QUEENSLAND AUSTRALIA

Partnerships

A state wide collaboration supporting medical training across regional, rural and remote Queensland


JCU Rural Clinical School (or campus)
JCU Rural Clinical Teaching sites
University Department of Rural Health
JCU GP training sites
Northern Queensland Regional Training Hubs sites
UQ Rural Clinical School
UQ Regional Training Hubs sites
Cape & Torres Strait
Cairns & Tablelands
North West
Townsville
Mackay
Central West
Central Queensland
Wide Bay
Sunshine Coast
South West
Darling Downs

Regional and Rural Medical Training State Forum

Tools & Reports generated via partnership

1. Positions Data Spreadsheet

2. Specialty Pathway Spreadsheets

3. Training Analyses in Rural, Remote and Regional Queensland Reports

			2018 northern Qld RTH Intern to Registrar positions						Position changes following on from Feb 2018	2019 northern Qld RTH Training positions						Position changes following on from Feb 2019
			Data Valid Date: Feb 18							Data Valid Date: Feb 19						
			PGY1	PGY2/3	PGY4+	Registrar Training Program				PGY1	PGY2/3	PGY4+	Registrar Training Program			
Specialty/ Department	Career Pathway level (pre-vocational training) &Specialty (vocational training)	Facility	Intern	JHO SHO	PHO	Basic	Advanced	Comments		Intern	JHO SHO	PHO	Basic	Advanced	Comments	
Psychiatry	**Psychiatry**	Mackay Base Hospital	1	2	2	5	0			1	2	3	5	2	7 registrars unsure split between basic and advanced	
	Psychiatry	Mackay Mater	0	0	0	0	0			0	0	0	0	0		
	Psychiatry	The Townsville Hosp.	2	7	7	9	4		Position numbers have been confirmed with Sarah Beaney 5/3/18 3 STP positions: Child & Adolescent; Aboriginal & Torres Strait Islander Mental Health; Neuropsychiatry	2	7	7	3	29		
	Psychiatry	Townsville Private Clinic	0	0	0	1	0			0	0	0	1	0		
	Psychiatry	Cairns Hospital	2	6	5	6	9	5 current training positions vacant. Relying on locums.	28.03.18 Basic (Year 1) and Proficient (Year 2 & 3) combined in one colum (Basic) 9 trainees in total. Advanced (Year 4 & 5) 5 trainees in total. Includes 2 STP (Basic trainees - Yr 1-3) and 2 RTP, 1 x Proficient (Year 2) and 1x Advanced (Yr 4). 9 vacant trainee positions currently.	2	6	7	7	12	28 registrar positions incl 3 relievers 25 Accredited trainee positions, 19 trainees plus 2 GP trainees,	
	Psychiatry	Mt Isa Hosp	0	0	0	0	0			0	0	0	0	0		

SPECIALTY	SUB-SPECIALTY	Basic Level Adult Psychiatry rotation (mths)	Psychiatry Acute Setting	Consultation - Liaison Psychiatry (mths)	Child & Adolescent Psychiatry (mths)	Rotation in: Addiction Psychiatry (mths)	Rotation in: Adult Psychiatry (mths)	Rotation in: Forensic Psychiatry (mths)	Rotation in: Indigenous Psychiatry(mths)	Rotation in: Psychiatry of old age (mths)	Consultation - Liaison Psychiatry (mths)	Child & Adolescent Psychiatry (mths)	Addiction Psychiatry (mths)	Adult Psychiatry (mths)	Forensic Psychiatry (mths)	Indigenous Psychiatry (mths)	Psychiatry of old age (mths)	Psycho therapies (mths)	Research/ medical education/ medical administration Psychiatry (mths)
PSYCHIATRY	Psychiatry	Stage 1		Stage 2							Stage 3								
		12 (includes 6 months in acute setting)		6	6	+ any 2 of these rotations = 12 mths					Any 4 of these rotations = 24 mths								
						6	6	6	6	6	6	6	6	6	6	6	6	6	6
The Townsville Hospital		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cairns Hospital		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mackay Base Hospital		✓	✓	✓	✓	✓	✓			✓	✓	✓	✓	✓			✓		
Rockhampton CQ MHAODS (CQHHS wide service)		✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓		✓		
Bundaberg Hospital		✓	✓	✓	✓		✓				✓	✓		✓					
Hervey Bay/Maryborough Hospitals		✓	✓	✓	✓		✓	*			✓	✓		✓	*				
Toowoomba Hospital		✓	✓	✓	✓	✓	✓	✓		✓	*	✓	✓	✓	✓		✓		

Networked Pathways

3-YEAR TRAINING PATHWAY ROTATIONS: The Townsville Hospital Rotation		
Year 1 (interchangeable with Year 2 or 3)	**Year 2 (interchangeable with Year 1 or 3)**	**Year 3 (interchangeable with Year 1 or 2**
12 months	12 months	12 months
TTH	LCCH	TTH

The Townsville Hospital Rotation including Royal Darwin Hospital		
Year 1 (interchangeable with Year 2 or 3)	**Year 2 (interchangeable with Year 1 or 3)**	**Year 3 (interchangeable with Year 1 or 2**
12 months	12 months	12 months
TTH	LCCH	Royal Darwin Hospital

LCCH Rotation		
Year 1 (interchangeable with Year 2 or 3)	**Year 2 (interchangeable with Year 1 or 3)**	**Year 3 (interchangeable with Year 1 or 2**
12 months	12 months	12 months
LCCH	LCCH	Cairns Hospital (or Mackay Hospital)

Training Analyses in Rural, Remote & Regional Queensland Reports

- Questions to help guide pathway analysis under categories of recruitment & selection, training pathway, allocation of trainees
- Report template (introduction, summary of analysis, challenges, enablers, key recs)
- Key interviewees

What has been achieved?

- Establishment of a Regional and Rural Medical Training State Forum
- The development of state wide common data collection tools
- Built repository of names of champions of respective specialties across Queensland
- Developed Training Analyses Reports
- State wide updates

Learnings so far…

- 80 to 90% of the work needs to occur at the local level
- Working in partnerships is the key
- Respect and acknowledge the achievements already made
- Being mindful of how the collaborative partnership of Regional Training Hubs is communicated

What next?

- Create more networked specialty training pathways with regional focus
- Work more with Colleges on activity in our region
- Developing the partnership with the jurisdiction beyond membership of the state wide forum

DESTINATION MEDICINE PODCASTS

Jennifer Rodwell

FRAME

DESTINATION MEDICINE

Regional Training Hubs – An Australian Government Initiative

A RTH collaborative project

University of Sydney	Broken Hill	UDRH FAR WEST NSW RTH
University of Sydney	Dubbo Orange	SRH WESTERN NSW RTH
University of Sydney	Lismore Northern	NSWLHD LISMORE RTH
University of Notre Dame	Wagga Wagga	RCS Riverina RTH

Purpose

To contribute to a sustainable rural medical workforce by

- **creating a podcast library of conversations**
- **provide information in a new and creative way**
- **motivate and assist individuals in making informed career pathway decisions with confidence**

This project is proposing to make an impact by presenting information in a professional but personal, easily accessible format which will appeal to a younger demographic.

Alignment with

Parameter 7 of the RHMT program: Regional leadership in developing innovative training solutions

Objectives of the RTH:

- **Improve the coordination of the stages of medical training to enable students intending to practise rurally to complete as much of their medical training as possible within regional and rural areas,**
- **Identify students with an interest in practising rurally and facilitate access to networked rural training opportunities at an early stage in their careers,**
- **Strengthen existing, and develop new connections with key stakeholders to improve the continuity of training for medical students/trainees within their region.**

Challenges in choosing a pathway

- Over 23 specialities,
- 81 fields of speciality practice
- 86 speciality titles
- Complexity
- Multiple entry points
- Numerous sources of information
- Perception of seriousness / permanency

Information sources about pathways

- Family / friends
- Websites, Social media, blogs
- Influential leaders and mentors
- Universities, lecturers, supervisors
- Colleagues
- Colleges and professional organisations
- Student clubs
- Workshops, conferences
- Regional training hubs

What is a podcast?

- A set of digital audio files that are available on the internet.
- “Radio’s first cousin”
- One to one - Host and listener
- Library of episodes accessed later
- Show notes
- Opt in via subscription
- 80% accessed on a mobile device

ABC 2018 survey:

- Podcast shows tripled since 2016 – over 700,000
- 62% of people have tried listening to a podcast
- 33% of people have listened in the last month

Why a podcast?

- Affordable
- Simplistic
- Efficient
- Rapidly growing / appropriate for target audience
- Mobile - access and convenience
- Engages with audience through story telling

What makes a quality podcast

- Clear purpose
- Engaging and appropriate title
- Content is paramount
- Only as long as it needs to be
- Good quality audio – a variety of ways to record a conversation
- Identifying your audience
- Tells a story/provides information your audience want to hear
- Has a style that appeals to your audience
- Consistency builds the audience
- Amplification is important

Audience

- Medical students, junior doctors and trainees
- High School students
- Mature age considering a career in medicine

Aiming for broad appeal to present the opportunities and attractiveness of careers in rural medicine to the largest possible audience including individuals who are not actively considering a rural career.

Progress to date

- Producer selection process
- Workshop with BE Media
- Editorial Committee established and meeting regularly
- Pilot project underway with 6 episodes in production
- Launch October RMA19 – invitation to all RTHs to join

Systems and processes developed:

- Introduction and general information document
- Pricing structure
- Episode submission and evaluation process
- Podcast Best Practice Guideline
- Website under construction *destinationmedicine.com.au*
- FAQ

Editorial Committee TOR

Purpose:

To provide a governance framework which ensures editorial consistency and quality of episodes which is coherent with the objectives of the national Regional Training Hubs program

Membership:

Participating RTH's

Objectives

1. Identify minimum quality standard & criteria for proposed episodes
2. Develop and oversee a systematic process of assessment of episode submissions against the minimum standard
3. Review and approval of episodes prior to release
4. Act as a central point of communication with the producers
5. Curate a content calendar
6. Provide a forum for strategic discussions
7. To identify and oversee promotion and marketing
8. Identify opportunities for optimising resources and activities
9. Develop and conduct a process of evaluation

Vision

Participation of all Australian RTH's

Each Hub producing only 2 episodes/year would easily achieve a weekly episode release

Acknowledgement and thankyou

Our progress to date would not have been possible without the generous and professional support of Nick Schildberger.

TRAINING PATHWAYS AND PROFESSIONAL SUPPORT FOR BUILDING A RURAL PHYSICIAN WORKFORCE

Matthew McGrail

FRAME

THE UNIVERSITY OF QUEENSLAND
AUSTRALIA
CREATE CHANGE

Research evidence: Training Pathways and Professional Support for Building a Rural Physician Workforce

Matthew McGrail (UQ RTHs)

Tamworth 2019

UQ RTH – Research (evidence)

Queensland:

- Social Network Analysis (Trainee – Stakeholder connectedness)
- Rural Junior Doctor Training Innovation Fund evaluation
- Mentorship of junior doctors: design and evaluation
- Partnership with Hospital and Health Services: workforce planning
- Longitudinal graduate tracking – training pathways, predictive models
- Critical review of specialty college selection / entry pathways / barriers

National:

- Internship rural preferencing, uptake, longitudinal outcomes
- Generalism: specialty choice decisions
- Generalism: reducing skills mismatch to population need
- Distribution of FGAMS (locally-trained international students)
- **Partnership with RACP: Building a rural physician workforce**

UQ RTH – Research opportunities

April 2018
(junior doctor):

*"I'd love to stay training rurally but I can't –
I must go metro for research opportunities"*

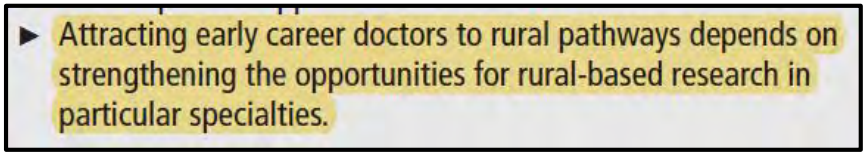
Action:


Original article

Importance of publishing research varies by doctors' career stage, specialty and location of work

Matthew Richard McGrail,[1] Belinda G O'Sullivan,[2] Hollie R Bendotti,[1] Srinivas Kondalsamy-Chennakesavan[3]

Key message:


▶ Attracting early career doctors to rural pathways depends on strengthening the opportunities for rural-based research in particular specialties.

UQ RTH/RCS Response: Numerous research capacity building activities with local health services, across ALL career stages

RTH: Major research project (RACP partnership)

Collaboration (Jul ‘18 - May ‘19): University of Queensland (UQ), Royal Australasian College of Physicians (RACP) and Queensland Rural Medical Service (QRMS).

Focus: The career attraction, intentions, experience and perspectives for physicians and paediatricians to train and work in rural communities.

Objective: To provide national evidence to support rural practice through enhancements for training, supervision, accreditation, incentives and organisations involved thus supporting the building of a rural physician workforce.

Research Projects (Themes)

P1: Observing and characterising the Rural Physician in Practice

P2: The Social Construction of Professional Identity

P3: Mapping Trainee Physician Context, Experience and Intentions

P4: Understanding Supervisor's Context, Experience and Intentions

P5: Principles for a Sustainable Regional and Rural Physician Workforce

Methods & Data

Generation of data:

- Utilises existing national data (Medicine in Australia: Balancing Employment and Life: MABEL, 2008-16) to observe rural physicians (metro comparisons)
- Two new national surveys during October and November 2018 were conducted and collected data directly from RACP's trainees, supervisors and fellows
- A series of in-depth interviews were carried out with relevant stakeholders and key informants, plus RACP's trainees, supervisors and other fellows

Each project's data:

P1: Physician consultants (2016): 165 rural, 978 metro; Physician trainees (2008-16 pooled): 1273 pre-enrolled, 1030 enrolled trainees, 353 early-career physicians

P2: Interviews with 36 key informants across RACP, Commonwealth & State governments, academics, other related rural stakeholders

P3: Surveys from 577 fellows; 20 interviews of rural fellows

P4: Surveys from 282 trainees; 14 interviews of rural and metro trainees

P5: Ongoing 'consultation' with stakeholders; training model development

Project 1: Observing rural physicians (baseline)

Consultants:

- Rural physicians are more likely men, later career stage, overseas-trained & >5 years childhood rural
- Generally, satisfaction high: work hours, variety of work, amount of responsibility, opportunities to use abilities, remuneration and overall satisfaction did not differ from metropolitan physicians
- Rural physician retention decreased for: females

Juniors / trainees:

- Majority are female
- Pre-enrolled physicians have less support and supervision from qualified specialists
- Satisfaction with physical working conditions, opportunities to use abilities, recognition for good work, work hours and overall satisfaction did not differ significantly between rural and metro junior physicians

Project 2: Professional identity “Rural physician”

- General physicians and General paediatricians working rurally share a strong sense of collective identity grounded in ‘general medicine’.
- Variations of nomenclature are contingent upon place and personal preference, most having crafted personalised, context-inflected identities that restore their centrality within their own narratives of identity, within their own lives and within their own communities

- The lack of a readily identifiable, universal name for the Rural Physician identity, may impede efforts by health policy makers and planners to resolve deficiencies of access

Project 3: Physician trainees (rural focus)

- Trainees are generally high in levels of work and life satisfaction regardless of geographical training location
- Less encouraging are the lower satisfaction levels that imply concerns around the administration of their training.
- Greater flexibility in training options and location preferences, as well family friendly policies were emphasised in the data – a myriad of life and social circumstances interact with the training experience.
- Greater duration of (PG) rural training was associated with higher level of agreement with each self-efficacy dimension (of rural practice)
- However, the “fragile environment” of rural training was noted (small teams with higher turnover) – good leadership is key.

Project 4: Physician supervisors (rural focus)

- High quality training sites depend on good leadership, including recognition of training as core business, promoting a culture that allows both training and clinical environments to flourish.
- Flexibility in the accreditation of sites is needed to enable high quality training in diverse settings that are responsive to population needs.
- Multi-level strategies are needed to foster attitudes and practices to reduce the rural/urban divide (of rural training/practice).
- Actions may include: Ensuring that rural physicians have a strong voice on accreditation and other policy committees and formalising relationships between metropolitan and rural areas through training networks.

Project 5: The way forward…

- Aggregating findings and recommendations from Projects 1-4
- Consultation with steering committee, study guests, international models
- Finalising ‘principles’ for stakeholders

Vision:

- ✓ Well supported trainees; well-supported supervisors; leading to well-supported communities.
- ✓ Exceptionally-trained rural general physicians and paediatricians in flourishing practices, with the resources they require, who meet the needs of the local community, 24 hours a day, seven days a week.
- ✓ An attractive career for both the future and current physicians and paediatricians.

Project 5: Foundational principles (for a sustainable regional and rural physician workforce)

1. Grow Your Own: Train Where You Will Practice
2. Trainee Selection Must Recognise and Support Rural Practice
3. Physician Training Must Be Grounded in Community Need
4. Rural Immersion, Not Exposure
5. Regional Medical Practice Optimises the Practice of General Medical
6. Training Models Must Include Service and Academic (Teaching & Research) Components
7. Gaps in the Alignment of Medical Specialist Training [disadvantages rural]

These are being finalised (as of May 2019)

Acknowledgements

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Project directors:
- A/Prof Srinivas Kondalsamy-Chennakesavan (UQ)
- Dr Matthew McGrail (UQ)

Project chairs:
- Prof Sarah Strasser (UQ)
- Prof Charles Gilks (UQ)

Other Theme leaders:
- A/Prof Peter Hill (UQ)
- A/Prof Linda Selvey (UQ)
- A/Prof Di Eley (UQ)
- Dr Remo Ostini (UQ

Study manager:
- Ms Alison Curtis

Other Steering committee:
- Prof Richard Doherty (RACP)
- Ms Robyn Burley (RACP)
- A/Prof Michael Gabbett (UQ, RACP)
- Dr Spencer Toombes (QHealth)
- Dr Ans Van Erp (QHealth)
- Dr Hwee Sin Chong (QHealth)

Other researchers:
- A/Prof Fran Boyle
- Dr Zoe Dettrick
- Dr Odewumi Adegbija
- Dr Megan Jennaway
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- Dr Vinu Verghis
- Mr Bhaskar Purohit

Thankyou:

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REPORT LAUNCH - BUILDING A RURAL PHYSICIAN WORKFORCE

Steve Flecknoe-Brown

FRAME

THE IMPACT OF ACEM'S NATIONAL PROGRAM ON RURAL & REMOTE EMERGENCY MEDICINE

ACEM - Ian Woodruff, GM, National Programs

FRAME

STP - TRAINING OPPORTUNITIES BEYOND THE ORDINARY

RANZCP - Kathryn Hertrick, Projects Manager, Specialist Training Program

FRAME

The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Specialist Training Program

Presented by: Kathryn Hertrick

OVERVIEW

Specialist Training Program
- 160 of 900 posts available
- 2018 fill rate 95%
- Contract 182 posts

Integrated Rural Training Pipeline
- 34 of 100 posts available
- 2018 fill rate 53%
- 2019 predicted fill rate 76%

Tasmania Project

Support Projects

INTEGRATED RURAL TRAINING PIPELINE (IRTP)

Rotation 2, 2017: Commenced with 14 Posts
Stage 3 and Pathway options

Rotation 2, 2018: Increased to 34 Posts
Pathway only

SITE VISITS

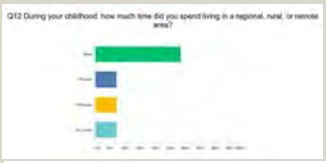
- In rotation 2, 2018 site visits were performed
- Sites funded from 2017 were prioritised

Outcomes

- Raised the profile of STP and the RANZCP
- Restructure of IRTP posts
- Improved understanding of program
- Meeting with regional training hubs
- Engagement with Stakeholders
- Feedback regarding opportunities and challenges
- Identifying success stories

EVALUATION

Recruiting a Suitable Trainee



SUCCESSES & CHALLENGES

Successes

- 3 x Northern Territory Posts
- 13 of 14 original posts are filled
- Producing confident and competent Consultants

Challenges

- Recruitment and filling posts

Psychiatry Interest Forum (PIF)

Free Membership includes:

- Invitations to lectures and workshops
- career guidance
- awards, prizes and grants
- journal articles
- monthly e-newsletter

Current Membership

- 2257 Members
- Launched in 2013 and 18% have entered the training program
- In 2019, 100 members (44%) have entered the training program

https://www.ranzcp.org/membership/psychiatry-interest-forum

PIF OPPORTUNITIES FOR UNIVERSITIES

Small Grants

- available to each university
- host psychiatry-specific education event
- e.g. Medfest

Introduction to Psychiatry workshops

Options for rural destinations in 2019

- Tasmania
- Townsville
- Newcastle

Psychiatry Jobs Hub

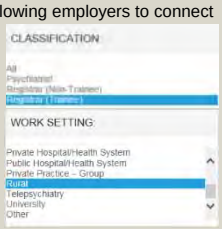
Employer

- post jobs in the place where the most qualified psychiatric professionals will find and apply for them
- have jobs emailed directly to job seekers
- search the database and contact qualified candidates proactively
- choose from a number of different job posting options

Psychiatry Jobs Hub

Job seeker

- filters for job type, specialty, classification, work setting and location
- job alerts
- an anonymous career profile facility, allowing employers to connect with job seekers
- career tools and resources



https://jobs.ranzcp.org/

ABORIGINAL AND TORRES STRAIT ISLANDER PATHWAY PROJECT

PIF	Trainees	Fellows
47	16	7

- Sponsorship of Medical Students to attend AIDA conference
- PIF Introduction to Psychiatry Workshop at AIDA pre-conference
- Annual Trainee Forum
- Examination Preparation Grants
- Mentoring Program
- 2 x IRTP posts in Northern Territory
- Financial support with voluntary repayment to the foundation

WHAT'S NEXT

- 10 Aboriginal and or Torres Strait Islander Trainees at Forum
- 9 Aboriginal and or Torres Strait Islander Trainees at Congress
- Cultural Intelligence throughout a lifetime Symposium
- Promotion of STP and IRTP at Congress

- Prioritise site visits and filling 20 new IRTP posts

Questions

Any Questions?

Thank you

kathryn.hertrick@ranzcp.org

SUCCESSES, CHALLENGES & OPPORTUNITIES IN RURAL SURGICAL TRAINING

RACS - Olivia Hartles, Program Manager, Specialist Training Program

FRAME

Successes, Challenges and Opportunities in Rural Surgical Training

Specialist Training Program

Presented By Olivia Hartles (STP Program Manager), Elaine Tieu (Policy Officer - Rural)

7th May 2019

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

RACS

Introduction to RACS STP

- The RACS STP team consists of:
  - Olivia Hartles – Program Manager
  - Jodie Wall – Senior Project Officer
  - Megan Ursic – Project Officer
- 70 FTE STP surgical trainee posts across mainland Australia
- 8.4 FTE Tasmania surgical posts
- Education Portfolio at RACS, under direction of Professor Julian Archer, Executive General Manager

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS RACS

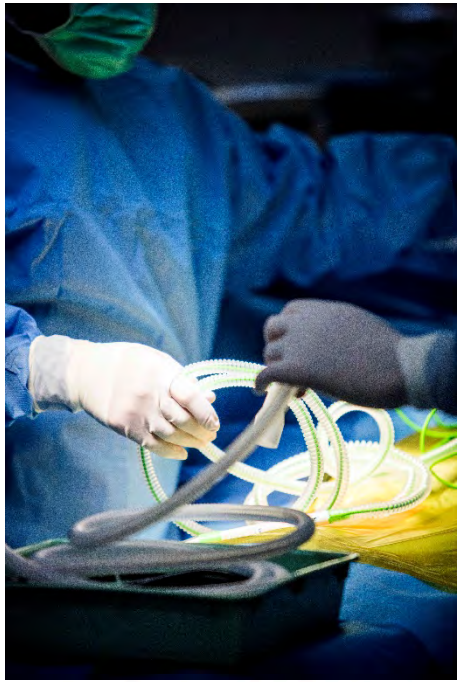
Successes

- From Trainee to Supervisor – Success Stories from Rural Surgeons
- Rural Coach Program
- Rural Workforce Summits

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS RACS

Challenges

- Previous IRTP experience
- Training post accreditation and SET selection
- Coordination between healthcare organisations
- Development and maintenance of effective rural training pathways
- Recognition that greater funding is needed to support a multi-pronged approach
- Ensuring existing funding is able to be co-ordinated and utilised effectively



ROYAL AUSTRALASIAN COLLEGE OF SURGEONS RACS

Opportunities

- RACS STP Business Development Manager
- STP Support Projects
  - Rural Gap Analysis
  - Supporting Surgical Pathways
- Investigating incentives for rural – focused surgical training
- 360 approach to the rural workforce

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS RACS

Thank You!

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rural@surgeons.org

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS RACS

STEPS TOWARDS DESIGNING, FUNDING & IMPLEMENTING AN OPHTHALMOLOGY REGIONAL TRAINING NETWORK

RANZCO - Kristen Bell

FRAME

Steps towards designing, funding and implementing an Ophthalmology Regional Training Network

Dr Kristin Bell

RANZCO

RANZCO | Celebrating our 50th year

THE LEADERS IN COLLABORATIVE EYE CARE

Right to access health services

Australia signed and agreed to

"….recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

- ICESCR Article 12, United Nations General Assembly.

Setting the scene

- Patients in remote, regional and rural areas should have access to the same high standard of health services as those in urban centres including in the field of ophthalmology.
- There is currently an ophthalmology workforce maldistribution in these areas resulting in reduced access to high-level ophthalmic care.
- Access to eye care is disproportionately problematic for Indigenous people, a higher proportion of whom live in rural and remote communities.

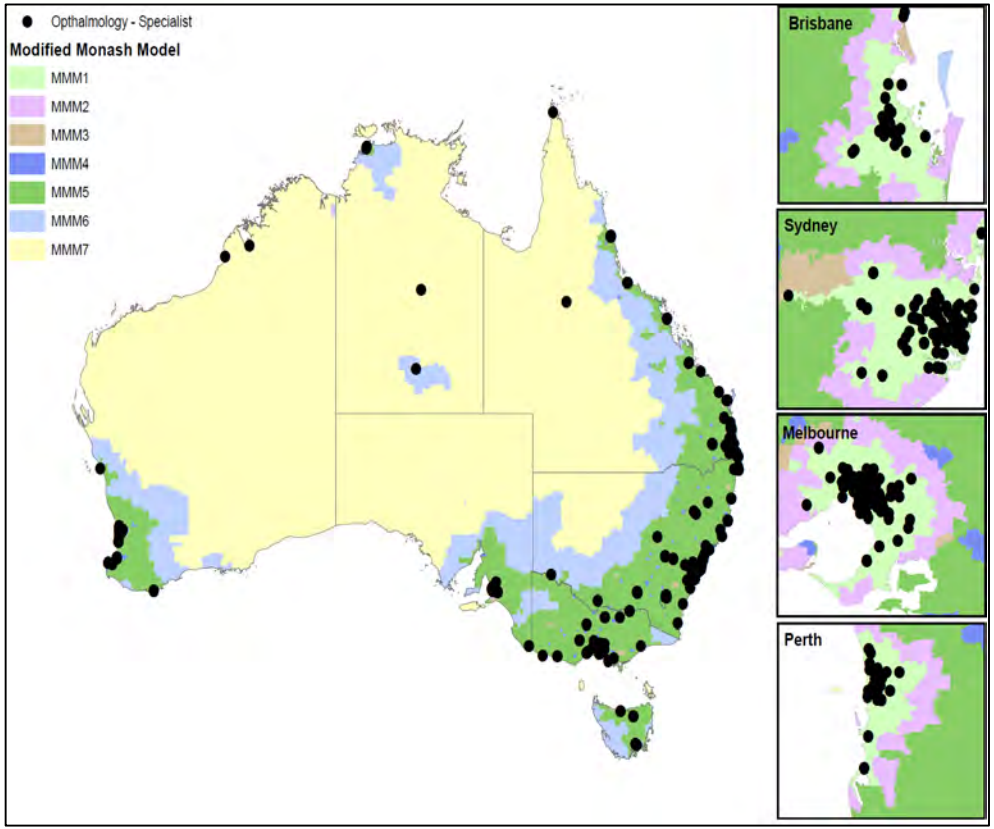
Workforce maldistribution

Table 6: Summary of ophthalmology workforce (Headcount and FTE) by MMM

Modified Monash Category	2015 population	Specialists and trainees (headcount)	Headcount per 100,000 population	Specialists and trainees (FTE)	FTE per 100,000 population
MMM1	16,885,670	830	4.9	880.1	5.2
MMM2	2,195,310	73	3.3	79.1	3.6
MMM3	1,543,912	65	4.2	72.8	4.7
MMM4	873,037	5	0.6	5.8	0.7
MMM5	1,779,535	4	0.2	3.7	0.2
MMM6	312,590	2	0.6	2.3	0.7
MMM7	218,161	6	2.8	6.3	2.9
Grand Total	**23,808,215**	**985**	**4.1**	**1,050.1**	**4.4**

Note – Trainee FTE is based on clinical hours and specialist FTE is based on total specialist hours.
Source: NHWDS, Medical Practitioner 2016

Current supply of Ophthalmology workforce (clinicians) by Modified Monash Model



In 2018, according to the ABS, 32.7% of Australians lived outside greater capital city areas and 28.2% lived outside major cities or areas classified between MMM2- 7.

18% of the total Ophthalmology workforce service these areas where 32.7% of the population live.

Australia's Future Health Workforce Report - Ophthalmology Recommendations for RANZCO July 2018

- The RANZCO investigate potential mechanisms to address maldistribution through:
  - **preferential selection of trainees with a rural background**, or who have undertaken rural placements as a medical student, or worked as a junior doctor in a rural area. This has **commenced.**
  - requiring trainees to undertake **at least six months training in a regional, rural or remote area** and/or experience working within an Indigenous health service.
  - ensure that final fellowship assessment demonstrates that Fellows are able to practice the **full scope** of ophthalmology across Australia
  - **scholarships** for regional, rural and remote trainees, including for final year trainees in these areas and in paediatric ophthalmology.

RANZCO Workforce Survey 2017

- Among Australian-based RANZCO Fellows, those who have studied in rural or remote areas were twice as likely as their colleagues to have at least one regular practice (more than once a week) in a rural or remote area (approx. 44% vs 22%).
- Furthermore, Australian-based Fellows who have studied in rural or remote areas were likely to spend over 35% of their work hours in rural or remote locations, compared to 15% among those who did not study in rural or remote areas.
- Currently, 11% of RANZCO fellows have a rural background.

Australia's Future Health Workforce - Ophthalmology Recommendations for RANZCO July 2018 continued

- The RANZCO increase their **focus on recruiting more Indigenous trainees** who may be better able to serve their communities (regardless of their location – remote or urban).
- Introducing a **points system** in the selection process to facilitate an increase in the number of Indigenous trainees may be an option. This has **commenced.**

Australia's Future Health Workforce - Ophthalmology Recommendations for RANZCO July 2018 continued

- The RANZCO **formalise training of additional supervisors**, particularly in regional, rural and remote settings, with an established method for identifying potential supervisors and providing ongoing supervisor support. This will address the issue of the inability to accredit positions due to lack of supervision or a freeze in consultant FTE.
- An **increased intake of trainees** is needed to counter the predicted undersupply of ophthalmologists in 2030. An increase of three per year from 2019 is recommended. A small increase occurred in 2018 when the training intake increased from 29 to 31 but this is insufficient and has been factored into the projections that arrive at undersupply.

Projected demand

- The demand for ophthalmology services is estimated to grow at 2.8 per cent to 2030
- Balance undersupply by increasing the first year trainee intake every year by an additional 3 new trainees per year from 2019.
- This will increase intake to 63 per year by 2030.
- This will add new fellows entering the workforce in 2023.

Addressing work-force maldistribution requires a multi-faceted approach.

- **Attract a group of applicants where a significant proportion of them have a rural background.**
- Have targeted selection policies to enroll trainees with a rural background and more Indigenous trainees. This has commenced.
- Train comprehensive ophthalmologists that are capable of and confident in working in regional, rural and remote Australia.
- Locate a significant number of training positions in sites outside of capitals and other major cities for all vocational training programs (VTPs).
- **Develop a flip-model VTP where trainees spend more time in non-urban than in urban posts.**
- **Train, resource and support the trainers and trainees – particularly in regional posts - good equipment, outreach support, telehealth, educational support, etc.**
- **For both trainers and trainees provide incentives such as good living conditions, relocation expenses, a safe working environment, public recognition/awards, scholarships, etc.**

Attracting applicants with a rural background

- There is a strong impression from medical graduates, interns and residents that getting on the ophthalmology training program is very difficult.
- **Graduates from regional medical schools and a rural background may feel more disadvantaged in the process and therefore less likely to apply**. **VTPs maybe less likely to accept them when they do apply.**
- Communicate to medical schools, particularly those with regional and rural programs, changes in the selection process targeting rurality.
- **15-17% of applicants for training positions this year have significant rural links.**

Attracting applicants with a regional background

- There is a relative shortage of ophthalmologists in some Modified Monash Model 1 (MMM1) areas compared to others. Say Newcastle/Geelong compared to Sydney/Melbourne.
- **Do medical students graduating from campuses in non-major metropolitan areas feel less likely to be successful in entering ophthalmology and are therefore less likely to apply/choose this as a career option? Are the VTPs less likely to accept them when they apply?**

Data to answer these questions

- Answers to additional questions, if incorporated into the annual AHPRA workforce survey, may provide this data.
- Asking registered doctors whether they have ever applied for or intended to apply for specialist training. Define which specialty.
- Asking a question or questions to define if they have a significant rural or regional background.
- Asking what medical school program they took part in – by both school and campus. And if they were part of any rural programs.
- Analysing the data to determine if graduates from a rural or regional background and/or medical degree are less likely to apply for specialist training. And also if they were less likely to be accepted for specialist training by specialist colleges.

Current VTPs

- West Australian
- South Australian
- Victorian
- Queensland
- Sydney Eye Hospital
- Prince of Wales Hospital, NSW

Rurality of current VTPs

12.6% of currently accredited training posts are MMM 2 or above

	MMM 1	MMM 2	MMM 3	MMM 4	MMM 5	MMM 6	MMM 7
Accredited training posts	111	10	5	0	0	1	0
Unaccredited training positions (May 2018)	45.75	1	0	0	0	0	0

Aims of the Regional Training Network – a flip-model VTP

- **To train comprehensive ophthalmologists (as per other VTPs) who have the skills to and are comfortable with practicing comprehensive ophthalmology post-fellowship in remote, rural and regional areas as well as in urban areas.**
- These skills include knowing what conditions can be appropriately managed by a comprehensive ophthalmologist and when to seek subspecialty advice with either telemedicine consultation, face-to-face consultation and/or surgery.
- **The long-term objective is to increase the numbers of RANZCO fellows practicing in non-urban areas.**
- It has been shown that doctors that have lived in non-urban areas prior to training and/or doctors that train in non-urban areas are more likely to take up practice in these areas.

Meeting the communities needs

- An immediate positive consequence of placing more training registrars in regional, remote and rural areas will be to **increase ophthalmic services in and funding to those areas in which these registrars are placed.**
- The addition of an accredited registrar training post in a workforce-poor regional area is likely to be an **incentive for other ophthalmologists to work in the area.**
- **It is essential that training posts meet the needs of the community as well as the training registrar by supplying a comprehensive ophthalmology service.**
- **This, symbiotic relationship between the training registrar and the community, engenders good will in the community and good training opportunities for the registrar likely ensuring longevity of the training post and the funding for it.**

The challenges of training comprehensive ophthalmologists

- In order to provide a workforce that is capable of and confident in working in regional, rural and remote Australia it is important that newly-qualified RANZCO fellows, from all VTPs, have broad-based skills and as such are confident in managing the entire spectrum of comprehensive ophthalmology.
- In the metropolitan VTP model of ophthalmology training the majority of non-cataract procedures are channeled into subspecialty posts.
- There are not enough subspecialty posts for each training registrar to train in all the subspecialties throughout their training program.
- Registrars in subspecialty units frequently have to compete for surgical procedures with doctors undertaking to visit overseas fellowships.
- Registrars frequently complain about the lack of procedures other than cataracts on their operating lists.
- The subspecialty model of care does not work for regional Australia.

RANZCO AMC accreditation 2016

- New standards
- Re-accredited for 3 years
- 53 conditions
- Opportunity for rapid improvements

Vocational Training Program objective

- To produce a specialist ophthalmologist who, on completion of training, is equipped to undertake safe, unsupervised, comprehensive, general ophthalmology practice

RANZCO
The Royal Australian and New Zealand College of Ophthalmologists
THE LEADERS IN COLLABORATIVE EYE CARE

Redesign of training - the new VTP

- **The purpose is to ensure a more solid grounding as a general ophthalmologist able to practice as such in regional areas.**
- The three stages of training in the current VTP mode will remain with two years of basic training, two years of advanced training and a fifth year.
- One major change is the plan to **make the final year a consolidation year which has to be served in Australia or New Zealand.**
- In support of these changes is the development of a **new curriculum** – a process which is well underway.

Redesign of training - the new VTP continued

- This consolidation year will be a further opportunity for trainees to reach the **necessary competency in surgical procedures other than cataracts (for which minimum numbers will be mandated).**
- While there are few 5th year jobs available currently it is anticipated that the health boards will want to create these positions in order to utilise these experienced trainees who will require less direct supervision than their more junior colleagues.
- 5th year trainees, when placed alongside other trainees, could help RANZCO fellows in supporting the more junior trainees in rural posts especially where there is significant workforce shortage.

Vocational Training Program

BASIC TRAINING
TWO YEARS

ADVANCED TRAINING
TWO YEARS

FINAL TRAINING
ONE YEAR

90% of Trainees finish in the five years

Avg. number of graduates per year = 30 - 35

Three – Six months rotations in Australia (Four months NZ)

Steps in planning and the work towards the funding submission

1. Determine where regional training can and should currently occur and how to use these posts to form an acceptable and cohesive training experience for trainees right now.
2. Map how regional training would look if there was no workforce shortage or maldistribution. This is likely to be a hub-spoke model. This is the goal of the process.
3. Outline how funding currently available for regional training will help in reaching this goal and define other changes needed to progress this goal.
4. Identify potential funding avenues and apply for them.

Preference for funding following the registrar

- Posts in regional, rural and remote areas are more likely to depend on one supervisor for success.
- Should a post fall over, for whatever reason, or fail to meet the training registrar's needs, having the funding attached to the registrar rather than the post will give more options and agility.

MMM1 Ophthalmology Workforce Shortages

- Many large cities in MMM1 areas, such as Newcastle, have relative workforce shortages and underdeveloped public hospital ophthalmology departments.
- For example, Newcastle (population 480,000) has 6.2% of the NSW population. Workforce survey data using Newcastle postcodes found 4.3% of total clinical hours in NSW occurred in Newcastle.
- Not surprisingly it will be difficult to achieve an adequate workforce FTE in the regional areas surrounding these large cities with workforce shortages.
- Large centres such as Newcastle with are likely to be beneficial as regional training hubs (spoking out to MMM2+ training posts in the surrounding region) in the future with the intention of providing a foundation year for a first-year trainee.
- Working with government to ensure adequate public clinic facility provision, public equipment provision and public ophthalmic FTE allocation (with sufficient recruitment incentives) is crucial in developing the role of these hubs as well as in catering for the needs of the population within these cities.

Private posts & public service provision

- Regional areas which have resident ophthalmologists but are significantly undersupplied by ophthalmological FTE/population overall are typically likely to have a mainly private-based model of care with an agreement with the local area health network for the provision of surgery and acceptance of referrals.
- Often ophthalmologists in these areas are under extensive pressure just to service the needs of the community in the private setting and would be unable to contribute FTE to a public clinic.
- They could be in the position to supervise a training registrar but likely not a first-year.
- As the FTE/population in an area increases to a point where the community needs are met comfortably and the ophthalmologists as a group become less busy the likelihood of them being willing and able to take on FTE at a public hospital clinic rises.

Training post development package

- Fellows in areas of workforce shortage are already under significant pressure making the facilitation of any post-development important.
- A post-development package will be put together to help fellows and other agencies determine if an accredited post is currently possible and if not, what steps would need to be taken.
- Such a package would include examples of how current posts do things – particularly in regional areas.
- College staff could help facilitate this process.

Access to Paediatric Ophthalmology Services

- Graduating RANZCO fellows with both competence in paediatric ophthalmology and willingness to see paediatric patients is essential in addressing workforce maldistribution and service delivery.
- This problem is brought into focus, for example, by the lack of paediatric ophthalmology services on the ground in Canberra and Newcastle.
- Further changes to the MBS could be used to add incentives to seeing paediatric patients.
- Additional complexity is the need for orthoptist services to work alongside comprehensive ophthalmologists seeing paediatric patients. This will also need to be considered in the mix.

Data for planning

- There are significant patient, community and government costs for a patient and an accompanying person (often taking carer's leave) travelling for medical services outside their area of residence.
- This also places pressure on metropolitan hospitals.
- There is currently no reliable data on the number of patients travelling significant distances to access medical services.
- The **HeaDS UPP workforce planning tool** which will include Medicare data may help with this, but this data is unlikely to be accessible any time soon.

Data for planning continued

- **State-wide waiting lists for outpatient and inpatient services** would be an enormous help in mapping overall patient service needs.
- A case could be made for a web portal-based state-wide electronic referral smart form.
- Use of a patient's Individual Healthcare Identifier (IHI) would be important to ensure correct patient identification. Even in the same facility patient duplication happens. The use of IHIs would eliminate this safety concern.

Data for planning continued

- Improving the existing workforce data would be helpful
- There are plans for targeted survey questions linked to RANZCO annual renewal as part of a web-portal (as per AHPRA).
- The AHPRA survey questions don't allow for more than 2 places of service provision – the RANZCO data shows that on average fellows works in 2.7 different places.
- The AHPRA data is also only for the past week – which may result in significant inaccuracy as many medical practitioners that do outreach may do so 3 to 4 time a year and this will not be picked up.

Next steps for RANZCO

- Determine where regional training can and should currently occur and apply for funding
- Develop an ideal Regional Training Network
- Improve our existing workforce data
- Focus planning on NSW and WA
- Training post-development package
- Prioritise, follow up and continue to engage with stakeholders

AFTERNOON TEA

(Lower Ground Foyer)

FRAME

Panel Discussion with PGY1-3 Focus

Prof Jenny May

FRAME

CONSIDERATIONS

- Prioritising training positions
- Training both a specialist and a generalist workforce
- How do stakeholders support PGY1-3 rural intention JMOs to pursue a rural career
- Selection processes and the weighting of rural experience, the utility and delivery of JRDTIF
- Optimising the pathway

FRAME

PANEL MEMBERS

- Dr Bek Ledingham is a GP/Medical educator in Broome Western Australia where she has lived for 7 and ½ years with her two kids Lucy and Daniel. She is working with the North West Hub to improve opportunities for training in the Kimberley, particularly outside of Broome.

- Dr Lisa Dark is a Senior Lecturer at UONDRH Regional Training Hub. She is a VMO Neurologist and General Physician at Tamworth Rural Referral Hospital, where she is also the Director of Physician Education. She is the Chair of the Australia and NZ Association of Neurologists Regional Neurology Committee.

- Ass Prof Michael Nowotny is a regional Paediatrician and clinical lead of Paediatrics at West Gippsland Healthcare in Victoria. He has been in rural specialist practice for his whole consultant career. He is the director of the Gippsland RTH and current chair of the Southern Hubs alliance

- Ass Prof Ruth Stewart lives and works on Thursday Island, Queensland, as a senior medical officer, and is the JCU Director of Rural Clinical training and Support. She is an immediate past president of ACRRM and the current chair of FRAME.

Robbie is a graduating medical student from a post graduate medical course. He was born in MM4 location and finished high school in his local community before moving to a thriving metropolis for his undergraduate science and then postgraduate medical course.

He elected to undertake the available rural stream and spent a full year in a MM4 location with supervision shared by 2 rural generalists. He identifies intent at this stage to return rurally.

By this time he has a partner who is now a qualified health professional and they decide to apply for a PGY 1 year in a regional hospital (MM3).

PANEL

- If Robbie was training at your regional hospital as an intern, what training options and opportunities would be available for him as a PGY1 and PGY2?

- What could and are Regional Training Hubs doing in the PGY 1 and 2 space to support regional and rural training?

Robbie becomes the chief umpire for the local hockey association and wants to stay in the community.

He has almost completed his internship, and finds that he is currently leaning towards physician training, though is still uncertain about whether rural generalism is still his preferred option.

He is aware that he would need extra experience to be a rural generalist if he chooses this path, and is prepared to invest extra time in a major centre acquiring skills.
He is in no rush to complete training. He has not ruled out taking a year off to travel and locum either.

PANEL

- What resources are available to this junior doctor to help in his decision making process?
- What work or study can he be engaged in to optimise his skills for any of his possible paths?
- If you are the Director of Medical Services or a regional health service planner, what factors influence what positions are allocated to generalist training (RG) vs specialist training vs service positions?
- Opportunities for primary care training positions for junior doctors (Rural Junior Training Innovation Fund) are being expanded but remain limited. How are these positions best allocated (specialist vs GP intent)?

PANEL AND AUDIENCE

- What are the mechanisms available to attempt to redress the mal-distribution of the medical workforce? What is currently working?
- What has been the experience so far of affirmative selection processes and quotas (race/ethnicity/gender/geographic location)?
- With increased numbers of trainees in rural locations, are we optimising the value of these positions? If so how much time in rural (ie 60/40 for IRTP) is the right amount?
- Is there other enabling infrastructure that should be considered to ensure safe, high quality rural training? eg accommodation, CPD

WORKFORCE DISTRIBUTION STRATEGIES

SELECTION	Additional Points/Quota
Training	How much/earlier/later?
Obligation	For how long? The same bar?
Financial Incentives	Recruitment or retention?
Non-financial incentives	Housing/accommodation/special access?

QUESTIONS

NATIONAL RTH EVALUATION AND WRAP UP

David Atkinson

FRAME

FRAME

FEDERATION OF RURAL AUSTRALIAN MEDICAL EDUCATORS