How Accreditation Practices Impact Building a **Non-General Practice Rural Specialist Medical Workforce**

REPORT

Contents

Acknowledgements

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A full list of acknowledgements is listed at Appendices – Appendix M.

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Acronyms

ABF	Activity Based Funding
ACD	Australasian College of Dermatologists
ACT	Australian Capital Territory
ACEM	Australasian College for Emergency Medicine
ACRRM	Australian College of Rural and Remote Medicine
AHMAC	Australian Health Ministers' Advisory Council
Ahpra	Australian Health Practitioner Regulation Authority
AMACDT	Australian Medical Association Council of Doctors in Training
AMC	Australian Medical Council
ANZAPS	Australian and New Zealand Association of Paediatric Surgeons
ANZCA	Australian and New Zealand College of Anaesthetists
ANZICS	Australian and New Zealand Intensive Care Society
ANZSCTS	Australian and New Zealand Society of Cardiac and Thoracic Surgeons
ANZSVS	Australian and New Zealand Society for Vascular Surgery
ASOHNS	Australian Society of Otolaryngology Head and Neck Surgery
ASPS	Australian Society of Plastic Surgeons
AOA	Australian Orthopaedic Association
BiGS	Australian Board in General Surgery
BPT	Basic Physician Training
CHO	Chief Health Officer
CICM	The College of Intensive Care Medicine of Australia and New Zealand
COAG	Council of Australian Governments
CPD	Continuing Professional Development
CPMC	Council of Presidents of Medical Colleges
DHHS	Department Health and Human Services
DRANZCOG	Diploma Royal Australian and New Zealand College of Obstetricians and Gynaecologists
EDMS	Executive Director Medical Services
EMET	Emergency Medicine Education and Training
EOI	Expression of Interest
EPA	Entrustable Professional Activity
FANZCA	Fellow of the Australian and New Zealand College of Anaesthetists
FACEM	Fellow of the Australasian College for Emergency Medicine
FCICM	Fellow of the College of Intensive Care Medicine of Australia and New Zealand
FIFO	Fly-in Fly-out
FPM	Faculty of Pain Medicine
FRACMA	Fellow of the Royal Australasian College of Medical Administrators
FRANZCOG	Fellow of the Australian and New Zealand College of Obstetricians and Gynaecologists
FRANZCP	Fellow of the Royal Australian and New Zealand College of Psychiatrists
FRCPA	Fellow of the Royal College of Pathologists Australasia
FTE	Full Time Equivalent
GSA	General Surgeons Australia
HAS	Hospital Accreditation System
HETI	Health Education and Training Institute
HR	Human Resources

ICM	Intensive Care Medicine	**RANZCOG**	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
ICU	Intensive Care Unit	**RANZCP**	Royal Australian and New Zealand College of Psychiatrists
IRTP	Integrated Rural Training Pipeline	**RANZCR**	Royal Australian and New Zealand College of Radiologists
JCT	Jurisdictional Coordinator of Training	**RCPA**	Royal College of Pathologists Australasia
LHD	Local Health District	**RDAQ**	Rural Doctors Association of Queensland
LHN	Local Health Network	**RFDS**	Royal Flying Doctors Service
MBA	Medical Board of Australia	**RHMT**	Rural Health Multidisciplinary Training
MDANZ	Medical Deans Australia and New Zealand	**RMO**	Resident Medical Officer
MM	Modified Monash (Model)	**RPL**	Recognition of Prior Learning
NMWS	National Medical Workforce Strategy	**RVTS**	Remote Vocational Training Scheme
NSA	Neurosurgical Society of Australasia	**SA**	South Australia
NSQHS	The Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards	**SET**	Surgical Education and Training Program
NSW	New South Wales	**SIMG**	Specialist International Medical Graduate
NT	Northern Territory	**STP**	Commonwealth Specialist Training Program
O&G	Obstetrics and Gynaecology	**US**	United States
PGY	Post-Graduate Year	**USANZ**	Urological Society of Australia and New Zealand
PHO	Principal House Officer (also known as service or unaccredited registrar)	**VMO**	Visiting Medical Officer
PITP	Provincial Integrated Training Program	**VMST**	Victorian Medical Specialist Training
QCH	Queensland Children's Hospital	**VR**	Vocationally Registered
RACMA	Royal Australasian College of Medical Administrators	**WA**	Western Australia
RACP	Royal Australasian College of Physicians	**WACHS**	Western Australia Country Health Service
RACS	Royal Australasian College of Surgeons		
RANZCO	Royal Australian and New Zealand College of Ophthalmologists		

Summary

Introduction

Around 28% of the Australian population live in regional, remote, and very remote areas of Australia.[1] Rural populations generally have poorer health outcomes with increased rates of mortality and morbidity compared to people living in metropolitan areas with the total burden of disease and mortality rates increasing with increased remoteness. In 2015, the rate of disease burden in remote and very remote areas was 1.4 times higher than major cities and mortality rates in very remote areas was 1.5 times higher for males and 1.7 times higher for females.[2]

There are well documented challenges with access to health care that contribute to this, particularly non-general practitioner (GP) specialist care, in rural areas. Medical workforce shortages and disparities in the distribution of the non-GP specialist medical workforce between metropolitan and rural area continue to exist.

Despite a growing rural population and increased need, there is reduced access to non-GP specialist services in rural areas. Distribution varies significantly across geographical locations with metropolitan areas having approximately 143 full time equivalent (FTE) non-GP medical specialists per 100,000 population. For inner regional areas this decreases to around 83 FTE, outer regional 63 FTE, remote 61 and very remote areas decreasing to 22 FTE per 100,000 population.[3]

The World Health Organization (WHO) published a global policy recommendation on the retention of health care workers in remote and rural areas in 2010. Education recommendations included increasing 'rural community experiences and clinical rotations in rural areas' during studies, and 'postgraduate curricula to include rural health topics so as to enhance the competencies of health professionals working in rural areas', which were viewed as key factors in recruiting and retaining physicians in rural areas.[4]

Indeed, the 2021 update of the *WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas* continues to highlight the importance of encouraging health education providers 'to be socially accountable and work closely with health services to produce the right kind of health workers for rural and remote health care'. Specifically, adopting a socially accountable mandate and developing strategies and partnerships to align education, research and service activities with identified health priorities of communities.[5]

To improve distribution and increase the numbers of specialists in rural areas, there needs to be an increase in specialty training in rural areas. Exposure to rural practice has been occurring for some time in specialist medical training via rural rotations. Evidence demonstrates that rural training experience aids in attracting

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1   Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW.

2   https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health, accessed 8 July 2021.

3   https://www.aihw.gov.au/reports/australias-health/rural-and-remote-health

4   WHO Global Policy Recommendations: Increasing access to health workers in remote and rural areas through improved retention, 2010.

5   WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas, 2021, https://www.who.int/publications/i/item/9789240024229

trainees to rural areas, providing for the development of rural practice skills through service provision and training. In Canada, trainees indicated that exposure to rural practice had influenced their decision to enter rural practice with 'residents trained in distributed sites 15 times more likely to enter practice in rural communities, small towns and regional centres than those who trained in metropolitan teaching centres'.[6]

Similarly, rurally based training programs can have a greater influence on medical practitioner retention in rural areas. A rurally located physician residency training program in the United States (US) provides full immersion in rural medicine with a success rate of more than sixty per cent of graduates from rurally-located programs practising in rural areas from the end of residency through four years post-graduation, with a high of 69.8 per cent at three years post-graduation.[7]

Other training programs supporting a minimum of two years in a rural practice such as the *Rural Training Track* in the US[8] have also contributed to an increase in rurally practising graduates with seventy-six per cent of *Rural Training Track* graduates practising in rural America with graduates describing themselves as prepared for rural practice. 'Almost half were located within the service area of their training'.[9]

A further international literature review on assessing the impact of rural rotations on urban based postgraduate learners found that 'rural rotations are a key strategy in the recruitment of rural physicians, influential in rural practice choice and longer-term rural rotations were more consistently associated with eventual rural practice'.[10]

Over the last decade, Australian Government investment in non-GP specialist medical training via the Specialist Training Program (STP) has increased substantially. This is primarily to support the extension of vocational training for non-GP specialist medical trainees into settings outside traditional metropolitan teaching hospitals, including regional, rural and remote and private facilities.

Over time the STP has grown from supporting 360 FTE training places in 2010 to supporting 957 FTE ongoing specialist training nationally and across specialties in 2020.

The STP has also expanded to include the 100 FTE rurally dedicated specialist training places under the Integrated Rural Training Pipeline (IRTP) with 50 places implemented in both 2017 and 2018 supporting all trainees in IRTP posts to complete at least two thirds of total Fellowship training in a rural area.

Since 2014, the STP has supported the Tasmanian Health System through the training and retention of specialists in Tasmania. This initiative was implemented with a target of 65.19 FTE training places and other supports (known as the Tasmanian Project).

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6   Jamieson J, Kernahan J, Calam B, Sivertz (the Late) KS. One program, multiple training sites: does site of family medicine training influence professional practice location? Rural and Remote Health 2013; 13: 2496. https://doi.org/10.22605/RRH2496

7   Patterson, D. G., C. Holly Andrilla, D. F. Schmitz, R. Longenecker, and D. V. Evans. Outcomes of rural-centric residency training to prepare Family Medicine Physicians for rural practice. Policy Brief #158. Seattle, WA: WWAMI Rural Health Center, University of Washington;2016, https://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2016/03/RHRC_PB158_Patterson.pdf, accessed 9 July 2021

8   Norris, T. E., Education for Rural Practice: A Saga of Pipelines and Plumbers, The Journal of Rural Health, Vol. 16, No. 3, https://onlinelibrary.wiley.com/doi/epdf/10.1111/j.1748-0361.2000.tb00458.x, accessed 9 July 2021

9   Rosenthal, T. C., 2000, Outcomes of rural training tracks: a review, *The Journal of Rural Health*, PMID: 11131760 DOI: 10.1111/j.1748-0361.2000.tb00459.x

10 Malhi RL, Ornstein J, Myhre D. The impact of rural rotations on urban based postgraduate learners: A literature review. *Med Teach*. 2019 Jul;41(7):830-838. doi: 10.1080/0142159X.2019.1588458. Epub 2019 May 1. PMID: 31043111.

This Australian Government commitment represents up to seven per cent of all non-GP specialist training in Australia with an overall investment of approximately $182.6 million in 2020–21.

Figure 1: Specialist Training Program – 2010 to 2020
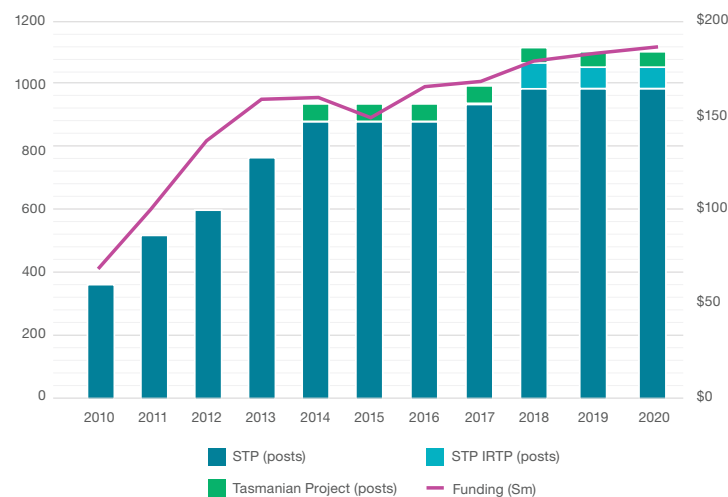
Source: Australian Government, Department of Health and Aged Care, Specialist Training Program

The above chart shows Australian Government investment in specialist medical training posts under the Specialist Training Program, noting it is intended to be indicative only as funding under the program supports activities beyond training posts. The data incorporates funding for the Emergency Medicine Education and Training (EMET) Program and also other STP activities not shown (support projects and administration), the Support for Rural Specialists in Australia and the Medical Physicists Support Program.

The 2017 Review of the STP identified that approximately thirteen per cent of specialist training was occurring in areas outside of metropolitan settings 'indicating that medical specialist training continues to be disproportionately located in major cities'. Since this time, despite the Australian Government increasing its commitment to support specialty training in rural areas through both the STP and the IRTP, the vast majority of specialty training is still delivered in metropolitan areas.

In November 2018, the first Rural Medical Specialist Training Summit was held with representatives from the Australian Government, states and territories, universities, specialist medical colleges, the Australian Medical Association, rural medical educators and regulators to discuss how to improve regionally-based specialist medical training. With around 50 attendees, the summit looked at the critical challenge of distribution and getting more non-GP medical specialists working in rural and regional Australia. A key focal point was how to support regionally-based specialist training and establish models whereby an individual's specialist training would be substantively rurally-based, with short rotations into major cities as required to meet specialty training requirements.

> Five key themes emerged from the summit including "Accreditation systems should be more flexible, allowing for outcomes-based approaches".[11]

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11 Australian Government, Department of Health, Rural Medical Specialist Summit Communique, 19 November 2018.

The Accreditation Project

With an increasing focus on supporting specialist training in regional, rural and remote health settings, under the auspice of the STP, the Department of Health and Aged Care (the 'Department') began this project to better understand the challenges and barriers to achieving further expansion of accredited training in rural communities.

The *How Accreditation Practices Impact Building a Non-GP Rural Specialist Medical Workforce* (the 'Accreditation Project') was initiated to consult with stakeholders on the impact specialist medical college accreditation systems have on the ability of health care settings to deliver more rural, regional and remote non-GP specialist medical training.

Noting that the STP supports trainees on the pathway to Fellowship, the Accreditation Project did not explore post-Fellowship training accreditation practices for any specialty. As consultations were completed prior to the COVID-19 pandemic period, this report does not reflect any challenges or opportunities that may have been identified in accreditation during this time.

The report findings and recommendations reflect a point-in-time perspective of stakeholders based on experience within the existing accreditation system. It must be noted that since the consultation phase of the project, change has continued to progress, and some specialist medical colleges have made further progress to support the expansion of rural specialist medical training.

Findings will inform future policy and program work by the Department in the area of non-GP specialist medical training. This includes alignment with the priorities and actions under the National Medical Workforce Strategy (NMWS) to ensure a coordinated approach to any system level reform impacting non-GP specialist medical training.

Methodology

Specialist medical colleges (hereon referred to as 'Colleges') and identified stakeholders involved in College accreditation were invited to participate in qualitative interviews. The rural health services invited to participate in consultations were identified participants in the STP, IRTP and/or Tasmania Project supporting accredited specialty training.

A desktop review of publicly available information was conducted to define the accreditation context, regulatory setting and College accreditation requirements for training settings, posts, programs and networks. The review included jurisdictional medical workforce strategic plans and activities related to the support of specialty medical training and other documentation on accreditation and the regulatory frameworks for Colleges.

The desktop review informed the development of a series of questions for the consultation ranging from high level accreditation system questions to detailed stakeholder specific questions for each of the stakeholder groups to gain a breadth and depth of information on accreditation practices and the impacts across the specialty medical training sector.

A list of stakeholder questions can be found at Appendices – Appendix N.

Colleges were invited to participate in an initial online survey to gather further preliminary qualitative data on accreditation practices and feedback ahead of face-to-face meetings. The survey results further informed

interview questions for College meetings, providing an opportunity for targeted discussion on College accreditation frameworks. Colleges[12] covered in this report are:

- Australasian College of Dermatologists (ACD)
- Australian and New Zealand College of Anaesthetists (ANZCA)
- Australasian College for Emergency Medicine (ACEM)
- The College of Intensive Care Medicine of Australia and New Zealand (CICM)
- Royal Australasian College of Medical Administrators (RACMA)
- Royal Australasian College of Physicians (RACP)
- Royal Australasian College of Surgeons (RACS)
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
- Royal Australian and New Zealand College of Ophthalmologists (RANZCO)
- Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- Royal Australian and New Zealand College of Radiologists (RANZCR), and
- Royal College of Pathologists Australasia (RCPA).

Over 60 stakeholders in all Australian jurisdictions were consulted via face-to-face, virtual and teleconference meetings from October 2019 to February 2020.

Consultations aimed to:

a) develop an evidence-based understanding of the issues that impact accreditation of rural and regional training places across the different medical specialties

b) gather case studies of successful and unsuccessful models for new specialty training posts, sites, networks and programs in rural and regional locations, and

c) identify potential opportunities to remove unnecessary barriers to rural specialist medical training.

The Accreditation Project also considered reviews of Colleges and recent accreditation reviews and documentation, including:

- The Australian Competition & Consumer Commission and Australian Health Workforce Officials' Committee, Report to Australian Health Ministers, Review of Australian Specialist Medical Colleges, July 2005.
- The Australian Health Ministers' Advisory Council's (AHMAC) 'Accreditation of Specialist Medical Training Sites Project', completed in 2015, which was aimed at streamlining accreditation processes and setting agreed domains, standards and criteria for all Colleges accreditation frameworks with the *National Accreditation Framework for Medical Specialty Training*.[13]
- The Australian Medical Council's (AMC) 'Standards for Assessment and Accreditation of Specialist Medical Colleges and Professional Development Programs' 2015 (the 'AMC Standards'), effective from 1 January 2016.[14]

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12 The Australasian College of Sports and Exercise Physicians did not participate in the project

13 COAG Health Council, 'Agreed Domains, Standards And Criteria: For use by Medical Colleges accrediting training sites for medical specialist training' (2015), https://cpmc.edu.au/wp-content/uploads/2015/12/Agreed-domainsstandards-criteria_Final_13Nov2015.pdf

14 Australian Medical Council, Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2015. https://www.amc.org.au/wp-content/uploads/accreditation_recognition/specialist_edu_and_training/assessment/standards_for_assessment.pdf

- The Council of Australian Governments (COAG) Health Council's 'Independent Accreditation Systems Review' (the 'Woods' Review'), to address concerns about cost, transparency, duplication and prescriptive approaches to accreditation functions, and the February 2020 response to recommendations from further work by AHMAC to consult on the costs, benefits and risks of implementing the recommendations and the proposed governance models.[15]

The term rural refers to rural, regional, and remote in this report. Rurality is defined using the Modified Monash Model (MM) with areas MM2 to MM7 classified as rural, remote and very remote.

The views presented in this report are those of the stakeholders involved in the consultation and reflect the honest and transparent feedback received. Any views of the Department are clearly identified as those of the Department.

Findings

The overarching theme that emerged during the Accreditation Project is that the specialist medical accreditation system for training posts, programs, sites and networks is well-regarded, although administratively burdensome and resource intensive. It is an important tool for ensuring that all the components required for safe patient care and high quality and safe training for trainees are in place, with appropriate resources and support. However, the benefits and value of training in a rural health service and mechanisms for supporting training in a rural area are often not recognised, considered or incorporated into College accreditation frameworks. Some Colleges have incorporated greater flexibility into accreditation frameworks enabling a broader cross section of health services to participate in training.

In accordance with AMC Standards, College accreditation standards should minimise variation in training across health settings. However, where Colleges have not integrated flexibility in accreditation frameworks and practices, this can negatively impact rural health services unable to meet all accreditation standards and criteria as stand-alone training facilities. Rural health services offer a quality training experience, nonetheless. Evidence indicates that these rural training experiences are often highly valued and sought after by trainees.

Rural specialists may be credentialed to a broader or extended scope of clinical practice than their metropolitan counterparts to meet the service needs of a rural health service and community. As a result, much of rural specialty training is more 'generalist' in nature with trainees able to experience learning environments with a broad scope of clinical practice. The requirement for trainees to access unique and complex specialist cases in metropolitan, urban or large regional centres remains.

The accreditation frameworks, standards and requirements under each criterion are derived from the requirements of the specialty training programs and curricula. It is specialty training programs and curricula that must also consider the broader health contexts, including rural. Health services also need to build capacity to facilitate access to or create the required training experiences, whether as stand-alone training sites or under network arrangements.

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15 COAG Health Council, 'Response to the Independent Accreditation Systems Review Final Report – Communiqué 12 February 2020'.

> "Accreditation is one of the levers that drives consistency, supervision requirements and resourcing to support training and service delivery needs. Accreditation is not the only lever, or even the most important thing in training and service delivery." Rural Health Service

It is important to note that the themes that emerged from consultation were interwoven with other components of specialty training, not specifically accreditation, such as workforce, the fiscal environment, differences in industrial arrangements, trainee selection, recruitment and allocation, supervision, service demand and delivery versus training, portability of entitlements and priorities set by state and territory governments. As such, accreditation cannot be considered in isolation when determining potential changes to improve the expansion of training in rural areas of Australia. Greater consideration needs to be given to the whole training system and potential solutions as levers for change to progress towards key priorities and reform identified in the NMWS and the broader medical workforce policy context.

Broader Policy Context

There is significant strategy and policy work in progress to address the critical challenge of increasing access to medical care for rural communities to improve health outcomes, particularly targeting medical workforce distribution and supply. The Australian Government currently has in place or is developing a number of strategies or plans related to the medical workforce that intersect with this report. These include:

- NMWS
- Stronger Rural Health Strategy
- National Mental Health Workforce Strategy
- *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031*
- National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023, and
- Royal Commission into Aged Care Quality and Safety Report.

The Accreditation Report strongly aligns with and complements the NMWS with recommendations for the specialist medical sector drawing focus to system level change to promote a positive rural medical education culture, integrate flexibility, and strengthen mechanisms to better support and expand high quality and safe specialist training in rural health settings.

This report identifies challenges to overcome and opportunities to achieve outcomes to further the expansion of accredited specialist training in rural communities, positively impacting state and territory medical workforce plans and the mental health, Indigenous health and the aged care sectors through improving access to specialist care for Australian rural communities.

Key findings

1. **Accreditation standards are generally well regarded** as providing a benchmark or baseline standard **for quality and safe training** and to ensure the appropriate support mechanisms are in place for supervisors and trainees at training sites.

2. The majority of **College policies and processes are metro-centric**. They have been developed and administered by metropolitan experienced College members and central offices and **do not consider rural or the broader health context**.

3. **Rural representation in College governance is key** to ensuring the rural context is considered in education, training and accreditation. Some Colleges have rural chapters or interest groups, and rural Fellows may also be included on rural site assessment accreditation teams, however, this is often ad hoc rather than formalised.

4. The **accreditation system is administratively burdensome** for Colleges and health services with Colleges **relying heavily on a volunteer member workforce**.

5. **There is little flexibility in College accreditation standards and practices** to allow for variations in rural health service delivery nor do they place a value on the rural health training experience. There are limitations for rural health services particularly when standards identify specific caseload and casemix numbers, trainee requirements and strict supervision arrangements. Some Colleges have integrated flexibility and allow for variations considering the bigger training picture. The consultations found that **applying flexibility does not diminish the quality and safety of the training**, rather, it takes into consideration the **added educational value that rural sites can offer.**

6. **Reaching and maintaining the critical mass of specialists in rural locations is an ongoing challenge to meet supervision requirements** set by specialities, particularly when onsite supervision with specific FTE is required. Alternative innovative or remote supervision models have not yet been extensively explored and the Specialist International Medical Graduate (SIMG) and locum workforce are not currently enabled by most Colleges to support supervision arrangements.

7. **Accreditation data is not shared between specialties.** Each College, and in some cases each specialty within a College, has its own method of accreditation data management. This varies from a combination of paper-based and basic database records such as 'off-the-shelf' Microsoft Excel databases to bespoke software programs tailored per specialty. This means there is **limited insight into 'whole-of-system' training capability and capacity** for medical workforce planners. There is an opportunity to further support medical workforce planning and distribution with the integration of technological solutions.

8. **Health service delivery versus training** is a tension in all health services which is particularly felt by smaller rural health services supporting training. **Service provision is the priority of health services.** This can impact accreditation, for example, supervision and training requirements, access to study leave and exam preparation time, and infrastructure or the required hours of work for accredited trainees which sometimes is misaligned with service need.

9. **Creating and further building on existing training networks can support rural health services in meeting accreditation standards where they may be unable to meet accreditation thresholds as standalone training sites.** Smaller rural health services can add significant value to training by collaborating with a group of health services to ensure the full breadth of training is accessible across a training network.

10. **Relationships and professional networks are critical** for the support of specialty training in rural locations. Health services indicated that accreditation is often reliant on one or two key specialists in what can be very vulnerable accredited training arrangements.

11. **Fostering and strengthening partnerships and networks between public and private settings in rural areas can increase rural training opportunities.** There can be limited engagement between public and private settings in rural areas to support training of specialists.

12. **Withdrawal of accreditation impacts rural health service planning, service delivery and training capacity.** It de-stabilises existing workforce and can increase workload for the medical workforce who remain if trainees are also withdrawn. In some cases, rural health services may never seek re-accreditation. College practices are evolving to increase support and collaboration with health services to remediate issues quickly to meet compliance measures.

Good Practices

Table 1. Examples of good practice by specialist medical colleges to support rural training. Further details of these practices can be found in Appendices A–L.

College	College Rural Health Focus	Rural Training Pathways	Accreditation Framework	Networks	Supervision	Accreditation Data Management	Rural Training Support	Accreditation Evaluation and Quality Improvement
ACD	Strategy with rural health focus		Mandatory and desirable criteria with flexibility to support rural posts	Yes – training is jurisdictional and cross jurisdictional inc. rural posts.		In development	Regional training toolkit built using STP funds	Yes
ACEM	Strategy with rural health focus Revised Curriculum with Rural and Regional Emergency Medicine Practice	6 month rural rotation	New accreditation framework with flexibility to support rural sites	Yes – Training is networked and inc. rural posts		Bespoke data management program		Yes
ANZCA	ANZCA Strategic Plan with Regional and Rural Workforce Strategy Rural Special Interest Group	Yes		Yes – Rotational training programs inc. rural posts	Levels of supervision that support flexible supervision models	Bespoke data management and workflow program		Yes – Inc. survey of sites post accreditation assessment for continuous improvement
CICM	Strategy with rural focus Rural Committee	3 month rural rotation	Flexibility			Bespoke data and workflow management program		Yes
RACMA	Position Statement on Remote, Rural and Regional Medical Leadership by Medical Administrators Rural Policy Advisory Group		Flexibility to support rural training Risk based approach		Flexible supervision arrangements inc. non-Fellow supervision	In development		Yes
RACP	Regional and Rural Physician Working Group	Mandatory rural training in general paediatrics	New accreditation framework inc. networks to support rural expansion	Yes	Flexible supervision arrangements – non-Fellow supervision for Basic Physician Training and Advanced Training, some clinical supervision by trainees and supervision requirements based on trainee competence	In development		Yes

College	College Rural Health Focus	Rural Training Pathways	Accreditation Framework	Networks	Supervision	Accreditation Data Management	Rural Training Support	Accreditation Evaluation and Quality Improvement
RACS	Rural Health Equity Strategic Action Plan Rural Surgery Section Committee Rural and Regional Surgical Services Position Paper	Yes	Jurisdictional representation on accreditation teams	Yes – national, jurisdictional and regional depending on specialty – inc. rural posts			Rural Coach Program	Yes
RANZCOG	Rural Focus with Provincial Integrated Training Program Regional Fellows Group	Yes and 6 month rural rotation	Flexibility	Yes – Integrated Training Programs inc. rural posts		In development		Yes – Accreditation Working Group
RANZCO	Strategy with workforce focus	In development	Mandatory and desirable criteria	Yes – seven networks all inc. rural and regional posts	Flexibility of supervision requirements to support rural training	Bespoke data management program		Yes
RANZCP	Strategy with workforce focus Section of Rural Psychiatry Rural Psychiatry Roadmap 2021-31 Rural Psychiatry Position Paper	Rural Psychiatry Training Pathway – in development	Flexibility	Yes training is networked inc. rural posts	Flexible supervision model to support rural training inc. remote and non-Fellow supervision	Bespoke data management program for accredited training posts.	Rural Psychiatry Rural Training Support	Yes – annual trainee surveys
RANZCR	RANZCR Strategic Plan 2022-2024 Rural and Regional Special Interest Group and Clinical Radiology Workforce Committee	3–6 month rotations and established IRTP positions (66% of training in regional)	Flexibility integrated through levels of accreditation and specific standards for networks	Training is networked inc. rural posts	Accredited clinical supervision – may inc. Fellow of another College. Variations also supported in line with competency.		Trainee Liason Officer	Yes
RCPA			Consistent standards with flexible implementation	Integration of metropolitan, regional, public and private sites in networks, and funding of co-ordinator roles	Supervision by a Fellow or approved accredited supervisor	Bespoke data management program	Personal visits by Education Advisors to support trainees and supervisors	Yes (Site visits and annual surveys

Out of Scope Feedback

The specialty training system is complex with many moving parts and accreditation is not a stand-alone function of Colleges.

Stakeholders identified additional challenges interconnected with accreditation, impacting specialist medical training and the expansion of training in rural areas. These issues have at times been interwoven in accreditation examples within the main report, however, are out of scope of this project. The Department will consider these issues in line with the priorities of the NMWS, the broader policy context and future work to support non-GP specialist medical training.

In relation to trainees, topics considered as out of scope include trainee selection, recruitment, and allocation and rotations of trainees to rural sites.

Matters relating more broadly to the construct, capability and capacity of training delivery were also reported. Issues such as supervision, supervisors and support, workforce, service demands versus training versus cost, service registrars, scope of practice and credentialing, fiscal and reputational and cultural challenges also are considered out of scope.

In addition, portability and recognition of entitlements was an issue raised that impacted employers, trainees and college programs, particularly those that cross borders, whether national or cross-jurisdictional.

With the Accreditation Project under the auspices of the STP, stakeholders provided feedback on the STP. Stakeholders raised concerns related to the administration of the program, funding and any other challenges impacting the successful delivery of the program. Again these issues are considered out of scope.

These matters are briefly explored in Section 7.0 of this report.

Recommendations

Recommendations have been developed to improve the expansion and strengthen the support of non-GP specialist training in rural, regional, and remote areas.

Consideration has been given to linkages with the recent Rural Health Multidisciplinary Training (RHMT) Program Evaluation[16], the body of work on specialist medical college accreditation auspiced by AHMAC in 2015, the AMC Standards, and recommendations made in the 2005 Review of Australian Specialist Medical Colleges.

Based on reoccurring themes and College and local solutions that have worked well in addressing barriers to accreditation, recommendations have been identified that could either be implemented under current frameworks or be integrated as part of future reform. These recommendations are reflected throughout the report and focus on:

• commitment to rural health equity

• networks to support training in rural areas, including the private sector

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16 Independent Evaluation of the Rural Health Multidisciplinary Training Program, Final Report to the Commonwealth Department of Health, May 2020, KBC Consulting, https://www.health.gov.au/resources/publications/evaluation-of-the-rural-health-multidisciplinary-training-rhmt-program?utm_source=health.gov.au&utm_medium=callout-auto-custom&utm_campaign=digital_transformation

- creating efficiencies and reducing administrative and regulatory burden
- increasing engagement and collaboration between stakeholders in non-GP specialist medical training in relation to workforce planning and distribution
- building training capability and capacity and strengthening support of supervisors and trainees in rural areas
- valuing and promoting the rural training experience
- encouraging innovation in the expansion of non-GP specialty training in rural areas, particularly in supervision.
- increased consistency and transparency in accreditation, and
- increased flexibility in accreditation of training posts to support rural training.

Whilst the scope of the project has been non-GP specialist training, there is also potential for recommendations to have a positive impact on general practice specialty training and accreditation to support more rural training.

Influencing the specialty training system to improve specialist medical workforce distribution and support the rural expansion of specialty training is complex. In directing efforts through 'funding power'[17], the mechanism government currently uses is the STP. The STP supports up to seven per cent of specialty training across Australia with a commitment to supporting a broad range of expanded settings, including rural and private. This means that in addition to supporting training posts under the STP, there needs to be consideration of other measures that will influence change in the specialty training system more broadly. This may include measures and mechanisms beyond the current framework of the STP, including College-based recommendations, government policy and program recommendations, jurisdictional collaboration and leveraging regulatory mechanisms for system wide reform.

Recommendation	Rationale
Commitment to rural health	
1. College commitment to rural health equity by recognising, valuing and promoting rural health and the rural training experience (Section 4.1).	Strategic commitment to rural health equity and a strengthened commitment to medical workforce planning and distribution to meet the health care needs of rural communities.
	To support the expansion of rural training, there is a need for greater rural representation across College decision making, particularly in specialty education and training programs and accreditation.
	Rural health equity commitment must include Aboriginal and Torres Strait Islander health with training experiences in Aboriginal and Torres Strait Islander health settings.
2. Build capacity in College accreditation frameworks to consider and accommodate the rural context (Section 4.1).	To encourage further expansion and support of specialty training in rural areas (where feasible).

17 Australian Government, Department Health (Jennifer Mason), Review of Australian Government Health Workforce Programs (2013)

Recommendation	Rationale
3. Review the composition of accreditation teams and governance to include rural Fellows or Fellows with rural expertise (Section 4.1).	To recognise, strengthen and promote the value of rural training. Rural expertise integrated into assessment teams and accreditation governance also strengthens accreditation decision-making This may include expertise in Aboriginal and Torres Strait Islander health.
Flexibility in Accreditation Frameworks	
4. Improve the geographical distribution of specialty training, through accreditation frameworks incorporating flexibility with individualised and contextualised assessments of health services against accreditation standards (Section 4.2).	With flexibility and consideration of local context in accreditation assessments, evidence demonstrates that there are opportunities to include valuable rural training experiences, including Aboriginal and Torres Strait Islander health, in specialty training.
Supervision of Specialty Training	
5. Increased engagement with rural supervisors to provide training, support and seek feedback on issues impacting rural training. Identify mechanisms to better support rural specialty training (Section 4.3).	To gain an understanding of issues impacting rural training and collaboratively develop improved support mechanisms to develop capability and both strengthen and expand rural training capacity.
6. Consideration of innovative models of supervision including network supervision arrangements, incorporation of digital technologies to accommodate tele-supervision, supervision models based on trainee competency, clinical skills and the potential for inclusion of non-Fellows, SIMGs and locums in supervision models (Section 4.3.2).	Feedback indicated that rural health services would welcome innovation in supervision models to support and build capacity in specialty training where currently there is difficulty in reaching critical mass of onsite specialist supervisors. **Alignment with RHMT Program Evaluation, Recommendation 11** – To strengthen supervision capacity and capability in rural, remote and regional sites, the RHMT program encourages universities to engage with current and potential supervisors on a regular basis to identify and implement: • supports and skills development required to commence or continue to provide supervision to students • employment or other engagement and recognition arrangements required recognising possible differences between localities, settings and disciplines, and • opportunities for localised or regional innovative supervision models.
7. An accredited, tiered system of training supervision that aligns with multidisciplinary teams and service delivery in rural areas. For example, fully-qualified specialists to provide specialist services (Tier one), doctors or other specialists with the Diploma or Certificate level qualifications in that specialty (Tier two) with the consideration of inclusion of rural generalists and senior or advanced trainees (Section 4.3.2).	Many rural health services indicated that with improved utilisation of multidisciplinary teams in supporting and supervising specialty training, there is opportunity to build and expand specialty training capacity.

Recommendation	Rationale
Impartiality, Transparency and Consistency	
8. Inclusion of jurisdictional representatives and / or independent observers in accreditation assessments, including site visits, desktop reviews or virtual accreditation assessments (Section 4.6).	Increase engagement between Colleges and jurisdictions to improve support of specialty training at jurisdictional level and remediation of accreditation issues. This also encourages greater collaboration in specialist medical workforce planning and encourages improved integrity and transparency in College processes and assessments.
9. Improve transparency in published accreditation standards, criteria and requirements (Section 4.6).	Feedback indicated that greater clarity and transparency is required in the criteria health services must meet to comply with accreditation standards and decision making in accreditation.
10. Robust conflict of interest policies and processes for accreditation teams to underpin fair and balanced accreditation assessments (Section 4.6).	Health services seek to be fairly assessed against accreditation standards; feedback indicated that having the ability to be involved in a 'conflict of interest' process would strengthen independent assessment.
11. Identification of commonalities and terminology across specialty accreditation frameworks with College adoption of common definitions and criteria to create efficiencies across the accreditation system (Section 4.6).	To create efficiencies, improve clarity and reduce administrative burden in the specialty training and accreditation system, develop and implement common terminology and definitions, for example, in relation to trainee wellbeing.
12. College collaboration with sharing of common accreditation information (Section 4.6).	Sharing of common accreditation information across Colleges, such as training governance, trainee and training support mechanisms at health service level, supports driving efficiencies and reducing administrative burden for health services and Colleges.
13. Review accreditation practices to improve consistency (Section 4.6).	The diversity of Colleges and specialties is acknowledged; however, analysis suggests that there is a need to improve consistency in accreditation assessments and governance with assessment variability depending on accreditation teams. Improved consistency through strengthened governance and assessor training creates greater clarity in standards and requirements for quality specialty training.
Medical Workforce – Rural and Regional Service Delivery	
14. Recognise workforce needs and the tension between providing training and clinical services. Provide supervisor support to enable greater access to protected time to facilitate supervision and other training requirements (Section 4.8).	The primary role of a health service is to provide health care. With this in focus there is often a tension between providing service and delivering training which impacts on both supervisors and trainees. Improved systems and support are required to release supervisors and trainees for training to further enhance and encourage quality training in rural areas.

Recommendation	Rationale
Efficiencies and Reducing Administrative Burden of Accreditation	
15. Resourcing administrative support for smaller sites with reduced capacity to respond to regulatory requirements and develop training infrastructure. Support to assist in preparing for accreditation activities and general specialty medical training support (Section 5.1).	Rural health services indicated they have limited capability and capacity to support building training capacity, meet regulatory requirements and for the coordination and support of training. Specialty training and accreditation are resource intensive requiring coordination and administrative support. Often there is no funding available for medical education officer roles or units either at health service or health region level.
16. Alignment and coordination of accreditation assessments to occur at the same time for some specialties, i.e. surgical and physician specialties (Section 5.1).	Evidence indicates that health services must prepare for multiple accreditation assessments annually creating significant administrative and resource burden. This recommendation aims to create efficiencies and reduce burden in accreditation for health services, particularly in surgical and physician specialties.
17. Recognition of accreditation by other bodies, specialties or subspecialties to reduce administrative burden and reduce repetition (Section 5.1).	To drive efficiencies and reduce regulatory and administrative burden for health services and Colleges.
18. Risk-based, data-driven collaborative accreditation systems with a quality assurance and quality improvement advocacy role for Colleges (Section 5.1).	Collaborative, risk-based accreditation of training promoting a partnership approach to support health services with accreditation and training, particularly when accreditation issues arise. Supports the integration of a continuous improvement approach with the potential to reduce the frequency of full accreditation assessments, thereby reducing the resource and administration burden.
19. Design and develop a common online accreditation portal to create efficiencies, reduce the administrative accreditation burden and create a synergistic approach to specialty medical training accreditation aiming to provide insight into health care system training capability and capacity for medical workforce planning and distribution (Section 5.0) and (Section 6.9).	Technological systems are required to enhance and drive efficiencies in accreditation systems, from reducing administrative burden for all users to managing workflow and enabling continuous quality improvement. A technological solution provides for a consistent and coordinated system approach enabling health services to centrally manage and coordinate accreditation data across all specialties, creating efficiencies, reducing administrative burden and enabling granular reporting on accredited training. A common portal for Colleges to enabling the capture and sharing of common accreditation requirements for each health service. A centralised system to also act as an early alert system for issues related to trainee wellbeing that may impact more broadly than one particular specialty. Provides a centralised portal with accredited training capacity data to support non-GP specialist medical workforce planning.

Recommendation	Rationale
Valuing and promoting the rural training experience	
20. Development and integration of specialty-specific rural curricula in College education and training programs (Section 6.1).	Rural rotations are one tool to provide exposure to rural health care and encourage and support more trainees in moving to rural and regional areas, however, rotations are not always possible for every specialty.
	Inclusion of elements of rural, regional and remote practice in College curricula and training programs may further encourage the development of more rural training pathways, support the development of rural practice skills and contribute to improving specialist workforce distribution in rural areas.
	Alignment with RHMT Program Evaluation, Recommendation 5 – The Department to consult with the universities to determine how exposure to rural health could be incorporated into their health program curricula.
21. Recognise the different strengths of specialist medical training in a variety of settings in specialty training programs and accreditation criteria and practices (Section 6.1).	Each training setting has strengths that contribute to developing specialist scope of practice. The strength of many rural areas is the varied casemix, the low resource environment to practice medicine and exposure to rural communities, including Aboriginal and Torres Strait Islander health.
	Inclusion of elements of rural, regional, remote, Aboriginal and Torres Strait Islander health and metropolitan practice in accreditation standards for specialty training programs may further encourage the expansion of training pathways in rural areas.
22. Increased collaboration between Colleges, jurisdictions and local health areas (incl. rural health service boards and executive teams) to target and support more training in rural areas (Section 6.1).	Specialty training in rural areas requires a collaborative approach to meet service and workforce needs, long term specialty distribution priorities and ensure long term sustainability of training capacity. This includes joint workforce planning and engagement at jurisdictional and local health service level.

Recommendation	Rationale
Clinical Leadership	
23. Support access to professional development programs for rural clinicians to become specialty supervisors or enhance supervision and develop and enhance leadership skills (Section 6.2).	Although there are funding programs available for rural specialists to access professional development support, this is not specifically linked to building and sustaining specialty training capacity in rural areas. This recommendation proposes targeted support to encourage specialists in rural areas to become training supervisors or current training supervisors to further enhance their leadership skills to strengthen training capacity and sustainability in rural areas. **Alignment with RHMT Program Evaluation, Recommendation 11** – To strengthen supervision capacity and capability in rural, remote and regional sites, the RHMT program encourages universities to engage with current and potential supervisors on a regular basis to identify and implement: • supports and skills development required to commence or continue to provide supervision to students • employment or other engagement and recognition arrangements require recognising possible differences between localities, settings and disciplines, and • opportunities for localised or regional innovative supervision models.
Networks	
24. Accreditation systems to facilitate and support accreditation of network training models, at local and rotational level (Section 6.3).	Evidence indicates that rural health services welcome the opportunity to be involved in network training models, particularly when they may be unable to achieve accreditation as stand-alone training sites. Network training models support professional practitioner networks, an improved ability to meet training and workforce needs as well as resourcing and administration for accreditation assessments. Systems need to enable localised and network management of accreditation and training related matters with jurisdictional and network support to ensure continuity and minimise disruption to service delivery and training in rural areas.
25. Network principles must ensure that all network participants are equal partners. Networks to consider 'home health service' concept, whereby trainees nominate the home health service to spend most of their training time and may be employed by the home health service to enable continuity of entitlements (Section 6.3).	Feedback indicated that for optimal function of rural training networks and/or networks with rural posts, it is important that all network participants are equal partners. This ensures that all network partners share the responsibility, accountability and success of the network supporting training and meeting workforce and service delivery requirements. Often primary, larger health services support smaller satellite sites with rotations, employment contracts for trainees, tutorials, study groups, etc. Evidence indicated that primary sites are either large regional centres (MM 2) or metropolitan, often in 'hub and spoke' network models with centralised control.

Recommendation	Rationale
26. Establish accredited, independent, state and territory training pathways and networks (where possible) to improve workforce planning, coordination and allocation of trainees for training rotations (Section 6.3).	Many training pathways and networks cross jurisdictional borders and whilst this is sometimes necessary for smaller specialties and national training program networks, establishing independent jurisdictional training networks better supports meeting jurisdictional workforce needs. This also supports trainees being allocated across a jurisdiction according to training needs and level of competency for service need, in the appropriate contextual environment with appropriate levels of support; whilst maintaining high quality training experiences.
27. Metropolitan and larger regional health services to have a leadership role in providing support to rural, regional and remote health services as part of network arrangements (Section 6.3).	Although this already occurs in some network training models, active leadership by metropolitan sites to assist and support rural health services in specialty training, particularly in accreditation, trainee selection, recruitment, rotations, tutorials, and study groups, is identified as critical for positive, successful and sustainable rural training for health services, supervisors and trainees.
28. Coordinated network training models – each network requires a coordinator per jurisdiction or per network, per discipline. This includes resourcing and administrative support (Section 6.3).	Evidence suggests that to establish, build, maintain and sustain training networks requires a significant amount of resources in terms of time, administration and funding. There is often no single source of funding to support network training, often relying on larger sites with available resources for sustainability. Support is required to enable further integration of network training models in specialty training.
29. Support for public / private collaborative training models in rural areas including the development of public / private 'campus accreditation' models (Section 6.4).	To further support expansion and sustainability of specialty training in rural areas. There is evidence that such arrangements successfully integrate a broader training experience for rural trainees to assist in attainment of training requirements and may provide an opportunity to extend accredited rotational terms in rural areas.
College Support	
30. Increased collaboration between jurisdictions, Colleges, and health services to improve medical workforce planning alignment with accreditation and specialty training outcomes (Section 6.6).	Evidence suggests that there is scope to further expand specialty training in rural areas with increased collaboration in specialist medical workforce planning across the sector ensuring alignment of specialty training with government, state and territory medical workforce priorities.
31. Increased stakeholder engagement and collaboration between Colleges, health services and jurisdictions to support a continuous quality improvement accreditation model and early notification of any issues that impact accreditation (Section 6.6).	Feedback indicated that there was an increase in positive outcomes the greater the collaboration between health services and Colleges in resolving accreditation related issues. The level of support provided by Colleges also had a direct correlation with the prompt and successful resolution of issues. The involvement of jurisdictions in supporting quality assurance and improvement in specialty training is also important.

Recommendation	Rationale
Increasing high-quality rural and regional specialty medical training	
32. Support for rural health services to build training capability and capacity including training specialist supervisors, medical education officer and training infrastructure support (Section 6.7).	To enable accredited training there needs to be a ready and trained workforce to support trainees, a strong evidence base of specialty service availability (including breadth and depth) and a concentrated effort by health services to plan and build the workforce to ensure a high-quality training environment for trainees. This requires significant resources, long term planning and support to achieve.
Improvements to Accreditation Frameworks	
33. Review of AHMAC National Accreditation Framework for Medical Specialty Training 2015. Standardising terminology and having a standard agreement on assessment with overarching standards and criteria may drive further efficiencies. Maintain specialty specific criteria and requirements and share common data (Section 6.9).	To drive further efficiencies in the specialist medical college accreditation system, review the AHMAC National Accreditation Framework for Medical Specialty Training. Integrate contemporary accreditation practices and lessons learnt and the evolution of accreditation practice as a result of the COVID pandemic to strengthen specialist medical training accreditation systems. This may be integrated with Recommendation 19.
34. Improve feedback mechanisms for trainees, supervisors and health services to raise and address issues related to accreditation (Section 6.11.1).	Improved management of accreditation related issues including raising, remediation and resolution through increased collaboration between Colleges, jurisdictions and health services and support for health services, supervisors and trainees.
35. Leverage the AMC Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs for system level reform (Section 6.11.1).	Target system level regulatory reform to improve the distribution and support of specialty training in rural, regional and remote areas.
36. Leverage the National Safety and Quality Health Service Standards, the current health service regulatory framework (Section 6.11.1).	Target system level reform to drive efficiencies and create greater alignment in health sector accreditation systems, strengthening the role of the medical workforce and specialty training in delivering safer high quality health care.

1.0 The accreditation context

Non-GP specialist medical training (hereon referred to as 'training') is undertaken in accredited training posts in various health services throughout Australia.

There are many bodies involved in the accreditation of training. The Health Ministers' Meeting, under the *Health Practitioner Regulation National Law Act 2009* (the 'National Law') oversees the National Registration and Accreditation Scheme (the 'National Scheme').

The then COAG established the National Scheme so there would be one scheme for registered health professionals in Australia. The scheme started in 2010 and now covers 15 professions, including medical practitioners. Each profession has a national board which regulates the profession, registers practitioners and develops standards, codes and guidelines for the profession.[18]

The National Scheme has a number of objectives, including to:

- help keep the public safe by ensuring that only health practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered
- facilitate workforce mobility for health practitioners
- facilitate provision of high-quality education and training for practitioners
- facilitate the assessment of overseas qualified practitioners
- facilitate access to services provided by health practitioners, and
- enable the continuous development of a flexible Australian health workforce.[19]

The Australian Health Practitioner Regulation Agency (Ahpra) administers the National Scheme and provides administrative support to the national boards such as the Medical Board of Australia (MBA).

The MBA:

- registers medical practitioners and medical students
- develops standards, codes and guidelines for the medical profession
- investigates notifications and complaints about medical practitioners
- where necessary, conducts panel hearings and refers serious matters to Tribunal hearings
- assesses international medical graduates who wish to practise in Australia, and
- approves accreditation standards and accredited courses of study.[20]

The MBA is responsible for approving accreditation standards and accredited courses of study, this function is delegated to the AMC. The AMC accredits education providers and their training programs which lead to qualifications for practice in recognised medical specialties. The accredited Colleges accredit health services, training posts, networks and programs to ensure they meet training program standards.

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18 https://www.health.gov.au/initiatives-and-programs/national-registration-and-accreditation-scheme

19 https://www.ahpra.gov.au/about-ahpra/what-we-do/faq.aspx

20 https://www.medicalboard.gov.au/About.aspx

Additionally, there are other contributors influencing accreditation, as demonstrated in the infographic below.

Figure 2: Accreditation Stakeholders and Influences

National Cabinet Health Reform Council

Health Practitioner Regulation National Law

National Registration and Accreditation Scheme

Medical Board of Australia

Australian Health Practitioner Regulation Agency

Australian Medical Council

University Medical Schools

Specialist Medical Colleges

University Departments of Rural Health

Rural Clinical Schools

Regional Training Hubs

Education and Training

Member Services

Accreditation Committee

Regional / Jurisdictional Committees

Accreditation Teams

Health Services

Government – State / Territory

The AMC is an independent national standards body for medical education and training. Its purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.[21]

The AMC has assessed and accredited specialist medical education and training and professional development programs since 2002. From 2002 to June 2010, the AMC process for accreditation of specialist education and training programs was a voluntary quality improvement process in which all Colleges agreed to participate. Since 1 July 2010, the process has been mandatory. The National Law makes the accreditation of specialist training programs an element of the process for approval of programs for the purposes of specialist registration. Similarly, the MBA's registration standards indicate that continuing professional development programs that meet AMC accreditation requirements also meet the MBA's continuing professional development requirements.[22]

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21 https://www.amc.org.au/about/about-2/about/

22 https://www.amc.org.au/accreditation-and-recognition/assessment-accreditation-specialist-medical-programs-assessment-accreditation-specialist-medical-programs/

The AMC's Specialist Education Accreditation Committee oversees the accreditation process. The Committee's roles are:

- developing guidelines, policy and procedures for the accreditation of specialist medical education and training programs

- overseeing the AMC's program of accreditation, and

- encouraging improvements in postgraduate medical education that respond to evolving health needs and practices, and educational and scientific developments.

AMC accreditation is based on self and peer assessment. Assessments are conducted by AMC teams which report to the Specialist Education Accreditation Committee. Teams include a mix of clinicians, specialist trainees, scientists, allied health professionals, health administrators and wider community representatives.

The AMC accredits Australian and New Zealand providers of specialist medical training and their specialist training programs which lead to qualifications for practice in recognised medical specialties. Recognition means that the Health Ministers' Meeting has made a decision to recognise a new specialty and, if necessary, approved an amendment to the *Health Insurance Regulations 1975*.

As the accreditation authority for medicine, the AMC develops accreditation standards for medical programs and their education providers. The current approved AMC accreditation standards (AMC Standards) are the *Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2015*.

The AMC uses accreditation standards to assess medical programs for the purposes of accreditation. Under the National Law, the AMC may grant accreditation if it is reasonably satisfied that a program of study and the education provider meet an approved accreditation standard. It may also grant accreditation if it is reasonably satisfied that the provider and the program of study substantially meet an approved accreditation standard, and the imposition of conditions will ensure the program meets the standard within a reasonable time. Having made a decision, the AMC reports its accreditation decision to the MBA to enable it to make a decision on the approval of the program of study for registration purposes.

The AMC accreditation standard that has reference to accreditation of training sites, programs and posts is **Standard 8.2 Training Sites and Posts** with **Standard 8.1 Supervisory and Education Roles** underpinning supervision requirements. (Appendices – Appendix O)

Throughout the AMC accreditation standards are references to the accreditation of training sites and posts in rural and regional areas. This is of potential interest when considering medical workforce planning priorities and supporting the expansion of training into these areas.

AHMAC National Accreditation Framework for Medical Specialty Training

During 2011, AHMAC commissioned the Accreditation of Specialist Medical Training Sites (Phase One) project to review accreditation practices for specialist medical hospital training posts. This work was progressed by the Health Workforce Principal Committee and completed in September 2011. Phase One reviewed the specialist medical colleges' accreditation processes and considered opportunities to streamline the accreditation process to improve efficiency and eliminate duplication. Following completion of Phase One, AHMAC commissioned Phase Two to progress further work.

Phase Two of the project commenced in May 2012 with the appointment of a Project Manager and establishment of a Project Reference Group. The Project Reference Group consisted of representatives from the Council of Presidents of Medical Colleges (CPMC), AMC, Australian Medical Association (AMA), Australian Medical Association Council of Doctors in Training, Australian Salaried Medical Officers' Federation, jurisdictions and hospitals.[23]

Following extensive consultation, the National Accreditation Framework for Medical Specialty Training (the 'AHMAC Accreditation Framework') was developed including the National Accreditation Guide for Medical Specialty Training, Accreditation Domains and Standards and an Evidence Collection Template for implementation by Colleges.

During this project, Colleges indicated that many had given consideration to the AHMAC Accreditation Framework, though only some Colleges have fully integrated and implemented the AHMAC recommendations. For those that have, this has been a lengthy process.

Specialist Medical Colleges

Specialist medical colleges are non-government, membership organisations responsible for training medical specialists, specialty education, professional development and advocacy for, and support of, the advancement of professional specialty standards in Australia and New Zealand.

In addition, Colleges advocate for policies and strategies to improve health outcomes, health advocacy (disease prevention and health support, provision of care, access to care, quality and safety, science and research), improvements to delivery of care, models of care, medical standards, safe practice guidelines, regulatory and legislative matters, medical workforce planning and distribution and specialty medical training expansion in private, rural and regional settings.

Colleges function for the benefit of their members ranging from Fellows to trainees and have a clearly articulated purpose in each College constitution.

Colleges train the specialist workforce in partnership with health services, and each College accredits training posts, health services, programs and/or networks for specialty training. All generally follow a common process of accreditation, with similar policy and frameworks to underpin the accreditation function. There are commonalities across standards with variations for each specialty or subspecialty, particularly in criteria and specific requirements aligned with training programs and curricula.

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23 Australian Health Minister's Advisory Council, Health Workforce Principal Committee, Accreditation of Specialist Medical Training Sites Project, Final Report, 2015

In determining 'How Accreditation Practices Impact Building a Non-GP Rural Specialist Medical Workforce', it was essential that the project gained an understanding of specialist medical training accreditation practices in order to consider and understand the impact of accreditation practices and any potential solutions to further support expansion of specialty training in rural areas. Detailed information on each of the participating College accreditation frameworks and practices is included at Appendices A–L.

The Specialty Medical Training System

As identified earlier, the specialty medical training system is complex. There are variations for training per specialty, sub-specialty, jurisdiction and health service. Each jurisdiction has different industrial arrangements and health services have varying resources, models of care, workforce and service delivery requirements across Australia with various other localised factors also impacting training.

Colleges are national or bi-national bodies that develop policy, regulation and process applicable across different countries, jurisdictions, sectors and health services with sometimes very different requirements.

Accreditation of training positions is only one element enabling training but it is an important lever to not only ensure quality and safe training for trainees, supervisors and patients, but also to implement reform. When training curricula and programs are reviewed by Colleges, accreditation frameworks must also be reviewed to ensure they support and enable the implementation of changes in delivery of training at health service or training organisation level.

During the consultation, stakeholders raised a number of issues that were impacting the ability of a health service, region or specialty to support training. These were separate to the accreditation of training posts, health services, networks and programs however, operationally, all are important considerations in enabling and supporting training. These issues were identified as being present even if accreditation of training was supported by Colleges in rural, regional and remote health services. These issues are out-of-scope for this project, however, have briefly been identified in this report with a view to future consideration in policy and program work and to inform the implementation of the NMWS and other national strategic frameworks.

2.0 What works well in specialist medical college accreditation

> "In Australia we have an accreditation process for specialist medical training that works in most cases and gets a result." (Rural Medical Administrator)

The quality of medical training in Australia is testament to one of the most effective medical education and training systems in the world in terms of graduate outcomes and the quality of specialists produced. There is a rigor in defining standards of training and appropriate places for trainees to be gaining experience and skills. One of the most effective parts of the accreditation process is the seriousness with which it is treated by jurisdictions and health services and the implications of losing accreditation impacting the ability to attract workforce across all areas of the health sector. Accreditation has been a major step towards improving training conditions and support of trainees and supervisors and improving the quality of medical training and education.

2.1 Quality assurance and quality improvement

The primary functions of the accreditation system are quality assurance, regulatory, and quality improvement. As a regulatory function alone, the accreditation system potentially misses out on opportunities for innovation through quality improvement, which is particularly relevant to rural training networks and training sites to influence the mindset of the future medical workforce about the type of clinical services that rural health services provide and the facilities that they can be working in the future.

An advantage of the current accreditation system is that there are set standards reviewed at regular intervals (four or five year cycles) with most Colleges advocating with health service executives about specialty training. This provides an opportunity for reflection at health service executive and departmental level on what is being done well in specialty training and finds areas of focus for continuous quality improvement for both training and service delivery.

Periodic reporting to Colleges ensures health services keep specialty training and accreditation at the forefront, creating a culture of regular and routine quality improvement rather than leaving it to a four or five year cycle to address accreditation issues.

The accreditation process and recommendations can raise training deficiency matters that health services know they are missing in the training environment they are providing for trainees. Health services welcome receiving College accreditation reports with findings and recommendations to leverage additional resources to support training.

The articulation of the responsibilities of the College and the employer and also of shared responsibilities in relation to specialty training are important.

Some Colleges are bringing to the forefront the role of the supervisor and the resourcing required for supervision through accreditation frameworks and the provision of support from Colleges for professional development, supervisor training and training networks. A training supervisor requires a different skill set to a clinical supervisor and accreditation has increased the focus of the Colleges on quality supervision.

The focus on quality care, ensuring that patients and the trainees are safe and the focus on adequate support for trainees, must continue to be the key principles of College accreditation. Specialties and Colleges must maintain the dual role of being responsible for both accreditation for training quality as well as for patient safety.

The Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service (NSQHS) Standards provide a nationally consistent statement of the level of care consumers can expect from health service organisations[24]. There are also Clinical Care Standards that describe the care patients should be offered by health professionals and health services for a specific clinical condition or defined clinical pathway in line with current best evidence.[25] There is a role for Colleges in contributing to setting and maintaining clinical standards, for example, the development of resources required to provide safe patient care and the best outcomes for a specialty. This may include workforce, expertise and infrastructure. This is particularly important when it comes to smaller health services that don't have the same resources as larger settings.

If a College makes a decision not to accredit a training post, health service, program or network, this can sometimes be related to minimum clinical standards as well as non-compliance with standards for accreditation of training. From a health service perspective, this can also mean that there are improvements that need to occur for the improvement of patient care and service delivery in that health service and an accreditation outcome can leverage with the health service executive the resources required for that to occur.

Accreditation standards have also provided a greater focus for health services on ensuring supervisors are well supported. If there isn't the senior medical workforce with the dedicated time to support, supervise and teach trainees and administrative support, there is limited ability to support a specialty training program.

When training posts are assessed for accreditation, there is often an acute response by a health service for the duration of the accreditation visit and assessment. There is an opportunity for evolution to an ongoing, collaborative focus on quality training and continuous improvement between health services and Colleges outside of the formal assessment cycle.

The oversight of Colleges by the AMC ensures there is scrutiny over College policies and processes. This is something stakeholders felt was positive and should continue.

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24 https://www.safetyandquality.gov.au/standards/nsqhs-standards

25 https://www.safetyandquality.gov.au/standards/clinical-care-standards

2.2 Setting the parameters for quality training

"What works well for health services is that each College has documented standards on what the expectation is that they need to meet to support specialty trainees. The accreditation standards not only keep the focus for the health service on teaching and learning, but also service delivery. Accreditation standards also provide guidance for supervisors to know exactly what they should be doing to support training.

The other benefit of accreditation standards is that it encourages health services to think about the training experience and to think outside the box about what else is required to support a good and quality experience in rural areas where they have less resources and sometimes require creative thinking to achieve the desired quality training outcome.

Colleges need to be more flexible and start thinking about rural areas as a different way of practising medicine, not just a training rotation to meet the requirements of the training program." (Regional Health Service)

Accreditation frameworks ensure a minimum level of training competency and infrastructure for a health service to support training.

Overall, feedback suggested that although accreditation site visits take some planning to have everyone in the same place at the same time, they work very well, are focussed, and a good opportunity for health services to engage with Colleges on training matters.

College Fellows have an important role in supporting their Colleges to set the parameters for quality training and education. Fellows involved in accreditation often have specific expertise or an interest in accreditation, with Colleges capitalising on any professional special interests to support balanced, considered and consistent accreditation assessments. Policy and process is also embedded to ensure independent, objective and transparent assessment to minimise the potential for bias and conflict of interest.

The composition of expertise on accreditation teams also assists with reinforcing parameters for quality training with Fellows participating in accreditation often involved in supervision and support of trainees and able to share positive experiences in supervision and training.

2.3 Opportunity for engagement

Accreditation can also be a form of strategic engagement between Colleges and health services, and at times, this may be the only formal engagement health services will have with Colleges. This provides an opportunity to empower trainees, supervisors, Fellows and the health service executive in relation to the medical workforce, training system and health system. The involvement of health service executives in accreditation visits helps ensure whole-of-health service ownership of training and accreditation and has the ability to influence improvements to support specialty training more broadly than just one specialty in a health service. Accountability for meeting the accreditation standards, criteria and requirements rests with health services more broadly, not just supervisors and departments with some issues raised in accreditation assessments only able to be resolved at senior levels of health services and / or health regions.

Health service executives also need to sight accreditation reports to have oversight of training and the importance of trainees to the provision of service delivery. Clinicians identified that the support of the Chief Executive and the health service Board is paramount to delivering positive training experience for trainees, particularly so trainees will want to return to rural practice once they become Fellows.

Engagement also provides opportunities to develop and strengthen clinical and professional networks to better support training outcomes.

2.4 Peer review

"Engaging other people who are stakeholders in specialty training programs as part of accreditation committees and accreditation teams is valuable because it is peer review reflection. Ensuring that the accreditation system keeps that professional input, quality improvement and peer review focus is what keeps accreditation a process that's worth having." (AMC)

Accreditation is predicated primarily on a peer review system, and whilst that can have challenges, for example, assessment teams may not come from rural areas, or have particular biases, this can be addressed through College policy, regulation and practice.

Having specialists who bring expertise, experience and understand the specialist training system, and the challenges of balancing the trainee versus service and training versus service paradigm, is critical in accreditation assessments. With diversity of experience and expertise on accreditation teams, there is an opportunity to leverage this to integrate a more flexible approach to outcomes-based accreditation across a variety of health settings.

Peer review also supports collective responsibility for self-governance. There is a strong role for peer review in quality improvement with accreditation assessors providing feedback to support health services to enhance quality training.

If the accreditation system ceased to include peer-review, there is a risk of fragmentation in accreditation and training with a loss of connection across health service and training information and between health services, Colleges, trainee groups and supervisors.

The AMC advised that Colleges' maturity as training organisations has seen an increase in the engagement of medical professionals and specialists either from within specialties or more broadly.

2.5 Trainee wellbeing

Overwhelmingly, feedback was highly complimentary of Colleges in relation to the increased focus on trainee wellbeing, experience and patient safety, which in turn stimulated positive change in training and the greater workforce in health services.

The issue of trainee wellbeing has been in the spotlight for a number of different reasons over the last few years, most particularly in relation to the discrimination, bullying, harassment and sexual harassment in health care settings raised in the Australian media in 2015.

In 2015, the AMC introduced 14 new standards focussing on trainee wellbeing and patient safety. Education providers were expected to meet these standards from 2016.

The AMC noted that Colleges focus on support and education of trainees, including casemix and health service support for trainees and not just the safety of patients, but also trainees. Accreditation provides guidance on how to ensure the delivery of a high-quality training program with a focus on the wellbeing of trainees.

College accreditation frameworks have focused the attention of health services on the need for anti-bullying and other training policies, peer support, improved patient ratios, fatigue management and safe working hours to support trainee wellbeing. There are safety aspects to accreditation which are present for patients and for trainees recognising the role also of employers and Colleges in supporting trainees in accessing quality and safe training experiences. Accreditation helps everyone involved in specialty training to understand what the parameters and requirements are for quality, well supported and safe specialty training. It has been particularly important for health services with Ahpra changes to mandatory reporting around substantial risk, to ensure that trainees are well supported.[26]

In addition, the inclusion of one-on-one interviews with trainees during accreditation visits (in the right environment) encourages trainees to speak their mind and provide open and honest feedback. Trainees are now also participating in many College accreditation teams providing the trainee perspective in assessment. This also positively impacts discussions with trainees during accreditation assessments encouraging honest feedback.

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26 https://www.ahpra.gov.au/Notifications/mandatorynotifications.aspx

3.0 Issues and challenges impacting the development of rural specialist training pathways

> "Rural and regional health services are being assessed fairly in a system that does not account for difference." (Rural Health Service Administrator)

The health service of the future is no longer a cookie-cutter model. Health services are starting to look and work differently. They may deliver similar services but how they deliver the service is different. Applying a cookie-cutter approach to accreditation creates barriers; some health services will fall short because they are different, and therefore, tailoring and flexibility is needed in the accreditation system to progress towards outcomes-based accreditation.

The following themes emerged in relation to the challenges within the current College accreditation frameworks and the impact on the development of rural training pathways:

- College accreditation frameworks, including standards and criteria, assessments and more broadly, the construct of specialty medical curricula and training programs, do not take training context into consideration, for example, health setting type, health service size, jurisdiction, location, and service delivery model
- Accreditation frameworks can be rigid and allow little adaptation or consideration that rural settings or training pathways are any different. However, there is progress towards integration of flexibility by some Colleges
- Decision-makers in Colleges are often metropolitan experienced and focussed resulting in predominantly metro-centric decisions made in the non-GP specialty training system
- It is difficult for rural health services to meet the critical mass of FTE supervisors, specialist workforce and organisational structures to support training in a similar way to metropolitan services
- There is no alignment of accreditation assessments across specialties and sometimes subspecialties, causing significant resource and administrative burden for health services undertaking multiple assessments each year
- College accreditation assessments can be inconsistent, despite published standards and procedures for accreditation
- There is a need for greater transparency in College governance and in detail of all accreditation criteria, for example, required case numbers and casemix
- Accreditation data management systems are variable, there is no common IT infrastructure to support the accreditation function and sharing does not occur across Colleges, specialties and rarely with jurisdictions
- Data sharing between Colleges and jurisdictions can be challenging and inhibit collaborative medical workforce planning
- There is no clear picture of specialty training capability and capacity in the Australian health system, particularly for jurisdictions, which impacts on medical workforce planning and support for specialty training

- With competing workforce pressures, rural and regional specialists do not always have capacity (and sometimes capability) to develop training pathways, business cases and requirements for the accreditation of training posts, and often have very little time and support to maintain accredited training posts

- Health service executives are not consistently engaged in specialty training activities or involved in site accreditation. Often accreditation outcomes can only be dealt with at health service executive level

- There is a significant opportunity for Colleges to align purpose with strategic medical workforce planning to achieve a balance in workforce supply and distribution, particularly improving training distribution in rural areas to meet community health care needs

- Training programs have been predicated on inputs such as time, process, and numbers-based education to achieve training requirements and competency. Although many Colleges either have or are progressing towards competency-based training, these traditional education methods are often reflected in accreditation standards and criteria. When smaller health services cannot meet numbers in accreditation criteria for caseload and casemix, incorporating flexibility in accreditation frameworks focussing on outcomes can support smaller health services to build specialty training capacity whilst maintaining quality training experiences

- Some accreditation criteria are not aligned with industrial arrangements i.e., work hours and rostering requirements for trainees, impacting on the composition of the medical workforce and health service delivery, and

- State and territory government medical workforce units have limited visibility and involvement in specialty medical training and accreditation.

3.1 State and territory government context

State and territory government feedback was representative of their role in medical workforce planning, at both a policy and program level, but also in supporting health service delivery. This included specific information on health systems and the medical workforce to highlight specific challenges in training and accreditation.

Consultations identified that currently only one College invites a state or territory department of health representative to participate in accreditation assessments. On occasion, representatives are only able to attend part of the accreditation assessment and invitations to participate can be reliant on whether the specialty deems it appropriate. The frequency of state or territory representation on accreditation assessments is also variable depending on several factors, including the availability of state and territory staff.

State and territory health departments identified the benefits of representation on College accreditation teams including improving jurisdictional understanding of the accreditation process and specialty training requirements which in turn enables better jurisdictional support of training. It is also beneficial for College accreditation teams as representatives can provide context on jurisdictional, metropolitan and rural, regional and remote site differences and broader state or territory medical workforce matters that may impact accreditation.

States and territories are sometimes involved in specialty trainee selection and training forums. There are some jurisdictional meetings and written submissions made to Colleges in relation to accreditation with a sharing of issues on accreditation and other training matters to determine any overlap or where there may be differences in College practices.

State and territory government summary

- State and territory health departments mostly reported limited engagement with Colleges. Some jurisdictions meet regularly with local College members on matters of mutual interest, including training and accreditation.
- Queensland holds monthly executive level meetings with health services, including rural sites. This has proven to be effective in supporting matters related to medical workforce and training.
- Most states and territories do not have data on accredited specialist training posts. Those that do source this information directly from health services and there is variability in accuracy.
- New South Wales, Queensland, and Victoria support specialist training through jurisdictional targeted medical workforce programs. These are designed to meet the needs of public health settings in rural and metropolitan areas based on jurisdictional workforce plans and priority areas, such as specialties in undersupply. There is no formal link between state-based programs and the STP, although priorities align closely with Australian Government priorities, particularly those identified in the NMWS.
- Reaching the critical mass of specialist supervisors in rural areas was identified by all jurisdictions as problematic.
- Workforce, service delivery models and training infrastructure vary by jurisdiction and sometimes by region. This often impacts on the ability to engage in and support training.

3.1.1 Australian Capital Territory Health

The size of the workforce of the Australian Capital Territory (ACT) is a significant factor for ACT Health in providing end-to-end training pathways and will often link to New South Wales (NSW) accredited sites with dependency on Southern NSW regional partners in Wagga Wagga, Bega and Queanbeyan.

The biggest challenge for emergency medicine in the ACT is the interdependence of other specialities and available accredited training posts limiting the number of trainees that can be trained. The continuous training pathway becomes limited by insufficient accredited Intensive Care Units (ICU) and / or anaesthesia terms.

In the ACT, the ACEM faculty chair along with the Directors of Emergency Departments from Calvary and Canberra Hospitals, meet with both the Minister for Health and the Minister for Mental Health three times a year. They discuss training and workforce requirements which includes both consultant and trainee training, including resourcing requirements. There is collaborative agreement for trainee and consultant numbers to support training across both sites.

Territory funded programs

The ACT does not provide any additional program funding support for specialty training.

3.1.2 New South Wales Ministry of Health

The New South Wales Ministry of Health (NSW Health) noted accreditation is metro-centric, and that while the standards should be the same for rural sites there needs to be flexibility in how they are applied. Networked training is utilised in NSW with rotations in metropolitan and rural settings. This supports improved workforce distribution and facilitates the use of 'length of training' contracts, which have been introduced for some specialities.

A challenge in NSW, and more so in rural health services in NSW, is the requirement for supervision of specialty training by specialists of that specialty. There is an opportunity to embrace remote supervision, tele-supervision models or even supervision by someone who is not a Fellow. For example, health services credential GPs to provide safe and effective palliative care and emergency services but under accreditation standards, a GP is unable to supervise and sign off on training assessments.

In rural NSW there are more specialist Visiting Medical Officers (VMOs) than local staff specialists. This may impact on the ability of health services to support training with VMOs as clinical supervisors. There is variability depending on how VMOs and trainees work together to support a service, and the perception of a health service or accreditation team as to what is appropriate clinical supervision.

In some cases, health services in NSW do not necessarily have the appropriate level of oversight on accreditation of training or the systems or resources to support the administration of accreditation. NSW Health advised that the escalation process of Colleges for accreditation issues is problematic. NSW Health is not always aware of a situation where accreditation issues arise in a health service and often only find out when accreditation is going to be withdrawn, making it difficult to provide support to the health service.

As such, NSW Health has introduced regular meetings with NSW specialty and College representatives to increase engagement and discuss matters related to training and accreditation more frequently. This is also assisting in sharing of information about accredited training posts and sites.

State funded programs

NSW Health provides support for specialist training under an ongoing jurisdictional Specialist Training Program. The majority of positions in NSW are funded by the Local Health Districts (LHD). The LHDs fund positions based on service need rather than any long-term workforce planning.

Through targeted funding from a 2015 NSW election commitment, 60 positions were funded in mainly rural and outer metropolitan areas via an expression of interest (EOI) round to identify those positions to be supported. The program supports both metropolitan and rural specialty training positions. Funding is indexed and goes straight to the LHD. Funding is not at the same level as the Commonwealth STP or IRTP. There is some flexibility built into the program to enable health services to meet their service need, and also recruit service registrars (unaccredited) trainees if they cannot fill an accredited position.

Dubbo Hospital accesses the NSW Specialist Training Program funding to support dual training pathways. Coffs Harbour Health Campus has two advanced physician training posts funded under the same program: general medicine and palliative care. The general medicine trainee is part of the Royal North Shore rotation, and the palliative care trainee is recruited directly by the health service with no link to any metropolitan site for rotations.

NSW Health also implemented the Metropolitan Access Scholarship (MAS) scheme to primarily support eligible rurally based vocational trainees (and Rural Preferential Recruitment Program Post Graduate Year 1–2 trainees) to undertake metropolitan rotations as there are no allowances or arrangements in

the award to support the cost of such rotations. Under the *Public Hospital Medical Officers (State) Award 2019,* trainees who rotate from metropolitan settings to rural can access an allowance and are provided accommodation and travel. The Health Education and Training Institute (HETI) administers MAS and in 2019 ran a campaign to increase uptake. The state has awarded approximately 80 scholarships to date.

NSW Health has developed a Map My Health Career website with examples of rural clinicians and their training and career pathway in rural health to support doctors in choosing their career pathways. The state will continue to support rural rotational opportunities for trainees to access as much specialty training in rural areas as possible.

3.1.3 Northern Territory Health

In the Northern Territory (NT), all medical practitioners need to be generalists as the jurisdiction is unable to support a narrow field of subspecialties. The three regional hospitals require generalists with additional skills. There is a requirement for paediatric skills in Katherine, and there is an outreach model in the emergency department and in obstetrics, but this model is expensive to run and it is not building capacity. Specialists in the NT have opportunities to work in Aboriginal Medical Services, general practice or in the government health care environment.

The vast physical distances between back up care and health services are a huge obstacle in the NT. Telehealth is well used to support remote service delivery. For example, NT Health reported that emergency physicians guided a local nurse to insert a life-saving chest tube in a patient in the remote community of Manangrida.

There are many non-vocationally registered (non-VR) medical practitioners in the NT, making it difficult to meet accreditation requirements for supervision. A non-VR medical practitioner is often unable to supervise a specialty trainee, despite being credentialed and highly experienced in the NT, in contrast to a specialist, two years post Fellowship, who is able to supervise.

The model of supervision is a barrier for the NT, and other accreditation issues are rarely about infrastructure, but relate to the expertise of the specialty supervisors and clinicians and the quality of training. For example, in the NT, there are complex public health issues including chronic disease, smoking and obesity. In one example related to supervision requirements, there have been issues raised for a public health trainee in working with environmental health experts to learn about water management, drinking water and wastewater and air quality as they are not supervised by doctors and not seeing patients. Although these trainees are learning about public health, the training experience is not recognised as accredited training time as supervision does not meet accreditation standards.

In the NT there is a need for a broader range of accredited supervisors with a broad experience base, which is at odds with the traditional accreditation framework and specialty training curricula. A vertical model of supervision is preferred with a Fellow teaching a senior registrar, a senior registrar teaching a junior registrar and further integration.

The NT has a number of specialist Fellows who can supervise. If there are only two Fellows in a specialty, there is a high dependency on a very small number of committed Fellows and a fragile training structure. As such, the NT can only deliver so many training places with the specialist workforce available because of the demands already on the workforce for health service delivery. There are many competing priorities and the jurisdiction is at risk of losing training positions at any time if a specialist leaves, particularly a sole practitioner specialist. Sustainability of specialty training programs, particularly the subspecialties, are most impacted.

Accredited networks or 'hub and spoke' models with a central control point in a metropolitan area has been prohibitive for the NT in building the medical workforce and training capacity, particularly when participant health settings do not have equal input and control in recruitment and allocations to meet their service delivery and workforce needs. Most training networks currently have trainees rotating to the NT for periods of training but always returning to other states or metropolitan settings. The NT has rarely been able to retain or attract trainees back to the NT. There is a lot of time and effort put into supporting and training trainees and there is a need for them to also be based in the NT and rotate to other settings. This is to encourage them to return to the NT.

In one example, the NT has similar numbers of facial trauma cases as Victoria per annum yet is unable to establish an accredited training post because there is a requirement for four trainees to be in the one location to satisfy accreditation requirements, which is not achievable for the NT with the current medical workforce structure.

The establishment of specialty training posts in the NT is complex because the specialty service and supervision must be within the scope of practice that's able to be practised in a health service. This may mean that a particular specialty is not within the scope of practice of a health service and therefore a health service will not be able to be considered for accredited specialty training.

The 'scope of practice' in the NT and other rural areas is different from metropolitan health services, particularly for generalist specialties such as General Surgery and General Medicine. It is sometimes referred to as an 'extended scope of practice'.

Territory funded programs

The NT does not provide any additional program funding support for specialty training.

3.1.4 Queensland Department of Health

The Queensland Department of Health (QLD Health) predominantly works with Colleges and health services for the medical workforce oversight and strategic planning function. Health services are the employers of the medical workforce and they have additional workforce and service planning responsibilities.

In Queensland, most of the specialty training pathways only have an ability to guarantee up to 18 months of training exclusively in a rural or regional area and for the remainder of training, trainees must rotate to metropolitan settings due to the way training pathways function.

Through the Queensland Executive Director of Medical Services (EDMS) forums and discussions with the Regional Training Hubs (Hubs), there is consistent feedback that it is difficult for rural health services to meet some College accreditation requirements.

In Queensland for those specialties that by their nature are metropolitan based or centralised, such as pathology, sometimes the service delivery does not exist in rural areas. If it is a metropolitan-based service delivery model, the state is not able to accredit a meaningful amount of rural training because that is not where the service is provided.

Some specialties have added mandatory requirements in accreditation standards which exceed Queensland Health industrial provisions and are disproportionate to other specialty accreditation standards. This industrial matter makes it less viable from a service delivery and cost perspective and even potentially less appealing for training sites to have accredited trainees. There is a view that if industrial provisions already exist for trainees, industrial provisions should prevail over accreditation requirements.

The industrial provisions are in place for trainee wellbeing, health and safety and should be recognised by Colleges. For Colleges to set benchmarks above an industrial provision does not consider service delivery or the health service context.

For example, there are fatigue provisions and the hours that registrars can work in the Medical Officers (Queensland Health) Award. Health services provide a 24-hour service and the manner in which health services use their Principal House Officers (PHOs) and non-registrar workforces can be due to the limitations on the way that they can use their accredited trainee workforce because of College accreditation requirements. A trainee who is in an accredited position may have a limitation on the times of the day they can work to access training requirements whereas someone who is a service registrar may have to work night or on-call rosters because of these limitations.

Queensland Health has a positive relationship with Colleges and has actively engaged with Colleges through a variety of meetings and forums. The quarterly Specialist College Virtual Forum is convened by Queensland Health and chaired by Chief Health Officer and Deputy Director-General Prevention Division. The forums are well attended with each College given opportunity to contribute with the objective to collectively explore potential strategies to address workforce and system issues and to share learnings. There are entitlements built into the Queensland industrial frameworks in relation to relocation support, allowances and accommodation. Under the current Medical Officers' Certified Agreement there's a working group that has been established to review all of the Resident Medical Officer (RMO) employment arrangements, entitlements and allowances to ensure that the entitlements are actually realised and used. There is also a review in progress of rural and regional employment arrangements for all medical officers.

State funded programs

Queensland has funded additional posts in some metropolitan areas to reduce bottlenecks in anaesthesia and radiology specialty training so that trainees can meet paediatric training requirements. As both specialties have networked training approaches across Queensland, there has been an increase in metropolitan funding for training posts to ensure that rotational programs can continue to function. As a result of the initiative, Queensland Health has been able to increase specialty training regionally.

Medi Nav, the state's website portal that assists with medical career planning, has been a significant benefactor of the increased engagement with Colleges which are now sharing more data with Queensland Health more frequently, confirming the number of trainees, the demographic characteristics of the trainees and the consultant workforce.

As part of the investment in training pathways, Queensland Health has been mapping out the future specialist workforce for the state across all specialties and have been tracking the junior doctors including where they are, what they are doing, how long they're working at each location and what training scheme they are on. There is an annual Queensland Resident Medical Officer (RMO) campaign; everyone seeking a job in Queensland Health applies to a single online site that has incorporated specialty specific information and questions.

Released in 2017, the *Medical Practitioner Workforce Plan for Queensland* (MPWP4Q) is a 10 year plan with key initiatives and deliverables aimed at building, strengthening and growing Queensland's medical practitioner workforce to reflect the health needs of local communities and the changing demographics of Queensland's population'.[27] One of the key initiatives in the plan is investment in training positions, supervision and resources in rural, regional and remote Queensland.

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27 https://www.health.qld.gov.au/system-governance/strategic-direction/plans/medical-practitioner-workforce-plan-for-queensland

In Phase 1 of the plan during 2016–2017, Queensland Health met individually with Colleges and then collectively through a series of forums that included Colleges, employers, private sector and, consumers to discuss the issue of geographic distribution and develop strategies and initiatives to address the issues. Funding of $9.4 million was committed over three years (2020/2021 to 2022/2023) to progress the initial strategic priorities and associated initiatives identified in the MPWP4Q. Further funding of approximately $3.3 million per annum for three years was also committed.

There were initiatives funded for Phase 1 which aimed to improve medical workforce distribution by attracting medical practitioners to train and work in rural and remote locations, or in specialties which are in, or at risk of, shortage such as psychiatry, anatomical pathology, public health medicine and addiction medicine.

In Phase 1, funds were allocated and then training posts were accredited. The EOI process did not stipulate accreditation was a requirement prior to approval of funding.

Phase 2 of the MPWP4Q addresses the issues around competitiveness for entry to specialist training programs, distribution, and regional and rural practice. In Phase 2, if a College or a health service expressed an interest for a funded training post, Queensland Health required the training post to be accredited prior to seeking funding.

3.1.5 South Australia Health

In South Australia (SA) supervision, casemix and levels of clinical activity are the biggest challenges that impact rural specialty training and accreditation. Another challenge in SA is the geography with Adelaide having the only large tertiary health facility. There is not the resident specialist medical workforce in rural areas to meet accreditation requirements, which are based upon the availability of 24 hour a day, seven days a week supervision. Backup supervisors are also required and must always be either on-site or can be on-site in a short period of time.

The biggest Local Health Network (LHN) in SA in terms of land size has the least population. Eyre and Far North, has a population of about 40,000. All of country SA has a population of 500,000 which is also widely dispersed, so it is difficult for any one health service to have the ability to meet supervision requirements for accreditation.

Activity and breadth of training experience are also a challenge in SA and some Colleges do not acknowledge the experience rural training offers, which is particularly difficult for SA. Trainees in rural and remote areas access valuable and totally different training experiences, and are part of a different style of team to meet the needs of rural health service delivery in SA. Trainees link more closely with primary care which has a benefit in metropolitan areas bridging the gap between specialist medical care and general practice, which is important for continuity of care.

One health service in rural SA has very different medical practitioner roles under current medical structures in rural areas, compared to the salary model throughout major metropolitan health systems. Ninety per cent of the current rural medical workforce is made up of private general practitioners. Health services are introducing some locums or semi-salaried models to build capacity and develop health service delivery models into the future. As a result of purchasing medical services with specialists and general practitioners, there is not a strong link between metropolitan and rural health services, nor the professional networks to support specialty training, which is a barrier for rural health services in SA.

The SA Rural Medical Workforce Plan 2019-2024 released in December 2019 aims to address immediate issues facing the rural medical workforce as well as delivering long-term workforce sustainability through expanded regional and rural training opportunities and improved recruitment and retention.[28] Initiatives include:

- undertaking a training capacity audit, including for accredited specialty training
- exploring opportunities to transition metropolitan training posts to rural
- the expansion of rural specialist training opportunities, and
- advocating for all specialty training to include rural training.

State funded programs

South Australia does not provide any additional program funding support for specialty training.

3.1.6 Tasmania Department of Health

In Tasmania, the geographic, population and health service sizes are the key challenges affecting the ability to meet accreditation standards and engage in specialist training. Over time, accreditation standards have evolved with increasing requirements to have a speciality workforce in place to support accredited training positions. This makes it difficult to run a sustainable service in Tasmania and provide enough activity for training.

Another challenge in Tasmania is meeting the number of supervisors set by Colleges. The state's high reliance on SIMGs limits the pool of available supervisors. Accredited training places are always in jeopardy outside of major hospitals as small movements in the workforce can make a big difference to the ability to train. Increasing stability in the specialist workforce is one of the biggest challenges in establishing accredited training places where they are needed.

In Tasmania, when health services are only accredited for Year 1 of training (or 12 months), the rural and regional sites in Tasmania often receive the least experienced trainees rather than the most experienced who need the least supervision, and this impacts not only the workforce and service delivery but can also potentially negatively impact trainees with less experience and their willingness to return.

For Tasmania, the accreditation of specialty training is managed through health services.

In December 2019, the Health Workforce Strategy 2040 was released by the Tasmanian Government, Department of Health. It is a 'long-term strategy which aims to shape a health workforce that meets the needs of Tasmanians now and into the future and improve the workforce through strategies to develop staff, recruit efficiently and build a positive workplace environment'.[29] There are many actions aimed at improving distribution of training across the state including:

- Work with education providers to improve workforce supply through the development of training pathways
- design placement plans to align with career opportunities and workforce priorities

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28 SA Rural Medical Workforce Plan 2019–2024, https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/our+local+health+networks/regional+health+services/rural+health+workforce/rural+medical+workforce+plan

29 Tasmanian Government, Department of Health, Health Workforce Strategy 2040, https://www.health.tas.gov.au/about/what-we-do/strategic-programs-and-initiatives/health-workforce-2040

- Develop networked training programs in Tasmania to improve self-sufficiency and distribution, in consultation with colleges, and

- Provide more medical specialty training in rural and regional areas of Tasmania.[30]

State funded programs

The Tasmanian Department of Health supports the majority of non-GP accredited specialty training through health service funding. There are no other specific rural training support programs provided outside of the Commonwealth STP and Tasmania Project funding.

3.1.7 Department of Health Victoria

The Victorian health system has a devolved model of governance. Victoria has 86 independent health services responsible for employing its own medical workforce. The Department of Health Victoria (VIC Department of Health) invests significantly to encourage medical specialists to train and work in rural and regional Victoria. A significant proportion of medical workforce investment is targeted towards creating and supporting rural training opportunities to increase exposure to rural health practice for the majority of junior doctors.

About thirty per cent of Victoria's population live outside Melbourne and there are large general teaching hospitals in six regional cities: Geelong, Albury-Wodonga, Ballarat, Bendigo, Sale and Shepparton. Despite this, there continues to be a maldistribution of doctors in rural/regional Victoria.

Apart from general practice, the overwhelming majority of Victorian medical specialist trainees are trained in metropolitan settings. This excludes Geelong, which the Victorian Government classifies as a regional location. In 2019, the VIC Department of Health identified that there are more than two dozen specialties where all the accredited training places are in Melbourne.

The challenges for Victoria include attracting specialist supervisors, accrediting training positions and attracting trainees to rural sites. Trainees can hold perceptions about the quality of supervision or training and concerns about future training and employment opportunities.

The VIC Department of Health seeks to work collaboratively with Colleges and health services on ways to increase training capacity and capability across rural and regional sites to meet accreditation criteria, including through innovation in training and supervision models. The VIC Department of Health strongly supports the development of rural and regional training networks and many health services have established formal partnerships to offer end-to-end training pathways.

State funded programs

The VIC Department of Health funds the Victorian Medical Specialist Training (VMST) program which provides targeted investment to support medical specialist training in Victoria. The VMST program's objectives are to:

- improve the distribution of specialists through targeted investment in training aligned with identified workforce needs, and

- support the health system to address changing patterns of service demand, by enabling access to a skilled medical specialist workforce.

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30 Tasmanian Government, Department of Health, Health Workforce Strategy 2040

Since 2015, the VIC Department of Health has invited health services to propose training positions via an Expression of Interest process. The funding for the VMST program was reviewed in 2020, with specialist training funding now focussed on increasing employment opportunities in priority specialties and in rural and regional Victoria. For the 2021 training year onwards, VMST funding comprises $20.17 million across 5.5 years to support 78 positions, of which 48 are located in a large hospital based in rural and regional Victoria.

VMST funding has enabled the establishment of an end-to-end pathway for accredited anaesthetic training in 2021 to be coordinated across a network of nine regional hospitals. The network will allow smaller regional hospitals, such as Mildura and Southwest Healthcare in Warrnambool, to achieve training accreditation by 2022. The network will prioritise recruitment from rural and regional hospitals. The aim is to train consultant anaesthetists who are more likely to choose a career in regional Victoria.

3.1.8 Western Australia Department of Health

In Western Australia (WA), the majority of training occurs in the metropolitan public hospital system. The three main tertiary hospitals in Perth manage, in collaboration with the specialty Colleges, an Inter Hospital Rotation Scheme for advanced training in 29 specialties and subspecialty areas. The tertiary hospital is the Primary Employing Health Service and placement health services that trainees may rotate to include secondary metropolitan sites, private hospitals (metropolitan and rural) and some rural public hospitals (under the jurisdiction of the WA Country Health Service (WACHS)).

In rural WA, geography and supporting infrastructure, including clinical volumes and casemix, are barriers to attracting a supervisory workforce and achieving accreditation to support expansion of training opportunities. Some health services may be accredited as they are able to meet all accreditation standards but are unable to facilitate training, or a rural health service may be able to deliver a portion of training based on accreditation status. Additionally, each of the WACHS regions and communities have individual health care and workforce needs so a limited 'one size fits all' approach will not work.

Financial constraints can impact on recruitment and secondment arrangements and can make rural settings appear less attractive.

In WA, there are two or three specialties which can achieve full training or the majority of training in a rural area. These are GP training, psychiatry with a 'flipped' training model (majority of training in a rural area with one year of training in metropolitan health service) and potentially emergency medicine. There is potential for other specialties to undertake significant portions of training in rural areas (e.g. ophthalmology, geriatric medicine), and for specialist workforces to be supported by rural generalists through a telehealth and / or a visiting specialist model. There are seven rural areas that are able to deliver training for six or 12 month rotations in various rural locations including Albany, Bunbury, Broome, Geraldton and Kalgoorlie.

In WA it is acknowledged that training in rural areas offers a unique experience that cannot be achieved in a metropolitan health service. Ideally, a combination of rural and metropolitan rotations would support expansion of existing training capacity and attraction and retention, along with the right support mechanisms in place and the development of innovative approaches to supporting training (e.g. Rural Workforce Agency networks, accommodation support, childcare, remote supervision, access to weekend exam practice, trial exams and tutorials which are often held in metropolitan health services etc.). The experience in WA is that trainees are not ready to commence advanced training without the breadth and depth of casemix at tertiary health services.

The vast majority of accreditation challenges in rural WA relate to the capacity of sites to deliver a complete training program and specifically relate to the following constraints:

- casemix
- location and continuity of supervisors (e.g. whether resident specialists are located rurally) to provide the supervision / training of the trainees. In the case of VMO* models, the visiting frequency of VMO supervisors, and
- availability of rotations back into metropolitan hospitals to support trainee progression through training.

* In the rural WA public hospital context, a 'VMO' often refers to a locally based, resident specialist who provides public hospital services as a 'visiting medical officer' (or sometimes designated 'CMP' contracted medical practitioner) and who works from a private practice base to provide the community with outpatient services.

State funded programs

Teaching, training and research in WA is block funded through Activity Based Funding (ABF)* with this funding provided to health service providers. This may impact on funding for some WACHS regions or health services. Low activity areas and outpatient clinics are disadvantaged in the ABF model due to the lower generation of activity and therefore funding which also impacts training and accreditation.

WA does not provide any additional targeted program funding support for specialty training. Whilst the STP funding contribution supports the base salary of trainees, health services are required to fund the gap. In the WACHS this may include accommodation and travel costs in addition to costs associated with supporting training supervisors, which are not often realised, acknowledged or incorporated into budgets.

* Block funding supports teaching, training and research in public hospitals, and public health programs. It is also used for certain public hospital services where Block funding is more appropriate, particularly for smaller rural and regional hospitals.[31] Categories of Block funding in 2020–21 included:

- Teaching, training and research
- Small rural hospitals
- Non-admitted mental health
- Non-admitted Child and Adolescent Mental Health Services (CAMHS)
- Non-admitted home ventilation
- Other non-admitted services (e.g. chronic disease management)
- Highly Specialised Therapies (e.g. CAR-T)

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31 https://www.publichospitalfunding.gov.au/public-hospital-funding/funding-types

3.2 Specialty specific accreditation issues

Specialty specific issues and examples were provided by stakeholders. College feedback broadly related to training and the accreditation system, including, but not limited to, the impact on rural training.

The below table identifies specialty specific accreditation issues for the expansion of training in rural areas. Importantly, these issues impact many other expanded settings, including but not limited to the private sector, community and Aboriginal and Torres Strait Islander health services.

Table 2.

Specialty by College	Accreditation Process – timeline, administrative burden, requirements	Supervision	Network Rotations	Service Delivery and Training – incl. service models	Interdependency with other specialties	Casemix, Case Load and Training Experience	Resources – financial and infrastructure
Anaesthesia		Critical mass of supervisors	Interdependence with metropolitan sites	Yes	Yes	Yes	
Dermatology		Critical mass of supervisors	Interdependence with metropolitan sites	No	No	Yes	
Emergency Medicine		Critical mass of supervisors	Interdependence with metropolitan sites			Yes	Yes
Intensive Care Medicine			Interdependence with metropolitan sites		Yes		Yes – ICU Units
Medical Administration				No	No	Yes	Yes
Obstetrics and Gynaecology		Critical mass of supervisors	Interdependence with private sector and metropolitan sites			Yes	Yes
Ophthalmology		Critical mass of supervisors	Interdependence with metropolitan sites				
Pathology		Critical mass of supervisors	Interdependence with metropolitan sites	Yes		Yes	Yes
Physicians	Yes	Critical mass of supervisors				Yes	
Psychiatry		Critical mass of supervisors	Bottlenecks for mandated training terms				
Clinical Radiology	Yes		Bottlenecks for mandated training terms	Yes		Yes	Yes
Radiation Oncology	Yes		Interdependence with private sector and metropolitan sites	Yes		Yes	Yes
Surgery	Yes	Critical mass of supervisors	Interdependence with metropolitan sites	Yes	Yes	Yes	Yes

3.2.1 Anaesthesia

The ANZCA has a broad curriculum that requires a combination of training sites, with certain volumes of practice and casemix. The aim of the College is to produce graduates who are generalist anaesthetists with a broad range of skills rather than subspecialists. Specifically, after becoming a Fellow, an anaesthetist must be able to work in any environment, including rural and regional. The biggest challenge for non-metropolitan accreditation and specialty training is that significant components of clinical services are not offered in rural settings and caseload and casemix are not sufficient, which means that as part of anaesthetic rotational schemes, there is still a dependence on metropolitan health services in almost all areas.

The service delivery versus workforce versus training balance is more of an issue in rural areas due to the smaller number of trainees that are at a site and the need to provide a 24 hour, seven day a week service. Anaesthetic trainees are seen as useful workers and the College cited examples of regional centres rostering anaesthetic trainees to after-hours shifts where their duties include ward-based care and response-type work rather than anaesthesia and a focus on specialty training. When the College reviews training progress and training data, trainees in such situations do not access sufficient anaesthesia training which then impacts on accreditation of the training site. This was identified by the College as a common friction point.

The sometimes tenuous construct of the rural medical workforce and the interdependency between specialities for the continuation of training experiences and maintenance of accreditation status can sometimes be a challenge which impacts broadly, particularly in the case of surgery, anaesthetics, intensive care and in some cases emergency medicine. In one example, a rural health service lost two surgeons of one specialty and one in another surgical specialty. The health service could no longer provide service for two surgical specialities, which directly reduced the casemix and caseload of surgical cases and indirectly reduced the complexity of casemix, the general casemix and caseload for both anaesthetic trainees and intensive care trainees. This negatively impacted anaesthesia accreditation reducing accredited raining from a maximum two-year rotational term to no more than 12 months.

In relation to the above example, the inverse can also occur when there is growth in service need, service delivery and medical workforce in a rural health service.

3.2.2 Dermatology

The ACD has difficulty in finding any 1.0 FTE specialist in rural private practice. The majority of new posts are 0.5 FTE in a rural setting or 1.0 FTE in a metropolitan public hospital. There is difficulty in achieving a 1.0 FTE rural dermatology training post in private practice because they are unable to meet accreditation standards in terms of casemix and case load. As a result, many rural sites become a component of a metropolitan site and rotational training network.

3.2.3 Emergency Medicine

The biggest challenge for ACEM accrediting training posts in rural areas is the lack of critical mass of Fellows of ACEM (FACEMs) for supervision. Rural health services have difficulty with the availability of resources and it is difficult to attract the workforce which means there are not enough FACEM consultants to supervise trainees. If they do have the workforce, the priority is service delivery, there is not always the 0.2 FTE available for supervision duties.

The WACHS Emergency Medicine Leadership Group provided advice on the changes to the emergency medicine training program and accreditation framework. One of the changes in the revised site accreditation classification is benchmarking peer comparison data on emergency department (ED) presentations to

determine which sites are appropriate for FACEM training and at what level or for what period of time. For example, a minimum of 30,000 ED presentations per year is required to support training. With a cut-off of presentations, this has the potential to negatively impact rural sites that may otherwise be good regional training centres. WA has advocated that ACEM approach this differently and consider FACEM-led regional centres as being appropriate for specialty training but also that the College acknowledges the challenge in terms of rural and regional workforce.

Other feedback indicated that the proposed ACEM accreditation of training sites and curriculum will particularly impact smaller sites with potential for unintended consequences if the broader context such as workforce, infrastructure, trainee movement and service delivery is not considered during accreditation assessment in addition to ED presentation benchmarks.

The revisions to the ACEM review in June 2020 identified that in relation to supervision, the Accreditation Subcommittee 'will make any additional recommendations based on site specific circumstances' and 'while peer comparison data is useful in informing and guiding the inspection panel, additional information gleaned from the site inspection would continue to play a major role in the accreditation process'.[32]

3.2.4 Intensive Care Medicine

CICM identifies four main challenges that affect rural training in intensive care medicine:

1. Lack of intensive care units in rural and regional areas rather than the accreditation framework inhibiting the expansion of specialty ICU training. CICM's training program require three years of core training in an ICU and there are often no ICUs in smaller rural health services. Trainees must do a year of anaesthesia training, a year of medicine, six months of paediatric training and three-month rural training. This exposure can be done in areas without an ICU.

2. The big attraction for ICU trainees is the opportunity to spend time outside of ICU in medical and anaesthetic positions. Those training positions can be critical for attracting trainees to rural and regional areas and improving the chance of accreditation for a rural and regional centre. These positions can be difficult to resource from a health service perspective and the College may not accredit the ICU if it makes an assessment that it is not a good experience for the trainee.

3. The limited capacity of a unit in rural areas. CICM accredits ICUs for specialty training, however, do not mandate how many trainees can be training in the unit. It is common for an accredited unit to have a mix of CICM trainees, trainees from other Colleges and non-trainees working within the unit. The number of intensive care trainees is at the discretion of the employer, the hospital and the unit. The College's guidelines on the expectations of a supervisor state a maximum ratio of one supervisor to ten trainees from any discipline. This can be used to influence the capacity of how many trainees can be supported in a rural unit.

4. If the head of an ICU is not an intensivist (Fellow of the College of Intensive Care Medicine of Australia and New Zealand), the unit may not be accredited even if there is compliance with all other accreditation standards and criteria. The College's accreditation process is fair and trainee centric, however, the College does not mandate how an ICU is staffed at a consultant level.

3.2.5 Medical Administration

One of the challenges faced by RACMA is having sufficient capacity to increase the number of medical administration training posts. There are not always Fellows available to supervise trainees directly or indirectly, particularly in rural areas.

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32 FACEM Training Program Accredited Site Classification Review, Proposed Revisions, June 2020

3.2.6 Obstetrics and Gynaecology

RANZCOG identified three things that impact rural obstetrics and gynaecology specialty training:

- The cost of training in rural areas; it is expensive to train and budgets are tight. For example, there could be a trainee in rural WA who could have a comprehensive rural experience, but it will cost $400,000 per annum because in addition to salary, accommodation and other costs, every time there is a clinic in a remote community, it costs $700 for the specialist to fly there so an employer will not pay for the specialist to take a registrar at an additional $700, plus accommodation and expenses.

- A rural Obstetrics & Gynaecology (O&G) training pathway is a very different training pathway to a metropolitan one. There is the ability to do a little bit of everything in rural. Metropolitan service delivery is becoming very subspecialised. For example, a rural hospital might be able to do surgery but there is no ultrasound service, or a gynaecological oncology unit, or a neonatal intensive care unit in that site. Therefore, a flexible approach to accreditation criteria is adopted when accrediting rural sites.

- Rural health services have a heavy reliance on locums. In WA there are three rural areas with O&G service delivery and two of them have had a Fellow of RANZCOG (FRANZCOG) depart, leaving no supervision to continue to support training.

3.2.7 Ophthalmology

RANZCO identified supervision arrangements for training posts as an emerging issue for further expansion of training in rural areas. The College is considering different ways of structuring supervision as there often are not three ophthalmologists onsite for supervision, as required under the current accreditation standards. There are already examples of accredited training posts without three Fellows of Ophthalmology (FRANZCO) supervisors that are successful. The College plans to extend more arrangements with ophthalmologists who 'fly-in fly-out' (FIFO) of rural areas and investigate the integration of telesupervision for more senior trainees.

3.2.8 Pathology

The biggest challenge for pathology is not having laboratories and infrastructure, the pathologist workforce in rural areas, or the range of disciplines of pathology to be able to train in the regional centres. Regional centres can offer excellent opportunities for some disciplines, for example Anatomical Pathology, however, be unsuitable for others such as Genetic or Forensic Pathology. From a business model perspective, centralised laboratories are appropriate for public and private practice.

3.2.9 Physicians

RACP identified that many rural health services cannot meet accreditation standards as stand-alone training sites. The RACP view networking as key to opening up rural positions and investment in staffing resources and coordination of network training arrangements is a critical consideration.

Health services identified that under the RACP's 2010 accreditation system, there was inconsistency in accreditation assessments and the process was dependent on individuals. Each individual health service or department within the health service has to engage in an accreditation assessment. That workload falls on the physician specialist who is the College representative of that health service, usually the Director of Physician Education or the Director of Paediatric Education. There is a lot of administrative work involved to match data against criteria and processes, produce the required documentation and there can be

inconsistency with assessment of this documentation. Some sites will be accredited based on submitted documentation and a desktop review and others will require a visit.

Directors of Physician Education also face pressures within their health services to justify their training programs and compete for funding to meet supervision requirements.

3.2.10   Psychiatry

The biggest challenge for psychiatry is related to workforce, service delivery and the shortage in some jurisdictions of mandatory accredited psychiatry training terms. Psychiatry is a generalist qualification that requires exposure to a variety of training experiences as part of the specialty training program. There are two mandatory terms in psychiatry specialty training during Stage 2: Child and Adolescent Psychiatry and Consultation-Liaison. This is where there are bottlenecks in training and difficulties in accreditation, this impacts on training programs with insufficient posts in those two areas. To avoid bottlenecks in the latter half of the training program, trainee numbers are closely managed in Stage 1.

Whilst a training program may comprise a network of public, community and private providers and does allow for some remote supervision, bottlenecks in training still frequently occur.

3.2.11   Clinical Radiology and Radiation Oncology

RANZCR are focussed on ensuring that both Clinical Radiology and Radiation Oncology are generalist specialties whereby Fellows are able to provide broad services across both specialties. As with psychiatry, RANZCR experience bottlenecks at certain points in training due to the generalist nature of the programs. This is particularly the case for paediatric radiology rotations.

The accreditation for clinical radiology and radiation oncology training posts are network models and because of that, the College will accredit rural sites that are part of an accredited network. All clinical radiology accredited networks have a rural rotation. In radiation oncology, rural rotations are available and encouraged, however, there is a much smaller training cohort than in clinical radiology, and access is more limited. The College recognises that no one site can be a stand-alone training site in clinical radiology as no one site can offer the variety of training experiences, supervision, and exposure as multiple sites in a network arrangement. Networks are constructed to ensure the network covers the breadth of the curriculum for every trainee in both Faculties. In some cases, there are deficiencies, and a network may need to work with another network to ensure trainees have appropriate exposure to training experiences.

When a new regional post is added to a clinical radiology or radiation oncology training network, the training network needs to ensure it has enough capacity in the network to support the parts of training not covered at the regional post. For every clinical radiology regional post, there will need to be a 12-week rotation available at a paediatric hospital and an eight-week women's imaging rotation. This means that for every new regional post, the specialist sites need to increase their capacity to support a regional trainee. The rotation structure in a radiation oncology training network covers a 12-month rotation period.

The issue for clinical radiology is in accessing paediatric radiology rotations. This impacts the accreditation of more positions in a network. Trainees need to do a 12-week rotation in a paediatric radiology department or in a department that has a paediatric radiologist. There are limited paediatric positions available and therefore they cannot add more clinical radiology training posts to the network if the bottleneck in paediatric radiology exists.

3.2.12 Surgery

RACS has an overarching accreditation framework with standards and guidelines. The nine surgical specialties fall under this framework with variations tailored per specialty according the requirements of the surgical education and training programs. A review of the accreditation framework is in progress by the College for further integration of common standards, sharing of information across specialties, creating efficiencies and reducing duplication and administrative burden for specialties and health services, particularly those with multiple surgical specialties to accredit. Stakeholders indicated varying experiences and sometimes conflicting information between the College and some surgical specialties.

RACS identified several challenges in accreditation that impact the development of rural training pathways for surgery:

- Caseload, casemix and training opportunities: often rural health services cannot meet the levels required.

- Some of the specialties' accreditation standards for the above are not published and therefore, health services do not know the benchmark until they've been through the process and failed.

- Supervisory requirements: most surgical specialties require at least three supervisors or 1.5 FTE within their surgical department. That allows for adequate supervision, access to cases, provision of service and release of trainees for mandatory education requirements.

- Service models that support specialty training: health services require both accredited trainees and service (unaccredited) registrars to support the surgical service delivery model and enable the Surgical Education and Training program (SET) trainees to access training requirements to manage the on-call hour restrictions, night rosters and extended work hours. Accreditation standards focus on trainee wellbeing and incorporate limits on hours of work for accredited trainees.

- Insufficient data to build the evidence for accreditation applications: when there is insufficient data to support an accreditation application for surgical training, specialty training boards may suggest a health service employ a service registrar to maintain a logbook of cases for a 12-month period of training experiences, demonstrate casemix and caseload. Once this period has lapsed, the health service can resubmit an accreditation application with the data.

- Lack of funding can deter a health service from proceeding with establishing a training post.

The Australian Orthopaedic Association (AOA) identified the biggest challenge as having an appropriate training environment and the need for trainees to get adequate experience and exposure across multiple health services. The challenge of having a rurally based training program is that there are very few hospitals around Australia that would be able to accommodate trainees for more than one to two years. Even a rural pathway where the majority of training was rural, trainees still need metropolitan experience, particularly with major trauma.

Most trainees will spend 12–18 months in rural training. If the AOA were to develop a rural training pathway, the aim would be to have three out of five years in rural. In orthopaedics there is difficulty in having enough breadth of experience in rural locations for trainees solely able to work rurally if they are to practise to their full scope of practice. A metropolitan training experience and skills are important for developing confident surgeons, even training in bigger regional centres, with particular exposure to metropolitan paediatric training. There is very limited exposure to paediatric orthopaedic training rurally, especially in trauma and tumours.

The Neurosurgical Society of Australasia advised that there are particular infrastructure and workforce requirements required to support neurosurgery, which limits the ability to provide service and support training outside of metropolitan health services.

4.0 Issues and challenges for rural accreditation

4.1 Metro-centric – accreditation standards, specialty training programs and decision making

Accreditation is predicated on traditional metropolitan training models and experiences with traditional downwards supervision by Fellows to curricula that is largely metropolitan-derived and metro-centric in focus.

Training programs and underpinning accreditation frameworks are traditionally designed in a way that many trainees should be based in metropolitan settings to finish training and achieve Fellowship.

For Colleges, the overwhelming majority of policies and processes that have been set up for specialty training are decided upon and administered through central offices and members with predominantly metropolitan experience. There appears to be little consideration of the context of rural health care, service delivery, support for rural specialty supervisors and trainees and what can be achieved in rural training. The 'one size fits all' model may not necessarily be feasible or appropriate for rural health services. In some cases, Colleges seek consultation from rural representatives or committees to inform policy and process, however this is not always evident in policy or practice.

A training post in a non-metropolitan area should not be of a lesser quality or standard than a training post in a metropolitan area.

Most accreditation frameworks do not incorporate criteria or elements to explicitly consider or support rural (or other) context. Stakeholders felt that some Colleges have been seen as blockers rather than enablers. For example, a regional health service in Victoria with one accredited and two service registrar positions had been trying to establish a second accredited training post, as the health service had the workload for two trainees. The College received conflicting information suggesting there was insufficient caseload to share across two training posts which may have resulted in a second accredited post not being supported. The health service was required to provide additional information to demonstrate a sufficient caseload and the training post was eventually accredited.

Training orientated to metropolitan hospital settings can imply bias and has the potential to predetermine outcomes on whether a rural setting can support a good training experience and training outcomes. This not only potentially impacts the ability of rural health services to achieve accreditation but also trainees rotating to rural health services with preconceived views that rural training experiences will not be positive.

Much of the service provision in rural areas is in general medicine with acute subspecialties. RACP requirements for acute subspecialty rotations for Basic Physician trainees, with half of trainee time dedicated to undertaking subspecialty rotations, is not possible in some rural health services to accommodate the full breadth of training. They often do not have numbers of specialists to provide sufficient training exposure in all required subspecialty rotations.

Acute cardiac and acute stroke patients in a metropolitan health service would be directed to neurology or cardiology, in a rural health service these cases often fall under general medicine. Casemix data over a two-year period demonstrated for one rural health service that there was sufficient physician subspecialty

exposure within general medicine with acute and subacute cases. Metropolitan hospitals have the ability to expose physician trainees all in one rotation whereas the equivalent exposure in a rural health service may be over a longer period of time and learning simultaneously with other disciplines.

Accreditation does not incorporate or consider organisational scope of practice and some Colleges are not sufficiently flexible in the assessment against accreditation standards for expanded settings such as rural health and Aboriginal and Torres Strait Islander health services. Whilst there may be the belief that accreditation standards for metropolitan should also apply for rural and other expanded settings, the context is different. Frameworks should be flexible enough to apply different ways of measuring quality and outcomes when the context is different.

There is sufficient evidence of some high-quality training positions in rural areas. These positions should be recognised and accredited as a valuable training experiences suited to rural settings for the purpose of training medical practitioners to deliver services in rural areas. There should be recognition that rural training experiences vary in comparison to metropolitan training experiences, they are broad, more general and comprise multidisciplinary teams in a range of settings.

There are valuable training experiences in rural health services that are currently not accredited for specialty training. These are experiences working more directly with the local community and different cases where trainees can still develop and improve their clinical acumen even if there is not access to every investigation, case, or imaging. There are other skills that need to be developed that are available in rural health services. Rural settings allow for better multidisciplinary learning as there are not as many specialists or sub-specialists and trainees must develop generalist skills with an understanding of the reliance on the non-medical workforce.

Specialty training curricula often incorporates rare cases with many of these experiences found only in metropolitan settings, particularly for procedural specialties, rather than training to develop safe practicing specialists in rural locations. Whilst that is not necessarily fair and equitable curricula for rural health service delivery, changes to specialty curricula to consider context and rural practice takes time. This is also reflected in accreditation standards and criteria which underpin specialty curricula and training programs.

There are some criteria in accreditation standards that stakeholders felt could be covertly metro-centric making it harder for rural health services, and especially smaller hospitals, to comply with accreditation requirements, for example, with specific levels of resourcing and support that may be stipulated. In an environment where there is financial pressure, stipulating particular requirements can make compliance more difficult. Or alternately, Colleges have imposed restrictions on what accredited trainees do and have responsibility for, forcing a health service to have to build up the service registrar workforce to support a smaller number of accredited trainees to meet training requirements and maintain compliance with accreditation standards. For example, with after-hours rosters where the service registrar workforce experiences different conditions to accredited trainees. Other accreditation challenges identified were issues with sufficient accommodation and infrastructure, such as internet access in rural areas.

Colleges are not always able to include special expertise such as rural Fellows on accreditation teams when assessing rural sites. This is often due to availability. It was reported that many accreditation team members that assess rural sites work in metropolitan facilities and some have a negative perception of rural facilities and training which can impact an accreditation assessment. The NMWS also describes the stigma about medical practice in rural and remote Australia with perceptions that working outside metropolitan areas is a form of exile or substandard practice. This is an important influence to consider.

One example provided by a rural health service was a paediatric accreditation assessment conducted by an adolescent physician and a generalist with no rural experience. This impacted the accreditation assessment and the health service felt they had not received a fair assessment as the accreditation team did not understand the rural context.

There is a need to support rural areas to have a greater voice in determining what specialty training programs can and should be supporting in rural areas and enabling the rural specialists who are involved in training to have greater input in College decision making.

Even when rural representation is present or incorporated in College structures, for example, where there is a rural representative on a College committee, often rural medical practitioners are unable to leave their health service to attend meetings in person due to service needs. Rural representation may be better facilitated with the increased use of virtual meeting platforms. More recently there has been increasing engagement through virtual means for business and training continuity with Colleges making significant progress in this arena. This is likely to continue in some form in the future.

Recommendations:

No.	Commitment to rural health
1.	College commitment to rural health equity by recognising, valuing and promoting the rural health training experience.
2.	Build capacity in College accreditation frameworks to consider and accommodate the rural context.
3.	Review the composition of accreditation teams and governance to include rural Fellows or Fellows with rural expertise.

4.2 Flexibility in accreditation frameworks

The lack of flexibility in many College accreditation frameworks does not support improvements in geographical distribution of specialty training. Accreditation standards and practices are predominantly 'one size fits all', often 'checklist' based and not contextualised to link and value rural training opportunities for well-rounded specialty training experiences and training outcomes.

There needs to be greater flexibility for accrediting outcomes rather than numbers or completing checklists when assessing rural health services. Accreditation based on case numbers is simplistic and resource intensive for health services. Some standards are quite easy to meet, particularly for large metropolitan health services, but they do not necessarily equate to good quality training and educational outcomes.

There can be a significant disparity between what Colleges are accrediting and what the intent of the accreditation is. Colleges have core tangible accreditation requirements, logbooks and training requirements for specialty training programs. Accrediting specialty training programs that are delivered in a variety of health contexts in responsive and dynamic environments is more appropriate to meet the needs of contemporary medical practice and service delivery in a variety of settings.

Quality supervision and feedback is a critical component of training which can be found in any health setting. The differences in infrastructure, caseload and casemix in rural health services can still potentially deliver a good educational outcome. There may still be core and non-core training requirements in a variety of contexts, so that there are still quality educational outcomes.

However, there is not the belief that there should be different standards for rural sites. Traditionally, accreditation standards have been developed based on a metropolitan hospital training experience, including elements such as research. All the criteria that are found in tertiary health services are not always available in a rural setting. The concept that the trainee experience in rural areas is good and positive in other ways should be recognised and valued.

Accreditation frameworks and standards can impact more broadly than accreditation itself. Under the 2010 RACP accreditation program, the RACP accredited health services and not training programs or training posts for Basic Physician Training. As such, difficulty was identified in the continuity of Paediatric Basic Physician Training at one large regional health service classified as a Level 2 training hospital, which is the highest accredited level training site in the state. With no Level 3 training site, all paediatric trainees need to go interstate at some stage to complete training. This impacts the retention of trainees in the state and the construct of the medical workforce teams only able to support trainees at a certain point in training.

The RANZCP identified that the accreditation framework and practices of the College are inherently flexible and accommodating of rural training due to the minimal requirements for physical infrastructure. The essential requirement for training is the availability of adequate supervision.

It is also important that accreditation standards and supervision arrangements are flexible enough to support a 'flipped' training model so that trainees can undertake majority of their training in a rural location and only go to metropolitan sites for essential training. CICM has some flexibility in the application of accreditation standards when assessing rural sites. For instance, an ICU may have ventilated patient case numbers below the standard, but the College will take into consideration the broader training experience at the site when making a decision on accreditation.

RANZCO recently introduced 'Mandatory' and 'Desirable' Criteria in their accreditation standards to better integrate and support rural training posts, apply flexibility and recognise the value of a rural training site to the overall training experience. All training posts must meet mandatory criteria to be accredited; desirable criteria are stretch targets for continuous improvement. For example, in the case of supervision arrangements for Alice Springs Hospital, there are only 2.0 FTE supervisors, which does not meet the 3.0 FTE supervisory requirement. The training experience the site was able to provide in service provision to outreach Indigenous communities was recognised as a valuable experience for trainees and the College approved accreditation.

Recommendation:

No.	Flexibility in Accreditation Frameworks
4.	Improve the geographical distribution of specialty training, through accreditation frameworks incorporating flexibility with individualised and contextualised assessments of health services against accreditation standards.

4.3 Supervision of specialty training

Expectations of supervisory and educational roles are articulated in accreditation standards to 'ensure there is an effective system of supervision to support trainees to achieve program requirements and graduate outcomes'.[33] They also define responsibilities of health services, medical practitioners and Colleges in the delivery of specialty training programs and ensuring quality and safe patient care as part of training. Under AMC Standard 8.1, Supervisory and educational roles, all Colleges must ensure that there is an effective system of clinical supervision, define responsibilities of practitioners, select supervisors capable for the role and provide training, support and professional development as well as evaluate supervisor performance using tools such as feedback surveys.[33]

There are common functions for educational supervisors such as direct supervision, training, overseeing programs in a training site or network with all responsible for patient safety.

Colleges mostly have historical models of supervision that require a certain FTE and structure of onsite, and direct specialist supervision that may not always align with contemporary health service delivery models, particularly for rural areas. In addition, the level of supervisor support and training in relation to accreditation requirements, including the continuous improvement cycle and accreditation administration, varies for each College making it difficult for rural health services to be responsive and maintain oversight.

Most Colleges require that trainees are only supervised by Fellows of that particular specialty. This becomes a challenge when trying to expand specialty training into rural areas with limited numbers of local staff specialists to meet accreditation standards.

Health services are trying to build a higher quality, skilled, rural specialist workforce but currently there are medical specialists, who do not qualify to be supervisors. SIMGs are often excluded from supervising trainees for a period of time by College policies. With many SIMGs in rural areas, there is an opportunity to engage these doctors earlier in supervision arrangements.

> The RANZCP have developed a flexible supervision model that includes some remote supervision and support for non-Fellows and locums (where appropriate) in becoming accredited supervisors.
>
> For the RANZCP, SIMG psychiatrists whose training has been assessed as substantially comparable, are able to supervise trainees during their final year of supervised practice and prior to their admission to the Fellowship. SIMG psychiatrists whose training has been assessed as partially comparable are not allowed to be supervising trainees, as the SIMG is on a training pathway with supervised terms, EPAs and examination requirements.

Physicians in WA, like many other specialities, do not have the workforce or critical mass of specialists to train trainees in rural, particularly remote areas. For example, unlike other states where, for example, they have dedicated cancer centres with permanent medical oncologists, in WA most of the regions are a FIFO medical oncology service. There are some respiratory physicians in regional areas, such as in Bunbury and in Broome, and there are a few other specialists, but those specialists may not always be interested in supporting training positions.

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33 Australian Medical Council Limited, Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2015, page 32 https://www.amc.org.au/wp-content/uploads/accreditation_recognition/specialist_edu_and_training/assessment/standards_for_assessment.pdf

One of the biggest challenges is that there can be an unwillingness to accommodate anything other than geographical co-location for supervisors for many specialties. There appears to be limited support for remote supervision, particularly for extended periods. Senior specialists are required to be physically present with trainees and sometimes there is not enough work for those specialists to be full time in a rural area. Unless remote delivery capability and remote supervision models for training are considered and supported by Colleges, jurisdictions like WA will be limited in expanding specialty training.

The biggest resource requirement is supervision, and this comes with an expense that may not actually fit within the health service strategic workforce plan or budget. As such, health services may or may not be able to afford to support accredited training.

To further support rural training, there could be consideration of supervision arrangements that focus on clinical skills rather than a profession under innovative supervision models.

An approach to supporting more networked supervision models would be beneficial for the expansion of rural training. Models of supervision that include remote supervision could increase training capacity.[34] This will require better enabling and use of technologies to be incorporated and supported through Colleges and accreditation frameworks as achieving the critical mass of onsite supervisors can take a long time to realise in some rural areas, and for some sites, will never be achievable.

The requirement for years of practice before permitting a Fellow to supervise is sometimes prohibitive if there is only a small pool of specialists in a rural workforce, particularly if that size and type of workforce is all the health service can attract, and they may not have the required level of experience. This also applies to the SIMG cohort. Many Colleges require potential supervisors to be at least three years post-Fellowship. The RANZCP has greater flexibility with new Fellows able to supervise from the day they are admitted to the Fellowship. RACMA has a minimum three-year pre-requisite post Fellowship to become a supervisor which is reconsidered on a case-by-case basis. Many highly experienced medical practitioners enter the training program who hold senior positions that RACMA may consider are sufficiently experienced to take on a supervisory role depending on circumstances.

Rural specialists can sometimes be inexperienced in preparing applications to establish training posts and develop training pathways. They are often busy providing services rather than having capacity for business planning and business cases that are required by the Colleges to get a site or training post accredited. There is a large volume of paperwork, data and administration associated with accreditation that must be undertaken by specialists and their departments. Rural areas rarely have the administrative resources, such as medical education officers or units, to support this activity.

There could be further consideration of the models of care in rural areas in relation to the potential construct of supervision, without compromising safety and quality of training. For example, non-Fellows such as a medical practitioner with advanced skills in a specialty, senior trainees, other specialists or suitably qualified and experienced clinicians may contribute to and participate in the support of specialty training.

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34 Wearne S, Dornan T, Teunissen PW, Skinner T. Twelve tips on how to set up postgraduate training via remote clinical supervision. Med Teach. 2013 Nov;35(11):891-4. doi: 10.3109/0142159X.2013.805878. Epub 2013 Jun 19. PMID: 23782042.

RACMA has flexibility in supervision arrangements, sometimes the direct line supervisor is a suitably experienced medical manager, not necessarily a Fellow of the College. RACMA is moving to a programmatic assessment model with the integration of workplace-based assessments. The specialty of medical administration is unique, a trainee may be undertaking training in financial management and potentially the finance manager could sign off the workplace-based assessments or the Human Resources (HR) Director could sign off on HR training requirements.

There is some flexibility regarding the level of supervision needed in years five and six of O&G specialty training. However, this is not the case in the first four years of the Integrated Training Program. In a rural location, it may be very appropriate for second or third year specialist trainees to work in a GP led obstetrics service with support from specialists in the metropolitan health services and supervised locally by experienced GPs with advanced skills. This is not currently an acceptable model of supervision for the RANZCOG; a more detailed knowledge of each hospital's staffing structure (experience and FTE) is required to accept any proposed innovative models of supervision. The College has indicated that it will progress consideration of innovative models of supervision to align with their rural training strategy.

Importantly, health services need to enable the development of training infrastructure which includes resourcing and workforce such as specialists and service delivery teams.

Psychiatry is a specialty in shortage with an under-subscribed training program and the RANZCP unable to fill the current accredited training posts. In consultation with QLD Health, the RANZCP identified a need to improve support for trainees and build the capacity of the program to make it more attractive to future trainees. In Queensland, there are a limited number of supervisors who are responsible for training in large geographical areas, which can be challenging. QLD Health increased the number of Director of Training positions to support network training through the MPWP4Q. The impact has been a substantial improvement to their ability to support psychiatry trainees, to build on resources and as a result of the support, there was an increase in interest in the psychiatry training program. Due to the success of the additional supervisor positions, funding by QLD Health has continued.

4.3.1 Locums

Locums are a potential supervisory workforce that is currently not broadly utilised.

They are an important part of the workforce in the regions for specialty service delivery and are usually very senior medical specialists that are carefully scrutinised through credentialing processes by health services and quite adaptable as professional locums. Locums are excluded by many Colleges from supervision even though some locums bring a wealth of knowledge, are experienced teachers and good clinicians.

If a rural health service has a heavy reliance on locums, this can compromise accreditation. Colleges will not accredit a site if there is not the critical mass of supervisors employed directly by the health service. In one ED example where the College changed supervision requirements in the accreditation framework, the casual FACEMs that were directly employed by the health service counted towards meeting accreditation supervision requirements.

However, the RANZCP advised that locums may undertake supervisor training to become accredited supervisors to address the tension between locum leave cover and training requirements. RACMA also supports supervision by locums which is assessed on a case-by-case basis.

In Victoria, it was reported that many anaesthetists will be ready to retire in the next few years, and one regional health service will have their ability to train compromised because they will be relying on locums if they are unable to start to build their specialist workforce locally.

4.3.2 Alternative supervision models

Most Colleges have not extensively explored alternate models of supervision and rely on traditional apprenticeship style models. However, the integration of Entrustable Professional Activities (EPAs) by many Colleges is forming the basis for improvements in determining competency of trainees and therefore the level of supervision required. For one College, although supervisor presence is required one hundred per cent of the time, depending on the competency of the trainee, supervision can occur remotely, such as the supervisor being available by phone.

RACMA supports non-Fellow direct line supervisors in a model of supervision that has the secondary supervisor who is a Fellow. Annual surveys of trainees indicate that learning and training experiences in medical leadership and management are still of a high quality, even without a Fellow of RACMA (FRACMA) direct line supervisor. RACMA has a preceptorship model, an additional training mentor who is not located in the same workplace as the trainee. The preceptor is matched with the trainee from the beginning to the end of training to support the continuum of training. The preceptor works with the supervisor and a Jurisdictional Coordinator of Training (JCT) to ensure the trainee is appropriately supported and progressing through training requirements, including accessing training experiences that may not be present in their workplace or during their training rotation. Preceptors are also a check point for any potential accreditation issues and can receive complaints or issues or provide notification to the College of any issues that may impact accreditation. Preceptors are generally allocated on a jurisdictional basis to trainees within their jurisdiction, however, on occasion, there are variations to enable and support training in a rural area. An example of this is an experienced, advanced medical administration trainee based at a remote hospital in WA who was linked with a FRACMA preceptor based in Melbourne. The trainee has a supervisor locally and a network of FRACMA support across WA. The link to the metropolitan based preceptor provides additional support to access and attain training requirements beyond the trainee's base in remote WA. In addition, the infrastructure provided by WACHS to integrate web-based meetings and telehealth into everyday activities facilitates access to online training and other College activities as required. For RACMA, there are other examples of successful rural training posts across Australia including Whyalla, Port Pirie, Alice Springs, Katherine, Geraldton, Bunbury, Townsville, and Cairns.

Dermatology training is mostly supervised by Fellows of the ACD (FACD). Alternate models of supervision are not always possible as particular procedures must be supervised by a Fellow. However, Plastic Surgeons or other surgeons can sign off on certain procedures. This is an arrangement with the supervisor of dermatology training and the non-Fellow within the jurisdictional area or health service, not formalised by the College and is reliant on local relationships. Internationally, there are trainees in Singapore and the UK who are supervised by non-Fellows of the College. There is one Fellow of the College in the UK who supports training locally in London. These non-Fellows of the ACD are specialist Dermatologists.

The ACD do not formally support remote supervision but on a case-by-case basis this has been considered, though not always supported. Tele-dermatology is currently being supported in Queensland for the Tiwi Islands whereby a remote trainee will review GP dermatology work.

For anaesthesia, someone who is providing clinical supervision of the workforce does not need to be a Fellow of ANZCA (FANZCA). They can also be someone who is recognised by the Australian Health Practitioner Regulation Authority (Ahpra) as a specialist anaesthetist, someone who has gone through an equivalent pathway. A clinical supervisor could be a SIMG who is substantially comparable in an approved program or a trainee who is in a Provisional Fellowship Program (final year of training) in transition to specialist year or it could be a medical practitioner who is providing clinical supervision of the workforce. GP anaesthetists are not able to be the clinical supervisor for ANZCA trainees, however, they can be involved in supporting learning and facilitating tutorials.

To support trainees ANZCA has Introductory Training Tutors, Clinical Fundamental Tutors, Education Officers, Departmental Scholar Role Tutor, Provisional Fellowship Supervisors and Specialised Study Unit (SSU) Supervisors. All must hold a FANZCA, except SSU supervisors, who must hold a FANZCA or a comparable qualification acceptable to ANZCA Council. For example, a Fellow of Intensive Care Medicine (FCICM) is an SSU supervisor for the intensive care medicine unit.

There are four levels of supervision recognised by ANZCA. As trainees progress through training, they gain competence and transition through the levels of supervision 1 (one-on-one) to 4 (remote supervision but available 'on call') at the point of the Provisional Fellowship year leading to the Fellowship Exam.

RANZCO advised that different models of supervision are currently in development including tele-supervision arrangements for trainees in rural training posts as many rural posts will rarely be able to meet the 3.0 FTE supervisor requirement set under accreditation standards. These models take into consideration the competency level of trainees.

In SA there is a cardiology network called Integrated Cardiovascular Clinical Network SA. The Clinical Director of the network based in Adelaide is supportive of the rural cardiology service established in Whyalla, and when the RACP required two consultants on site at all times to meet supervision requirements, the Clinical Director advocated for Whyalla that there was appropriate supervision with one cardiologist onsite and locums on continuous rotation. The College approved accreditation for the training post, accepting that the health service does not have full-time consultants in Whyalla, but they are within the network.

Some Colleges leverage heavily from other specialities for supervision of elective training terms with non-Fellows of the College, such as ICU trainees undertaking an anaesthesia rotation with an anaesthetist supervisor. Other examples include dual training such as pathology and physician training. There are joint training programs with the paediatric, emergency, pathology, radiology and haematology specialties. In terms of RCPA policies and accepting different supervisors, there are training programs that will accept Fellows of other Colleges as supervisors, provided the trainee has at least one Fellow of RCPA (FRCPA) supervisor.

The RANZCP advised that for the psychiatry training program supervision can be provided by someone who is not a Fellow of the College, such as an Affiliate member, as long as they have undertaken training and are accredited to do so, as occurs with Fellows of RANZCP (FRANZCP). This arrangement is more common in New Zealand because there are many more Affiliate members in New Zealand than in Australia because of the relatively larger SIMG workforce. Supervision can also be provided by others who are not members of the College in some circumstances for some elements of the training program, such as psychotherapy EPAs which can be signed off by psychologists.

The RANZCP also supports a model of remote supervision for Stage 3 of training in cases where there are FIFO consultants. The model has been developed to ensure that in such situations, trainees are appropriately supervised and in accordance with accreditation standards.

For example, for a training post in Tamworth, there is no resident consultant psychiatrist to supervise, but there is a FIFO consultant onsite two full days of the week which meets the requirements for the supervision. The accreditation standards require three sessions co-located with increased flexibility in this remote supervision model if there is a Year 5, Stage 3 trainee who is approaching transition to Fellowship. Key to the success of the model is that trainees know exactly who the clinical line of responsibility is so if the consultant supervisor is not there on particular days, they know who to contact and how, as well as having a contactable secondary supervisor. There is a particular training program in NSW that has a Specialist Coordinator of Training and a Rural Specialist Coordinator of Training, who has responsibility and oversight of rural and remote trainees in the network of training sites.

The need for two onsite surgical supervisors to meet accreditation standards is limiting. To overcome this, Kalgoorlie Health Campus applied for an alternative model of supervision, establishing one local supervisor, one core supervisor in the metropolitan centre and a mentor in the rural clinical school, not linked to direct or clinical supervision. This model was supported by RACS.

There also needs to be a greater acknowledgment of the resources and professional development that goes into the role of a supervisor, both by health services and Colleges to better support supervisors in rural areas.

Recommendations:

No.	Supervision of Specialty Training
5.	Increased engagement with rural supervisors to provide training, support and seek feedback on issues impacting rural training. Identify mechanisms to better support rural specialty training.
6.	Consideration of innovative models of supervision including network supervision arrangements, incorporation of digital technologies to accommodate tele-supervision, supervision models based on trainee competency, clinical skills and the potential for inclusion of non-Fellows, SIMGs and locums in supervision models.
7.	An accredited, tiered system of training supervision that aligns with multidisciplinary teams and service delivery in rural areas. For example, fully qualified specialists to provide specialist services (Tier one), doctors or other specialists with the Diploma or Certificate level qualifications in that specialty (Tier two) with the consideration of inclusion of rural generalists and senior or advanced trainees.

4.4 Casemix breadth, depth, and caseload

Casemix and caseload are scrutinised by accreditation teams during accreditation inspections, this occurs with documentation and data provided by the training site and verified in interviews with trainees, supervisors and other site personnel.

Rural health services often have difficulty in meeting caseload and casemix numbers due to the nature and volume of service delivery relative to the needs of the communities they serve.

There are also limitations on health service scope of practice impacting not only caseload and casemix but specialties that practice in these areas. Often there is simply not the volume of work available to employ a specialist full time making it difficult to establish a department of resident specialists to build training capability and capacity.

Some procedural numbers and restrictions in accreditation standards are historical and not necessarily based on current evidence. With digitisation, linkages and virtual platforms, there needs to be consideration of the relevance of such accreditation criteria for a safe and quality training experience.

Case numbers will not determine the competence of a trainee, nor the quality of the training experience nor training outcomes. A health service that meets such numbers may not provide the best training experience. Recognising the individual learning needs of trainees where some require less training and some more, is an important consideration for specialties. This should be reflected in accreditation standards rather than health services required to meet a set number of caseload and casemix per training post.

Some of the casemix issues arise for health services when there are discussions with Colleges on how to reduce fatigue in trainees. One rural health service advised that trainees are the biggest overtime consumer, and in some cases, working excessive hours. When the health service approached the College to request extra trainees to form part of the roster to try to reduce overtime, the health service was advised that such an action would jeopardise the accreditation of the training posts because trainees would not access enough case volume for training requirements.

In Broome, procedural numbers are the biggest issues for procedural specialties. General Surgery in Broome, for example, can only accept one trainee at a time and this contributes to issues in the General Surgery workforce. General surgeons in Broome have limited range, breadth and depth of experience with different surgical procedures with a limited scope of practice. There are emergency surgeries, routine day procedures and a small number of elective major cases. There is no breast surgery, thyroid surgery, or anorectal and colon surgery and therefore, junior consultants seek more activity in major cases and choose to go elsewhere.

Broome has been very successful with the physician, paediatric and mental health workforces in having trainees rotate for training who then stay on as junior consultants. There are significant procedural numbers and good retention because of the training pathways and the consultant workforce.

In some cases, clinical case volumes in regional and rural areas are excellent, allowing trainees to be primary operators. For example, cardiac surgical trainees in Townsville undertake approximately 400 heart procedures a year.

For anaesthesia training, trainees complete an online training portfolio to record training experiences to demonstrate that they have completed the minimum volume of practice. The information in the portfolio reflects that trainees are completing training requirements; however, it does not always reflect true caseload and casemix. It has been identified by ANZCA that trainees enter the time that they have spent in training

to meet requirements, once they have met requirements, other additional work is no longer recorded and as such might not capture all the individual cases undertaken by trainees.

The absence of comprehensive information of caseload and casemix for trainees does not completely represent the type of clinical experience that the trainees are getting. This can be an issue for accreditation to accurately identify caseload and casemix at each accredited site and to ensure trainee safety.

Many of the procedural specialties require trainees to complete a logbook to indicate access and completion of caseload and casemix training requirements. These are signed off by supervisors and in most cases, this data is considered in accreditation assessments. When a health service wishes to establish a new training post that has never existed, logbook data will be critical information and often service registrars are a critical component to demonstrate that a health service has the specialty caseload and casemix available to support establishing an accredited training post. Colleges indicated that logbook data is only one source of information that contributes to an accreditation assessment.

A recent example of changes to incorporate broader consideration of context rather than simply relying on caseload and casemix is the revised 'three tier' classification system for ACEM accreditation. ACEM identified general casemix characteristics for each tier classification, derived from 2018 census accreditation data, based on presentation numbers and transfers occurring at sites. While this data is useful for informing and guiding accreditation teams, this data alone may preclude some smaller rural health services from maintaining or meeting such accreditation standards. ACEM will continue to ensure that additional information and site-specific circumstances will be considered and continue to contribute to the accreditation assessment process. This data is suggested to be used as a guide and comparison tool only by accreditation teams.

4.5 Infrastructure

Although much of the infrastructure requirements set under accreditation standards are an absolute requirement for training, there are significant challenges for rural health services who may only have certain infrastructure based on the scope of practice of the organisation and limited resources. When there is growth and expansion of service provision, a health service may need to build infrastructure. Even with new infrastructure there can still be limitations on what can be accommodated. Unless located in a large regional centre, health services will rarely have the ability to match the infrastructure of a metropolitan tertiary health service.

For some specialties, infrastructure does not exist in rural areas because it is not the service delivery model. This is also reflected in the presence of specialist workforce in rural areas. In other examples, such as radiology, infrastructure requires significant resources and physical space to accommodate the size of the equipment and safety requirements.

In the case of intensive care medicine, if there is no ICU, there is no ability to establish training.

Colleges are progressing to accommodate rural and expanded settings in a training system that does not differentiate between metropolitan, large, well-resourced sound health services and those smaller sites, with limited infrastructure and limited resources, in some cases, with jurisdictional and local challenges.

One health service described the challenges when accreditation standards require certain infrastructure, such as a trainee teaching and training room. No such facility existed in the health service and even with

the construction of a new building, there were no available resources to accommodate a training room to support training.

The respiratory department at a rural health service undertook to establish an accredited training position. They successfully applied for Commonwealth STP funding for a specialist trainee but encountered difficulty in meeting accreditation standards for the proposed training post without a Lung Function Laboratory for complex respiratory function testing and reporting. As a result, the College did not approve accreditation of the training post and the training post was unable to proceed.

The need for particular infrastructure, or equipment at every accredited site (as identified above with the Lung Function Laboratory), does not recognise that such sites can still provide a respiratory service and a valuable training experience in rural locations. Networked training models are vital to recognise that rural and other expanded health settings that may not meet all the requirements still have a valuable training experience and can link to the larger sites with the ability to provide exposure to particular equipment and training experiences for a rotational term.

Another example is the infrastructure and staffing requirements for accreditation of paediatric training. A Paediatric ICU or Neonatal ICU is required at a hospital as well as a Director of Clinical Training. Trainees also must be employed by health services that have a Director of Clinical Training which makes it impossible to have a training network outside of a tertiary centre.

There are also expectations of similar organisational structures across all health services no matter the location and a lack of understanding of rural health services and service delivery. For surgical training there is the requirement for infrastructure that is readily available in metropolitan health services that does not exist in rural areas.

Access to research in rural areas can sometimes impact on the ability of health services to meet accreditation requirements. Training for most specialties also involves research or academic engagement, and many trainees are interested in academic positions which are frequently less available in rural areas. The capacity to undertake rural research is hindered by lack of research infrastructure compared to metropolitan health services. In this case, greater consideration could be given to linkages with rural universities and medical schools to support and facilitate research opportunities which may then support the ability to meet accreditation requirements.

4.6 Impartiality, transparency, and consistency

In accordance with AMC standard 8.2 (Appendices – Appendix O), every College has an accreditation framework with guidelines, standards and criteria with benchmarks of minimum requirements that link to outcomes of specialist medical programs as a basis for all health services to be measured against during assessment. There is standardisation where possible in accreditation practice and documentation. Colleges draw on member accreditation and specialty specific expertise in accreditation committees and teams, to contribute to establishing and maintaining policies, regulation and process to drive consistency and underpin the framework ensuring safe, quality specialty training. Colleges have cyclical accreditation with regular monitoring and review of accredited training sites, posts, networks and programs and mechanisms to address issues that arise that impact accreditation.

There has also been the establishment of clearer College governance structures and processes to oversee the accreditation function.

Colleges apply guiding and governing principles for accreditation assessments, particularly that all accredited health services, training posts, networks have a positive learning environment with appropriate supervision, support, infrastructure, resources and an adequate volume and diversity of experience to meet the requirements of training programs.

Accreditation teams often consist of two Fellows, one College staff member and occasionally a trainee and / or state or territory representative with peer review applied throughout the governance process. To avoid subjectivity during an assessment, the assessment is balanced across accreditation team members and with other accreditation committee members at check points within the accreditation process. Further College specific information can be found in Appendices A–L.

Stakeholders expressed that despite such measures, sometimes accreditation assessments and outcomes are not transparent, consistent or without bias.

4.6.1 Transparency

Over time, accreditation frameworks and processes of Colleges have become fairer and more transparent. However, there is room for greater clarity and transparency of requirements a health service must meet to comply with standards, criteria and accreditation decision making.

College transparency and engagement in accreditation were identified as a challenge for health services and states and territory departments of health. Some College requirements and processes have insufficient information in published accreditation criteria reducing transparency for health services as to what requirements need to be met to comply with accreditation standards. Information on websites can be very high level and without the detail required for health services to make decisions on medical workforce and training infrastructure prior to applying for accreditation. For example, with a requirement for clinical governance to meet an accreditation standard, clinical governance can be wide-ranging. Clarity is required for health services to understand what level of clinical governance is needed for a first-year trainee versus a final-year trainee for optimum training outcomes.

Other examples include that for some specialties, particular details of criteria such as caseload or casemix, are not publicly available. This makes it extremely difficult for health services to understand what they need to meet accreditation standards. It also creates a reliance on informal networks to gain such information which may or may not be correct and may be influenced by other factors which ultimately can impact whether a health service is deemed suitable for accreditation.

Another important element of accreditation is the provision of a copy of the draft assessment report to health services for correction of fact. On occasion, health services had not received a draft assessment report or only received a letter with limited and incorrect information which may have broader organisational impact. Health services would prefer to see a full draft assessment report to ensure facts are correctly presented and that information and evidence are thoroughly considered to support accreditation outcomes.

Anecdotal feedback indicated that sometimes politics within a speciality can influence accreditation assessments, such as one group of specialists that does not support a health service being accredited and has differing views with the specialty team in that health service. There may be specialists who are not aligned in a region and in competition in private practice as well. This can risk influencing the assessment of a health service and approach of an accreditation team.

One health service due to undergo re-accreditation was gathering information to address an issue of being blocked from establishing an additional training posts by the primary or 'feeder' health service

within the network with a strong voice on the College training and accreditation committees. The health service produced logbook data with a service registrar demonstrating evidence of enough activity for an additional trainee, critically needed by the health service to run a 24-hour, seven day a week service and on-call coverage.

There is a view that it may be preferred for trainees to access certain procedures to meet core training requirements during a rotation in a rural health service as usually there is little competition with other trainees in comparison to metropolitan sites. This is not always aligned with the needs of rural health service delivery. There are broader training experiences available and health services should be enabled and supported to broaden the training experience rather than restricting what trainees have access to, which is not in the overall vested interest of the organisation or the broader community.

The recent RACP Accreditation Program changes include alignment of standards and the accreditation program across the RACP and make progress towards improved transparency of processes and outcomes.

4.6.2 Consistency

Inconsistency in the assessment of health services against standards was expressed in feedback, in addition to inconsistency across Colleges of accreditation requirements. Every College accreditation process asks a component of the same question or a version of the same question related to supporting training without consistency in terminology across Colleges. For example, trainee wellbeing means something different to every college, the MBA and the AMC. There are different requirements in accreditation standards and criteria. It also means something different to each jurisdiction for intern accreditation. There are commonalities and variations but there is no common language and no common definitions. This not only creates inconsistency in assessment across Colleges for similar standards but adds to the regulatory burden.

Health services acknowledged the diversity of Colleges, however, the issue of inconsistency of accreditation assessments relative to different accreditation teams undertaking assessments was raised on a number of occasions with reports that assessment has at times seemed haphazard to health services.

It was reported that accreditation teams assessing rural health services without knowledge of the rural health service environment, or with a particular subspecialist special interest area, can redirect the focus of accreditation teams away from standard process negatively impacting an assessment. This can be inconsistent between facilities and variations in assessment appear. Accreditation requires strong governance for accreditation teams with balanced expertise, assessor training and management of biases. Ideally, gender and diversity balance and Aboriginal and Torres Strait Islander representation in accreditation teams should also be considered, however, Colleges rely on voluntary participation from members and may have a small pool of members to choose from who are interested in accreditation, have appropriate expertise and are available to participate.

Accreditation standards and criteria need to be appropriate and reasonable. Rural health services must be supported to provide a quality training environment for trainees to be competitive in training and able to attract quality trainees. Another challenge is inconsistency in setting standards, for example, setting requirements that are outside the employer award or agreement. When this occurs, it creates inconsistency for other specialty trainees and is an unfair expectation to place on rural health services who are often unable to meet these varying requirements the way metropolitan sites can.

It also creates issues for one state between metropolitan and rural health services trainee rotations sometimes playing off facilities against each other and who will pay for relocation and accommodation for trainees. Trainees are sometimes 'bartered' to a rural location if a health service has restrictions

on the amount of leave it can offer to trainees for the time releases required for training. It creates a tiered system for accredited trainees and service registrars; the 'have' and 'have nots'. As a result, trainees in accredited training have access to a higher level of support and supervision, better roster arrangements, other provisions, and as the accreditation and the training requirements become stricter, they become more elevated within the health service. Service registrars have to take up the burden of rosters, especially the unpalatable after-hours roster, and access less teaching if there is more quarantine time for accredited trainees.

Recommendations:

No.	Impartiality, Transparency and Consistency
8.	Inclusion of jurisdictional representatives and / or independent observers in accreditation assessments, including site visits, desktop reviews or virtual accreditation assessments.
9.	Improve transparency in published accreditation standards, criteria and requirements.
10.	Robust conflict of interest policies and processes for accreditation teams to underpin fair and balanced accreditation assessments.
11.	Identification of commonalities and terminology across specialty accreditation frameworks with College adoption of common definitions and criteria to create efficiencies across the accreditation system.
12.	College collaboration with sharing of common accreditation information.
13.	Review accreditation practices to improve consistency.

4.7 Accreditation standards and industrial arrangements

Accreditation standards and criteria need to be appropriate and reasonable. As outlined above, requirements outside the employer award or agreement creates inconsistency across specialties and workforce and stakeholders indicated that they are an unfair expectation to place on rural health services who are often unable to meet these requirements the way metropolitan sites can.

Furthermore, the reliance on service registrars to support service delivery and accredited rotations, impacts the junior medical workforce on a range of cultural issues such as the reluctance to claim overtime and to be seen to be standing up for their own industrial rights because they are working within the environment of service registrars, all hoping to get onto a specialty training program. This directly impacts accreditation in relation to health service governance and the level of organisational support provided to all trainees for training, welfare and safety.

Some Colleges have increased requirements relative to changes in industrial arrangements or changes that misalign with industrial arrangements under awards, which may be out of the control of health services to address. For example, the impact of when trainees rotate from one jurisdiction or between the public and private sector and paid under different agreements or state and territory awards being difficult to manage for rural health services with fiscal limitations.

In the General Surgery accreditation standards, there is a limit of two weeks of nights per month for an accredited trainee. This affects rostering, staffing and costs for a health service and is not consistent with the RACS College rules.

There is a degree of artificiality with some of the criteria of accreditation standards, particularly in a rural setting in that the tension between service and training misses the point that a lot of service demand has significant training value. By trying to cloister the accredited trainees away from service demand puts them into an artificial world and trains in procedural and technical skills, and often miss the real-world stresses and strains and complications to become well-rounded and effective specialists able to practice in any environment.

4.8 Rural medical workforce and service delivery

Rural health services need to map the service demands, workforce and their capacity for training within their regions. Not every health service will require specialist services such as heart or cardiothoracic surgical units. Workforce need will depend on case numbers, mapping data, a clinical services plan, level of care, the capability of an organisational scope and practice based on a number of factors including nursing staff, infrastructure, etc. Health services need to determine the capability of the organisation to accommodate and support specialty training within the organisation's scope of practice.

In addition to workforce service delivery planning, each health service needs to have a clear goal and direction about the purpose of their training system. A health service may determine their goal is to train a doctor to become a specialist to build, stabilise and sustain their workforce so the health service can reduce their reliance on FIFO and locum doctors and provide some return on investment. If that is not their goal, then there may be no reason to pursue building training capacity.

Sometimes having the capacity to train is not the workforce solution to meet service delivery needs for some rural health services.

In SA, one health region has implemented a VMO and service registrar model of care to provide services rather than focussing on training.

Port Augusta, Port Lincoln and Mount Gambier have a successful rotating General Surgery VMO service model from Queen Elizabeth and Royal Adelaide Hospitals with consultants that rotate one week in four to provide 24-hour, seven day a week coverage. Along with the consultants, sometimes an accredited surgical trainee attends and a service registrar assists in providing the service locally. This became the alternate arrangement for Port Augusta to meet elective surgery service needs in the region when accreditation for General Surgery was withdrawn.

The service registrar keeps a logbook in the event the health service ever wants to reinstate accreditation, however, there is a reluctance to re-accredit the health service as currently elective surgery benchmarks are being met. The service registrar does not require additional training supervision or specific roster allocations to meet caseload and casemix requirements and with the position (originally funded by STP) no longer funded, the LHN would need to fund a training position. For the same rural health service, a urologist visits two days a month and there is no mechanism for the trainee from the metropolitan site to attend with the Fellow. Additionally, funding would be required to support the extraction of the trainee from the metropolitan site.

To maintain accreditation, health services are required to satisfy a certain volume of practice in specialty or subspecialty units and in rural areas that can often be reliant on one specialist to provide all the volume of practice for that specialty or subspecialty. The training system can be very fragile and reliant on too few people in rural areas; if one person is sick, retires or moves away, a health service can lose a significant volume of practice and be at risk of losing accreditation.

The vulnerability and fragility of specialty training within small departments in rural areas is an ongoing concern. The range of rules and inflexibility by some Colleges for supervision, duration of training rotations and training experience make it difficult to engage in training. This can be impractical and hard to manage in addition to difficulties in attracting specialists without a trainee workforce.

A big challenge for rural health services is the limitations accreditation places on service delivery and workforce. This comes back to metro-centric accreditation standards that are appropriate for larger tertiary health services who have sufficient medical workforce and workforce diversity to meet most, if not all, service delivery needs and accreditation standards. For example, a health service suggested that given there was a workforce shortage in the region that General Surgery trainees could assist in other surgical areas of service delivery. The health service was advised that this was not possible as it risked diluting the required training experience for the General Surgery trainees and did not meet accreditation standards. For the health service, the opportunity for trainees to work across other surgical areas not only provided additional medical workforce support, but also exposed trainees to other relevant training experiences that a regional health service could offer. As such, health services must recruit service registrars to assist in fulfilling service requirements for on-call and weekends, which comes at a significant cost.

With respect to unreasonable expectations, a rural Head of Department was required to employ three specialists to support one accredited training post where there were already limitations on available workforce. Some health services in a 'local district' health care model can leverage the district health services in meeting some of the requirements to support training such as tutorials, study groups, technological support, etc., but in some cases, health services may not be a part of a larger district or region and are reliant on the ability to join networks or meet requirements to be a stand-alone training site.

There is increasing vigilance to monitor the workload for junior medical staff and ratios of medical staff to patient load, overtime, and fatigue management. Rural health services have the ability to support only a certain number of accredited positions because of the types of services and workloads, particularly for a primarily VMO model of service delivery. A health service often needs to recruit service registrars which can also be difficult for rural areas competing with tertiary health services. Health services reported that there are always challenges attracting and maintaining a senior medical workforce resulting in a reliance on a locum workforce. The more accredited training posts a health service has, generally the easier they are to fill and the easier it is to attract a specialist workforce.

Latrobe Regional Hospital in Victoria has been active in workforce planning. Ten years ago, they had 50 specialists, now there are over 200 specialists supporting service delivery. The health service has designed the next stage of expansion and a significant growth in services which will see an additional 50 specialists by 2023 including intensive care, emergency medicine, anaesthesia, and surgery. The site will have ten operating theatres and a projected sixty per cent increase in ICU with an elective surgery list six days a week to meet targets. Workforce is forecast to be a major issue, so the health service is committed to growing their own and providing a quality training experience for all trainees.

From a clinical perspective there is development of regional network models including the proposed Rural Paediatric Training Program, partnering with Bairnsdale and Warragul around integrated clinical service plans with shared specialists. For example, for medical oncology, Latrobe Regional Hospital will provide all the oncologists across the region in a hub and spoke arrangement. Eventually there will be the development of a renal hub in the Gippsland region.

Often success is how health services support the training environment to balance their workforce needs. ANZCA reported that there are examples of rural health services that have rostered trainees and structured their workforce in a different way where the trainee experience and the trainee environment is excellent.

Recommendations:

No.	Medical Workforce – Rural and Regional Service Delivery
14.	Recognise workforce needs and the tension between providing training and clinical services. Provide supervisor support to enable greater access to protected time to facilitate supervision and other training requirements.

4.9 Service delivery

Colleges do not have oversight of health service capability, operational requirements and nuances of different health services or their capacity for training. Capacity to train across a health service, region or network of sites should be explored to support accredited training.

Significant changes in health service delivery can impact the accreditation status of a health service or training posts. In one example, accreditation was jeopardised when the casemix changed due to a temporary arrangement to contract services to the co-located private hospital. The health service planned for the work to be moved back to the public health service, but the public health service was questioned as to why the trainees had not met training requirements. The transition period was not recognised as a temporary arrangement nor was support provided by the College during the transition period. There was also disconnect between the College state committee accreditation process and the College national committee determining accreditation outcomes as to the appropriate course of action.

Feedback indicated that there is a need for Colleges to better understand health service delivery in different settings and contexts and how accreditation decisions impact service delivery and vice versa to make informed accreditation assessments. This would minimise the impacts of these decisions on training and service delivery. In the above case, collaborative engagement with the health service on what could be done to address any deficiencies and ensure trainees were supported to achieve training requirements may have produced a mutually beneficial outcome such as the opportunity to explore networked training and jointly accredit both public and private services with most of the same specialists working across both health services.

4.10 Proposals to establish accredited training posts, training pathways or networks that have not been supported or accredited

The limited collaboration between Colleges and health services has at times inhibited the expansion of training.

Whilst exploring models or programs of training that were developed and not supported (not accredited), some stakeholders indicated they had developed innovative models for specialty training in rural areas but hesitated to submit these to Colleges as they did not fully meet accreditation standards. Some proposals included tele-supervision arrangements not currently supported by many Colleges under accreditation standards.

There were several examples of rural health services that had applied and had not been supported as a result of the availability of supervisors. Other reasons for not supporting innovative proposals included the proposed training program was not aligned with the requirements of the existing training programs, casemix and caseload were not optimal (in some cases the mix was appropriate, but the numbers did not meet criteria) or model of training was not aligned with traditional training models.

A proposal for Basic Physician Training in Paediatrics and Child Health was developed for a completely 'out-of-the-box' model of training experience in Far North Queensland. Although the team establishing the training post consulted extensively, and the Directors of Physician Education from Brisbane provided positive feedback on the proposal, it was not supported by the RACP because it did not fit within the existing model of training.

Another rural health service that worked on an application to accredit a specialty training post for 18 months and met accreditation requirements, found the biggest challenge to overcome was the attachment to a training network and sharing training with a metropolitan site. The metropolitan site did not support the application as it felt it would make their training program less attractive to trainees if they had a rural attachment. Accreditation was not supported.

For paediatric and child health physician training to be supported under the IRTP program, a three year, networked rural training program was developed by the WA Rural Paediatricians Network. Working collaboratively with other sites, rural clinical schools and tertiary paediatric sites, the proposed program included:

• three months GP training in Kalgoorlie (supporting Indigenous communities)

• three months Obstetrics and Gynaecology training

• six months supervised research

• six months as a General Paediatric trainee in Kalgoorlie

• six months tertiary neonatal care (metropolitan)

• three months Emergency Department training, and

• three months physician subspecialty training.

The proposed program was submitted to RACP once approved by health service executives, however, was not approved on the basis that it did not meet new accreditation requirements which had changed during the course of a submission and appeals process.

In rural NSW, the proposed establishment of a specialty training post illustrated some of the barriers in accreditation. A Regional Training Hub (Hub) in NSW assisted two specialists to compile the required accreditation documentation for a proposed specialty training post. In the proposal, the rural health service could support a core year and a research year and had the casemix and the volume of specialists to meet accreditation criteria with two years onsite. The resistance in establishing the training post was from other specialists in the area who felt such training could not be done in a regional centre. The head of unit wrote to the College Board, the Director of Specialty at the College and other doctors wrote to the trainee representative on the College Board. The site did not receive a response from the College, only once the jurisdiction intervened did the College discuss the proposal with the rural health service, schedule an accreditation assessment and approved the accreditation of the training post.

4.11   Withdrawal of accreditation

All Colleges advised that the matter of withdrawal of accreditation was taken very seriously with every reported issue investigated thoroughly before deciding on the most appropriate course of action. The decision to withdraw accreditation is often made only after remedial action is unsuccessful or there are concerns for trainee and / or patient safety. Colleges employ a range of measures for health services to remediate and resolve identified issues to make progress towards accreditation compliance including:

- step measures with milestones,
- site visits,
- increased periodic reviews,
- downgrading of accreditation status, and
- the potential removal of trainees, either on a temporary or permanent basis.

Accreditation issues are escalated within College governance structures with withdrawal of accreditation decisions often approved at the most senior levels of a College. Further details can be found in Appendices A–L.

The tipping point and the basis for the withdrawal of accreditation is not always clear for health services or jurisdictions. State and territory health departments advised that frequently they were not advised early enough to provide assistance and support to both health services and Colleges. Sometimes a crisis has been developing for 12 to 18 months in a health service and it is critical that situations are actively managed, supported and escalated (where appropriate) during this time. This can only be done if there is an early warning mechanism to alert jurisdictions.

Scenarios were reported where rural health services had accreditation withdrawn due to unsubstantiated complaints. The progression of withdrawal of accreditation can be extremely problematic for health services and negatively impact service delivery. Trainee safety and support is paramount however, health services would like to be able to continue to deliver services with the collaborative support of Colleges and jurisdictions whilst remediating any issues.

There is also a significant reputational risk associated with the loss of accreditation and this can have a far greater impact on a health service long term, particularly in rural areas. The loss of accreditation means it can be difficult to attract and retain trainees and the required workforce if there is a perception that a health service does not meet standards. When a rural health service cannot offer all the training experiences that are offered at other sites, it can also make a rural health service appear much less attractive. This becomes demoralising for the whole health workforce, not just trainees and the medical workforce.

Safety is a priority for training environments, however, sometimes the threat of taking away accreditation can aggravate an already difficult situation for health services. Health services reported that taking away training was seen as devaluing to the specialists that work in a health service and often specialists are already stressed with service and workforce imperatives and do not always have sufficient resources and support for training. One of the risks is that it may become too difficult for smaller health services to manage the process of remediation and re-accreditation, and specialists and health services may not seek to regain accreditation.

Accreditation standards exist for health services to adhere to them, including when things are not going well. This can be difficult for a health service without College support. When Colleges work with health services to support remediation, it gives health services a clear understanding of deficiencies and the resources and changes required to meet the minimum standards for accreditation to regain accreditation.

The AMC ran workshops with Colleges in 2019 on managing the process of dealing with accreditation issues and how to manage when a situation does not go well in relation to quality of training in a health service. The feedback from the AMC was that collectively Colleges agreed on the importance of transparent and clear communication with health services during such processes.

In one jurisdiction, an ICU had an accreditation downgrade from C6 to Foundation. The hospital had gone through change, the issues identified related to service provision, and the ICU was set up under different circumstances, impacting casemix, caseload and trainee safety. The ICU worked hard to gain accreditation originally, but following investigation by the College, it became clear that it was not a good training experience for trainees. Stakeholder feedback indicated that it was an entirely appropriate decision by the College.

In an example of good College support, a rural health service Department of O&G almost had accreditation withdrawn, however, reported that with support from RANZCOG, issues were resolved minimising impact on service provision. The health service did not meet supervision requirements as the service delivery model included experienced senior medical officer workforce who were not specialists. This in tandem with other issues impacted accreditation for training. The College did not withdraw accreditation, instead giving the health service a warning and a remediation plan to support the health service to remediate, become compliant and continue to be accredited and provide service delivery.

One regional health service lost emergency medicine accreditation in 2000 and regained it with the support of ACEM. The health service advised it has now gone from strength to strength supporting and building training capacity.

Another rural health service lost accreditation for different specialities at various times, often due to lack of staff and supervisors to be able to provide the training or to demonstrate the capacity to train as well as rostering issues related to workforce shortages.

A regional health service lost Basic Physician Training accreditation due to difficulty recruiting specialists and was unable to offer all the subspecialties required for training. Although the health service had specialists in place by March, several delays in the accreditation process meant that the accreditation assessment visit was not conducted until October and a decision to ratify the accreditation decision delayed until January the following year, just prior to the commencement of trainees, and well after the recruitment period. Had provisional accreditation not been assigned at the site visit in October, the health service would have been unable to carry out trainee recruitment and without trainees for another 12 months. The health service also had to undertake additional risk planning and seek alternative employment and training for the trainees recruited if accreditation was not approved.

Since this time, the health service has been able to recruit the required subspecialists to rebuild service and training capacity. During the period that the health service lost Basic Physician Training accreditation, it retained Advanced Training accreditation in several subspecialties.

One rural health service that lost emergency medicine accreditation had approximately 50,000 ED presentations per annum and was reduced to 3.5 FTE FACEMS plus locums. This significantly impacted training. With a new Director of Emergency, support from the health service executive and ACEM, the health service was able to rebuild the specialist workforce with a view to further increasing the number of FACEMs and reducing their reliance on locums. The health service advised that the loss of accreditation helped them to turnaround the workforce and make significant improvements in the ED and support of training.

Mechanisms need to be in place to not only ensure continuity of College governance processes for accreditation, but also to support health services in a collaborative manner to ensure safety, and minimise risk and impact on workforce and delivery of specialist services for rural communities.

Recommendations 5, 6, 8, 21, 31 and 34 can positively impact the issues identified in this section.

5.0 Challenges across the non-GP specialist medical college accreditation system

There are other challenges in the accreditation system that sometimes have a greater impact in rural health services due to their size but are common challenges whether it is accreditation of metropolitan, private, rural, community or other setting.

5.1 The administrative burden of accreditation for health services

A site or a training post may be worthy of accrediting, but sometimes it can be too much of an imposition on a rural health service to commit to developing it to accreditation stage.

A NSW rural health service outlined the process they undertook to successfully accredit a training post for a general medicine advance trainee. The model of training was designed to ensure the trainee stayed at the health service for two years rather than rotating for a three or six month term. To achieve accreditation and establish the post, it took two years from start to finish. Before the health service could submit the application form, they researched how to design the training program, appropriate subspecialty rotations and consulted with every specialist in the health service to develop a training program in each department for each rotation. The health service sought feedback from HETI, other health services and the RACP. It also required significant influencing and negotiating, working with the health service executive and confirming funding through the NSW Ministry of Health Specialist Training Program to establish the training post.

Colleges generally provide notice before a health service will undergo an accreditation or re-accreditation site visit assessment to enable the health service to gather the information, documentation and data required and schedule meetings and staff to be available for the assessment. As part of the preparation for an accreditation assessment, the non-procedural specialties review the learning opportunities that can be accessed in the organisation, often including a role description, and the procedural specialties review case data, trainee logbooks, casemix and caseload the trainees are able to access during their training term.

Stakeholders indicated that it could take anywhere from 40 hours to twelve months to prepare, gather and collate data and information for accreditation assessments. The total data set requires a significant amount of time and input from many different people involved in training and administrative support is not always available to support the process. A central person coordinates all accreditation activity, usually the specialist who is head of the department being accredited. Collated data is provided to Colleges, who undertake a preliminary review and advise the next steps. This can involve waiting for the next College accreditation committee meeting to make a determination, depending on the College process. Sometimes extra information needs to be provided which requires additional time and resources to complete. There is also a significant administrative burden associated with multiple accreditation assessments, many requesting similar information.

The volume of documentation, time commitment and the burden of administration related to the accreditation process is prohibitive for health services trying to establish new training posts. Re-accreditation can be simpler but often still requires significant data and the production of documentation associated with training.

Other concerns for rural health services are the different time frames at which accreditation is undertaken, for example, a surgical department may be required to go through three cycles of accreditation within a two-year period for three surgical specialties which is a significant burden for small teams to support.

For physician accreditation, each individual advanced training speciality is separately accredited through their own committee. If a health service is accrediting for physician advanced training, each specialty has a separate process looked after by a separate nominee for that particular specialty. There is a different data set, a different timeframe and a different process for each specialty. The RACP renewed the accreditation program for setting accreditation and Basic Training Program accreditation which commenced in 2021. The next phase is to develop accreditation requirements, classification provisions and facilities, services, and work profile framework for each Advanced Training program.

There are common training infrastructure requirements and information that every College asks from health services in accreditation standards and criteria to support trainees such as human resources, industrial relations, trainee wellbeing and safety policies and measures that are generic across health services, not specific to any specialty. All Colleges seeking this information adds to the administrative burden of accreditation.

CICM has six steps for an application for accreditation which includes letters, the Director's curriculum vitae, rosters, data and endorsement from the Regional Committee before a site assessment is conducted. The College accreditation committee meets four times a year to consider accreditation recommendations. CICM accreditation is a prescriptive process which takes a 12 month period to complete, with articulation of requirements provided on the College website. For a smaller rural health service where there may only be two intensivists sharing the non-clinical portfolio, this is quite a burden of work in addition to service delivery.

Another rural health service with no additional resources to support accreditation had just been through ICU re-accreditation. The Director of Medical Services spent eight hours preparing and presenting information and the intensivist contributed approximately 40 hours' work to prepare for the re-accreditation. In addition, the health service could not roster staff during the day of the assessment so they could meet with College assessors.

For emergency medicine re-accreditation, one rural health service advised that it took approximately 100 hours of work to collect and collate the required data. The health service created a website to provide the data to ACEM. Most of the preparation work must be done by specialists as they are required to meet with assessors during an accreditation assessment.

For another emergency medicine re-accreditation, a rural health service advised that the last two re-accreditations have been across two different versions of accreditation requirements and documentation. The investment of time by specialists is significant, and in both cases, specialists shared the workload then collated the information in one submission. Much of the administration work is recording three to four years of data beforehand which in turn relies on a specialist having the time or administrative staff to record the information. There are few administrative or medical education staff in rural health services to support supervisors, education and training. This takes time and attention away from other things such as service delivery and specialists often undertake the additional work in their own time. Most rural health services do not have the ability to fund a medical education officer or unit to support education and training activities.

It can take approximately three weeks full time work for a surgical training post to collate accreditation data and information, assuming data has been collected, documentation is complete and nothing further is requested. Health services do not have assistance from Surgical Specialty Training Boards to support the surgical accreditation process.

One regional health service has a 'grow your own' philosophy and has spent the last 20 years actively building up accreditation in almost every specialty to meet community need. As a result, the resourcing and administration of accreditation is particularly burdensome in addition to scheduling of assessment visits.

In rural and smaller health services there is often not the infrastructure to support the accreditation process.

In Victoria, assistance from medical education officers (where available) and Hubs are helping provide more rural training and making it easier for health services to meet accreditation standards in terms of the training infrastructure and support requirements.

As a larger regional centre, Townsville has a medical education and workforce service which consists of a medical workforce unit and a medical education unit overseen by the Executive Director of Medical Services. There are some useful synergies within the education unit where the health service has used Hub resources to build in career counselling and support for trainees. In addition, the Hub has developed a database of accredited training posts across Far North Queensland which it shares with all the health services in the region.

One large regional health service advised that the Director of Medical Education has oversight of all the accreditation in the organisation to ensure that where possible, early warnings about issues and potential problems are raised and dealt with. Although there is oversight, the specialities tend to coordinate accreditation requirements and visits such as the schedule and meetings with health service staff and the accreditation teams. The health service executive team is generally involved, especially if something contentious is raised, for example, if there are recommendations following the accreditation visit which have broader implications for the organisation. In one case, there were factual errors in the accreditation letter returned to the health service that required the attention of the executive to address.

In some jurisdictions, medical education units at local health district level support all surrounding health services with accreditation requirements and collating information and data for accreditation assessments.

In NSW, HETI has provided some short-term administration to assist health services with the accreditation.

Aims of the new RACP Accreditation Program include making training providers accountable for training rather than educators with all of the information that applies to a health service as a whole will be gathered once and 'whole of health service' accreditation. The RACP is also automating the accreditation process to limit burden and collect data which will improve monitoring between visits. One health service advised that this may be difficult to implement in practice due to the coordination of everyone in physician specialities to accredit at the same time. There may still be fragmentation with much of the accreditation work still devolved to individuals rather than being carried at a whole of health service level.

No.	Efficiencies and Reducing Administrative Burden of Accreditation
15.	Resourcing administrative support for smaller sites with reduced capacity to respond to regulatory requirements and develop training infrastructure. Support to assist in preparing for accreditation activities and general specialty medical training support.
16.	Alignment and coordination of accreditation assessments to occur at the same time for some specialties, i.e., surgical and physician specialties.
17.	Recognition of accreditation by other bodies, specialties or subspecialties to reduce administrative burden and reduce repetition.
18.	Risk-based, data-driven collaborative accreditation systems with a quality assurance and quality improvement advocacy role for Colleges.

5.2 The administrative and resource burden for specialist medical colleges

Accreditation is an essential component of the operations of Colleges. The accreditation system is very burdensome for Colleges in terms of administration and resources with sometimes large volumes of training posts or sites to accredit annually. The larger the volume of accreditation, the more resource intensive the accreditation program.

Although Colleges have four to five year accreditation cycles, some reported accrediting up to 120 training posts or sites per annum. Most Colleges group accreditation visits where possible to maximise the time availability of Fellows and minimise travel requirements, for example, by jurisdiction or by region. Colleges undertake accreditation assessments via a variety of methods including:

- desktop or paper-based reviews

- teleconference assessment

- video/web conference assessment, and

- site visit assessment.

- The determination of method may be a risk-based approach or a standard part of the accreditation process. Many Colleges have significantly progressed the integration of assessment via virtual means to create efficiencies and reduce time and resource costs in the accreditation process, particularly in relation to travel expenses. This has been extremely important to integrate as a component of training continuity measures during COVID. In the case of high-risk situations, Colleges will always conduct a site visit.

- Site visits are the most resource intensive in terms of administration, coordination, expense, time and staffing and include a significant amount of travel, often from various locations across Australia and New Zealand, depending on the sites being accredited and the composition of accreditation teams.

- Out-of-cycle accreditation visits are often more resource intensive and risk being a 'stick rather than a carrot' approach.

- The engagement of Fellows (on a volunteer basis) in College activities is critical to the function of Colleges, particularly supporting specialty training and accreditation. The engagement of Fellows in College activities ranges from twenty per cent in one College to sixty per cent identified by another. Specifically, for accreditation activities, there is often a limited pool of Fellows available either with accreditation expertise or an interest in accreditation.

- The availability of Fellows to support accreditation is difficult to navigate as practicing specialists rarely have availability away from service unless College activities have a long lead time for planning. Periods of availability can sometimes be extremely limited such as one day (or less) at a time. This is an issue for the construct of accreditation teams and logistics of travelling to sites across Australia and New Zealand. Some accreditation visits take several days, depending on the location, specialty, the size of the health service being assessed and any other sites that may be linked under network arrangements and require accreditation during the same visit.

- This also impacts ensuring accreditation teams are well balanced with appropriate expertise, knowledge, and the consideration of potential conflict of interest.

- The entire peer-review process of accreditation relies on Fellows. Geographically, Australia is a big country; Colleges are mostly bi-national and not all Colleges have the financial resources, or the volume of Fellows required to support accreditation activities and the number of sites that need to be accredited.

- The volunteer workforce of specialists is supported by health services or employers, often in the form of professional development leave for specialists to engage in College activities. Colleges support Fellow involvement in College activities by awarding Continuing Professional Development (CPD) points per activity which contribute to a specialist's annual CPD requirement for Ahpra registration.[35] For example, a one-hour accreditation committee meeting may be an allocation of one CPD point.

5.3 Dealing with issues associated with accreditation

Accreditation is a significant responsibility for Colleges. A decision that a site is unsuitable to be accredited for training, or that accreditation needs to be withdrawn, can have a far-reaching impact. Colleges need to have rigorous accreditation frameworks including governance, policy, process and standards to justify decisions and defend actions taken.

Colleges reported that when issues arise that impact accreditation in one specialty, this can sometimes impact across other specialties in a health service, for example, in situations related to culture, bullying and harassment. Such situations can be complex and require collaboration and time to investigate, remediate and resolve.

Feedback from the AMC identified that Colleges are all making progress towards increased responsiveness in dealing with culture, bullying and harassment. Colleges have all taken account of these issues in various training policies and statements about wellbeing and a 'zero tolerance' on bad behaviour that have been integrated into most accreditation policies, processes and standards.

The AMC receives feedback where things go wrong in accreditation relationships between Colleges and health services. Colleges are very professional and hold themselves and health service cultures to account, however, it has been a quick system change for some health services and also for some Colleges and occasionally relationships and communications about accreditation issues do not always go well; particularly when there is a decision to withdraw accreditation. Health services sometimes do not agree with College decisions or on issues raised despite Colleges feeling they were clear on issues and actions in the lead-up to the decision.

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35 https://www.medicalboard.gov.au/Registration-Standards.aspx

In non-traditional training locations, such as rural health services, there are particular issues where trainees and supervisors are in close contact and raising issues about culture can be difficult.

The size of a health service can present challenges in relation to the visibility of issues. In a large metropolitan health setting with many trainees and supervisors, if an issue is raised that impacts accreditation, there is a greater likelihood of trainees and supervisors feeling they can speak up anonymously. There is also a greater likelihood of the ability of the health service to support the continuation of training whilst responding to the situation and remediating issues. Particularly with many having established medical workforce units to support workforce, including education and training.

In a smaller health services, particularly in rural communities, anonymity is rarely possible for trainees or supervisors and if issues are raised, the impact of issues can often be felt more strongly with training, workforce and service delivery all potentially affected. In addition, rural communities are often interwoven with the health service and issues can have a greater reach and impact across the community.

Accreditation issues can creep up and become a large problem very quickly if not addressed promptly and appropriately. The current timing of accreditation cycles are designed to find a balance between administrative burden, changes in a health service environment, staff movements and monitoring to ensure that quality, safe and supportive training is occurring and accreditation standards continue to be met. Over time Colleges have developed and integrated feedback mechanisms to better support trainees and supervisors in raising issues that require College attention. This could be strengthened to improve support for smaller teams of trainees and supervisors in rural areas.

Overwhelmingly, health services support the increased focus on trainee wellbeing and that trainees have a stronger voice in specialty training. This needs to be coupled with a balanced and considered approach by Colleges when issues arise that impact accreditation.

5.4 Accreditation process timeframe

The accreditation process is led by Colleges who have accountability for governance, coordination, and administration.

Colleges identified that accreditation process timelines are onerous along the entire accreditation workflow, particularly for smaller specialties with fewer Fellows and limited resource availability.

The subject matter experts for accreditation are practising specialists with limited availability to participate in accreditation impacting accreditation timelines. It can take six to 18 months for accreditation to be finalised which impacts health services and Colleges' ability to be responsive to workforce needs and government priorities, including the STP. Colleges with set accreditation application timelines have implemented these to accommodate the lead time required to align with and support trainee selection, recruitment, and allocation to rotations.

The process to establish a new training post can take anywhere from six to 18 months, in some cases up to two years. Generically, this process includes the submission of an application, desktop review by College staff, desktop assessment by an accreditation team and/or committee, accreditation site visit, draft report, review of draft report by health service, final report and the final accreditation recommendation approval.

This timeframe omits the enormous amount of background work by clinicians, specialty teams and medical education units to develop a business case for a health service to support the establishment of a new training post or to accredit a unit from both a financial and workforce perspective. It also omits the amount of

time taken to influence and negotiate inclusion of a proposed post or unit in a rotational training program (where applicable) and to garner support regional or jurisdictional College committee level and the wider membership group in the jurisdiction before an application is submitted to a College for consideration.

When issues occur at a health service that impacts accreditation, resolution of issues takes time. It requires significant investigation, collaboration and responsive action with Colleges, medical workforce teams, local health networks and in some cases jurisdictions, to reach a point of remediation and resolution. Once recommendations for action have been determined by a College, it can often take 12 months for accreditation non-compliances to be rectified by a health service. Sometimes a remediation plan is developed over a longer period of time to accommodate larger change measures such as infrastructure updates.

Establishing new training posts is mainly driven by health services rather than Colleges exploring the potential for growth, improving specialist distribution or actively engaging with health services to build the specialist medical workforce. Proactive models of accreditation and engagement with health services is something most Colleges are not engaged in. Sometimes this is due to devolved models of accreditation and training delivery, College capacity and resourcing and / or there is no strategic imperative to do so.

Sometimes there is delay in some of the Colleges in recognising changes in the health care system and the impact on training and accreditation.

In Victoria, some large regional health services changed significantly, and it took a long time for services to be reaccredited or gain a different level of accreditation. In addition, health services advised that without clarity of accreditation criteria and requirements, there is limited ability to conduct planning and self-assessment against standards to progress developing higher level training capacity in advance of an accreditation assessment.

One regional health service sought to progress to a higher level of accreditation to provide a broader training experience and accommodate a longer period of rotation for trainees in the region. It took over three years to progress from Level 1 to Level 2 accreditation and during this time the health service could only employ a trainee for six months at a time. This was very disruptive to their ability to attract and to build long term capability and capacity in their workforce and address future medical workforce supply for the service.

Details on each College accreditation process can be found in Appendices A–L.

Recommendation:

No.	Efficiencies and Reducing Administrative Burden of Accreditation
19.	Design and develop a common online accreditation portal to create efficiencies, reduce the administrative accreditation burden and create a synergistic approach to specialty medical training accreditation aiming to provide insight into health care system training capability and capacity for medical workforce planning and distribution.

6.0 Opportunities for change to improve geographical distribution of non-GP specialist medical training

6.1 Valuing the rural training experience

Colleges must have the engagement of their membership to function effectively. For the delivery of specialty training, Colleges must have Fellows involved in developing curriculum, education and training programs, supervision, assessment, education and training governance and many other College activities.

Fellows are elected to College committees such as education, training, curriculum and boards, and most committees of Colleges have no formalised rural representation. A significant portion of College engagement and decision-making is by metropolitan experienced Fellows. This implicitly favours the metropolitan perspective limiting the consideration of the broader health care context.

Not only do Colleges need to include rural specialists to provide rural context for specialties and training, there is a clear role for rural medical leaders and champions, who work and train in rural areas and understand the rural context to drive change and put themselves forward to participate in College governance committees.

Training pathways are heavily skewed for metropolitan training making it difficult for rural health services to meet accreditation requirements and deliver comparable training experiences.

Currently, accreditation frameworks and some specialty training pathways are functioning in the absence of consideration of the rural health context. There needs to be recognition and genuine valuing of rural education, training and regionally based specialty training to enable and support the expansion of accredited training in rural areas to meet the needs of rural communities. Consistently, stakeholders indicated that rural training experiences were overlooked or not given the same or similar weighting as metropolitan experiences, whether by Colleges, specialists, or trainees.

Feedback indicated that there should not be separate accreditation standards for rural health services nor the lowering of accreditation standards to accommodate rural training. Rather, accreditation standards should be considered in terms of training and graduate outcomes. When Colleges undertake an accreditation assessment of a rural health service, there should be consideration of the broader local context, service delivery, educational value and overall training experience, ensuring that training is well supported, not compromised, and that trainees have a good quality and broad training experience.

The strength of most rural areas is the varied casemix (although often not in the numbers needed), multidisciplinary teams and a low resource environment to practice medicine. The other strength of rural is exposure to other parts of health care that is not always available in a metropolitan tertiary health service such as Aboriginal and Torres Strait Islander health services. Trainees have the opportunity to learn more about Aboriginal and Torres Strait Islander health in many rural areas and exposure to non-government and not-for-profit organisations that provide medical services to rural communities. Rural health services have strong connections with these organisations to enable trainees to access to a broader range of training experiences, including outreach models of care.

One rural health service indicated it had become reliant on a significant portion of overseas trained medical workforce with 3.0 of 4.8 FTE O&G specialists being SIMGs. The health service was unable to attain the desired accreditation level for O&G trainees, and although the main criteria the health service could not meet was sufficient levels of major surgery, there was also the issue of insufficient supervision. In this case, the health service felt that the value of the rural, remote and Indigenous training experience was overlooked and not recognised, even though the health service could provide a broad range of training, including in Aboriginal and Torres Strait Islander health.

Following this outcome, the health service created additional positions for two SIMGs who were assessed by RANZCOG as substantially comparable to an Australian trained O&G specialist. One SIMG with laparoscopic experience dramatically increased major surgeries and as a result, the health service was in a position two years later, with appropriate supervision levels, to have training posts accredited and trainees added to the workforce.

Rural health services may not have the quantity, complexity or in some cases acuity, that larger metropolitan health services have, but from an educational perspective, often the experience of specialists outweighs this, particularly in some of the general specialties. The scope of practice of a general physician in a metropolitan setting is different from that of a general physician in rural area, which is more often an expanded scope of practice.

In 2010, the World Health Organization (WHO) released global policy recommendations on 'Increasing access to health workers in remote and rural areas through improved retention' providing a number of recommendations related to education. One recommendation identified that to overcome the shortage of rural practitioners, a revision of 'postgraduate curricula to include rural health topics so as to enhance the competencies of health professionals working in rural areas, and thereby increase their job satisfaction and retention'.[36]

The updated *WHO guideline on health workforce development, attraction, recruitment, and retention in rural and remote areas* further identifies the importance of social accountability of health education providers to have an obligation to align education and training with the needs of communities to ensure the development of a 'fit-for-purpose' health and medical workforce.[37]

Colleges have for some time incorporated accredited rural rotations as part of specialty training programs. When this is optional or an elective for trainees, it was reported that often trainees will still preference rotations in metropolitan health services. In some instances, Colleges have awarded Recognition of Prior Learning for rural exposure meaning that some trainees will never access rural rotations. There is greater inclusion of rural training posts in network training arrangements, particularly where rural posts may not be able to provide a full range of training experiences, however, often these rotations are accredited for short terms.

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36 World Health Organization, 'Increasing access to health works in remote and rural areas through improved retention' (2010), page 21

37 WHO 'Guideline on health workforce development, attraction, recruitment and retention in rural and remote areas' (2021), page 24, https://www.who.int/publications/i/item/9789240024229

Some Colleges are making further progress towards rural health equity through strategic plans, policy positions, statements and roadmaps that have a strong focus on promoting, valuing and advocating for the rural health sector. This has included the establishment of rural sections, branches and committees as well as implementing elements in College activities such as rural selection, rural education and training, mentor programs, support and retention strategies. Details of these are in Table 1.

ACEM considers community need under its accreditation framework with a strong advocacy focus for community with smaller EDs and rural EDs having allowances and modifications to some of the accreditation requirements to enable them to qualify as a training site. The College has been undertaking an extensive review of the curriculum, specialty training program and Training Program Accredited Site Classification System. The ACEM Workforce Planning Committee is currently exploring the integration of rural training in the specialty training program.

The Rural & Regional Emergency Medicine Practice program is still in development; however, the curriculum makes a significant step towards considering context for training and supporting longterm workforce distribution in rural and regional areas. The program anticipates inclusion of training experiences in three different clinical situations associated with rural and regional health services, as well as the proposed methods of training delivery. There is no link to formalised rotations in rural areas to gain this experience, however, there is an elective ED term of six months that can be undertaken in a rural or regional health service. The program identifies learning outcomes for emergency medicine in the context of rural and regional areas across the CanMEDS domains adopted by the College for the curriculum framework of the emergency medicine specialty training program.

In addition, changes to the ACEM accreditation framework to a three-tiered system focusses on the supervision and casemix requirements to determine the maximum length of time a trainee can spend at a site and site accreditation limits. Whilst minimum supervision requirements are specified, the assessment of 'safe and effective clinical supervision' will continue to be at the discretion of the accreditation team. Additional information is considered in the assessment of appropriate supervision for specialty training including model of care, ED layout and site-specific circumstances. This provides an increase in accredited terms for rural health services who continue to meet accreditation standards and criteria. The change will see Tier 3 (predominantly rural sites) currently accredited rural sites increase from a six-month accreditation to a 12-month accreditation, meaning trainees can spend up to 12 months at a Tier 3 site assisting sites to remove recruitment barriers and improve retention in rural areas.

The AMC is committed to improving health outcomes for Indigenous people across Australia and New Zealand. One way the AMC addressed this was by embedding Indigenous health in the AMC Standards for education providers to implement from 2016. For example, 'The community responsibilities embedded in the purpose of the education provider should address the health care needs of the communities it serves and reducing health disparities in the community, most particularly, improving health outcomes for Aboriginal and Torres Strait Islander peoples of Australia and/ or Maori of New Zealand through improving the education of practitioners in Indigenous Health.'[38]

The AMC also embedded Indigenous health in accreditation standards for medical schools as part of a 'high level and targeted policy that supports the implementation of globally relevant and place-based activity to develop the next generation of the health and medical workforce'. Ewen et al. (2017) found that 'Where an

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38 https://www.amc.org.au/wp-content/uploads/accreditation_recognition/specialist_edu_and_training/assessment/standards_for_assessment.pdf, Standard 2, page 6.

accreditation body includes specific standards related to Indigenous health, there is an increased number of references to specific actions taken regarding Indigenous health in medical programs'.[39]

Similarly, Colleges responded to the new AMC accreditation standards in several ways, one being the development and implementation of Indigenous Health training in specialty training and professional development programs.

Inclusion of elements of rural, regional, and remote practice in the AMC accreditation standards for specialty training programs may further encourage the consideration of context, the valuing of the rural training experience, promote a positive rural medical education culture, and the development of more training pathways in rural areas.

Recommendations:

No.	Valuing and promoting the rural training experience
20.	Development and integration of specialty-specific rural curricula in College education and training programs.
21.	Recognise the different strengths of specialist medical training in a variety of settings in specialty training programs and accreditation criteria and practices.
22.	Increased collaboration between Colleges, jurisdictions and local health areas (incl. rural health service boards and executive teams) to target and support more training in rural areas.

6.2 Rural medical leadership

The success of training expansion in rural areas can be highly variable and dependent on rural medical leaders or champions; those specialists with enthusiasm, expertise, reputation, influence, and a willingness to impart knowledge and support the next generation of rural doctors.

On many occasions, successful rural training always starts with one person taking the lead on what can be a very lengthy and onerous journey of networking and negotiation. Often the success of a rural training post or health service to support the delivery relies heavily on the advocacy of clinical and medical leaders. This includes executive level involvement, the ability to develop a business case that meets all relevant criteria for the health service from a fiscal and medical workforce perspective, not only accreditation. In some cases, it may take years to negotiate the establishment of new training posts and networked training pathways. Advocacy and strategic support from health service boards is critical for specialty training programs to be supported within organisations and for sustained rural health service endeavour.

Medical leaders consulted during this project were all passionate about their specialities and their regions, sharing knowledge and building capacity in their workforce and regions to provide services to the communities they serve. They are outward looking, dynamic medical leaders with a focus on teamwork, stakeholder engagement and bringing people along on the training journey.

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39 Ewen S, Mazel O, Barrett J, , et al. 2016, 'Reforming Indigenous health in medical education: Medical school accreditation as a targeted policy initiative', *MedEdPublish*, 5, [2], 55, https://doi.org/10.15694/mep.2016.000083

SA has a successful rural paediatric training model led by a paediatrician who networks with and relies on resources from metropolitan health services and vice versa to support the fragile rural training arrangements. The importance of strong leadership and clinical leadership cannot be overlooked to help establish positions for the long term and develop solutions to assist with difficult issues and the easier components of training. Rural training places are much more vulnerable unless there is a 'circle of security' and appropriate scaffolding to support and ensure sustainability long term.

In Victoria, the development of a Rural Paediatric Training Network was led by a paediatrician with support from paediatricians from across the jurisdiction, state government and various College committees.

For Queensland Health, the medical administrators make a big difference to the medical workforce activity and development. The medical administrators are in leadership roles with medical workforce oversight and visibility. There are monthly meetings of the EDMS and 'there are passionate, driven rural and regional medical administrators who not only drive a medical workforce activity, but they also advocate about the medical workforce issues and potential solutions in rural Queensland' (Queensland Health).

Throughout consultation, Colleges, jurisdictions, and health services showcased many more examples of the work of rural clinical champions in surgery, neurology, paediatrics, anaesthesia, general medicine, obstetrics and gynaecology, intensive care, medical administration, emergency medicine, cardiology and ophthalmology.

Recommendation:

No.	Clinical Leadership
23.	Support access to professional development programs for rural clinicians to become specialty supervisors or enhance supervision and develop and enhance leadership skills.

6.3 Networks

Network training arrangements are not new and many metropolitan health services work together to support accredited specialty training rotations. Over time, with the gradual expansion of training into rural areas, networks have been developed to expressly include rural sites, either for short term rotations of three to six months, or more recently longer-term rotations. Depending on the specialty and accreditation, some training can be fully completed in rural areas across a network of rural training sites.

The recognition by some Colleges that not all health services need to provide the full depth and breadth of training is positive and has led to more network training arrangements to ensure that trainees have access to everything they need to complete specialty training across a network of health services. This is also reflected to some degree in accreditation standards with some specialties providing some flexibility to accredit rural health services that may not meet all accreditation requirements as a stand-alone training site but could participate in an accredited training network to provide a component of accredited training. These network arrangements can also support more access to training experiences in remote and Aboriginal and Torres Strait Islander health settings.

Not all specialties have formalised training rotations or networks, some leave the training journey up to trainees to determine with specialist jurisdictional committees, members and informal networks. In addition,

it must be acknowledged that for some specialties, there is no centralisation of rotation allocation and recruitment of trainees must be done locally by health services.

There is difficulty in mapping longitudinal training and learning outcomes as most current College accreditation frameworks reinforce the silo effect by considering only training posts and breaking accreditation down into training posts rather than a program of training across several posts.

Where network training models and collaboration are informal rather than formal there is a missed opportunity to strengthen and support rural workforce and training models. Increasing focus on regionalisation and supporting networks under accreditation is positive progress. Network training and accreditation models give smaller sites the opportunity to be involved in specialty training which is particularly important for building capacity and capability in rural health services.

On the other hand, there were some identified downsides to network training arrangements.

When a network training arrangement is centralised in a metropolitan health service or coordinated by metropolitan health services, sometimes rural health services have no ability to choose which trainees are sent to them. In some cases, trainees were not sent to rural training posts at all because there was a shortage of trainees. This resulted in posts in metropolitan areas being filled first, and in other cases, health services reported that occasionally trainees were withdrawn mid-term from rural health services to fill positions in metropolitan health services.

Cross-jurisdictional networks can also be problematic with pay levels and continuity of entitlements as well as being engineered for trainees to have to return to their original jurisdiction to complete training requirements, for example, with a Victorian-Tasmanian training network with coordination based in Victoria. The matter of continuity of pay and entitlements was also a prominent issue for national network training programs or arrangements.

Apart from national training programs, in cross-jurisdictional networks, usually the larger jurisdictions coordinate the allocation of trainees. There is little ability for the receiving jurisdictions or health services to have input into allocations based on trainee competence and service need. In some cases, rural health services receive trainees with low level competence that require high levels of support, something which can be a challenge to provide in rural areas. This can result in lower levels of rural health service engagement in training if they are unable to provide high levels of supervisor support. In addition, this also limits the ability of the receiving jurisdiction or health service to effectively plan and build the workforce it needs.

Royal Darwin Hospital belongs to many interstate training networks. There is concern by the health service that rotations to Darwin are not prioritised and the level of influence or 'power base' within a network to ensure the continuity of rotations and trainee workforce to rural areas.

Another challenge for the expansion of training in rural areas, is understanding and working within a consortium of stakeholders collaboratively and cohesively between health services, Colleges and the education entities or committees involved to enable and deliver training. Significant effort and time is required to influence and build relationships to enable effective training networks across health services, and often these begin as informal medical professional connections. Also having the right people engaged and timing accreditation to establish a network is critical for success.

Rural health services in network arrangements with metropolitan health services not only rely on metropolitan health services for trainee rotations, but there is also a reliance for supervisor support, training support including tutorials and educational activities, exam practice and the provision of support

for backfilling leave arrangements. Although there were many examples of strong links and support from metropolitan health services, stakeholders advised that this was not always the case.

One example demonstrating the high dependence of rural health services on links to metropolitan training programs was where a metropolitan children's hospital held education sessions via video conference across the state. When the hospital stopped the education sessions, this impacted all the rural sites that otherwise did not have the resources to be able to provide quarantined teaching experiences and extended learning opportunities for trainees.

> The accredited dermatology networked training arrangements (faculties) across multiple large public metropolitan sites, private practice and rural sites is the preferred model of training for dermatology trainees. These networks are constructed so that trainees receive a well-rounded training experience with varied supervision across sites with broader case exposure in public hospital and simpler cases in private practice. Further details can be found in the Appendices – Appendix A.

Advanced physician training accreditation has flexibility to enable informal health service networks to function, for example, where a health service has a relationship with other health services to enable trainees to go and work at other health services during a rotation, which is also enabled by flexible training program requirements. The RACP advised that if health services are accredited, most of the networks in advanced training are usually job-based networks and not as focussed on formal training networks.

NSW Health advocates that overcoming challenges in accreditation for rural health services will be supported through the accreditation of networks rather than single health services. Trainees should be part of a network and rotate around the network to ensure that trainees access all the experiences that they require and that they can get the best of what every site can offer.

If more rural training posts need to be accredited, rural health services must be prepared to invest in training by setting up networks and having networks appropriately resourced in terms of coordination and administration. It takes substantial investment from the health system and will only occur over a long period of time. There also needs to be planning of trainee pathways within networks as trainees will not be able to access all the required training in one rural site. This will require rotations to other sites, including metropolitan sites to meet all training requirements. It was identified that rural trainees often fear they can't navigate tertiary metropolitan health service requirements. Coordination is critical to supporting network training arrangements, providing clarity on learning pathways and assisting trainees to navigate the training system. Networks also need to be big enough to give trainees the training experiences they require throughout a network.

In the Basic Physician Training network there are Network Directors who are generally based in larger metropolitan health services with oversight across all health services in their network. In such a network model, rural health services are also supported.

RANZCR has a networked approach to training which includes rural sites where possible. The current review of the accreditation framework has a significant focus on network training arrangements and will ensure that the governance structures of the networks reflect the needs of a networked training model. The principles underpinning accreditation remain the same, evidence requirements to demonstrate compliance with accreditation standards will have greater clarity. In addition, with a new curriculum and training programs, the accreditation standards will reflect the changes in both.

There will be a greater focus on engagement, collaboration, and communication in accreditation, particularly in working with a volunteer specialist workforce. The College will assist and support sites further as part of the accreditation process, including providing direct support to Directors of Training with respect to how to respond to and provide evidence against accreditation criteria. Further details on RANZCR accreditation can be found in the Appendices – Appendix K.

In psychiatry, all training is via network training arrangements called programs which include rural and private sector training posts. Further details can be found in the Appendices – Appendix J.

For emergency medicine accreditation, smaller rural health services can 'link' with an accredited host training site to meet accreditation requirements that they otherwise would not meet as a stand-alone facility. The host training site provides support for education, training, and other resources. Linked sites are only accredited for limited periods of time, usually six months of specialty emergency medicine training. Under this classification, although the training site still needs to have a level of minimum supervision, there are lower supervision requirements to meet under the standards. Further details on ACEM accreditation can be found in the Appendices – Appendix B.

The anaesthesia program in Tasmania has been very successful establishing and increasing training posts by building a network training arrangement.

Additional examples of successful training networks can be found in 6.3.1 Case studies of accredited network arrangements to support rural training.

Recommendations:

No.	Networks
24.	Accreditation systems to facilitate and support accreditation of network training models, at local and rotational level.
25.	Network principles must ensure that all network participants are equal partners. Networks to consider 'home health service' concept, whereby trainees nominate the home health service to spend most of their training time and may be employed by the home health service to enable continuity of entitlements.
26.	Establish accredited, independent, state and territory training pathways and networks (where possible) to improve workforce planning, coordination and allocation of trainees for training rotations.
27.	Metropolitan and larger regional health services to have a leadership role in providing support to rural, regional and remote health services as part of network arrangements.
28.	Coordinated network training models – each network requires a coordinator per jurisdiction or per network, per discipline. This includes resourcing and administrative support.

6.3.1 Case studies of accredited network arrangements that support rural training

ANZCA Queensland Anaesthetic Rotational Training Scheme (QARTS)

The Queensland Anaesthetic Rotational Training Scheme (QARTS) oversees the four ANZCA accredited anaesthesia rotations in Queensland.

QARTS is a sponsored body providing advice to employing organisations and administers the selection and placement of trainees in anaesthesia throughout Queensland in conjunction with Queensland Health and the Directors of Anaesthesia Group in accredited training hospitals. QARTS reports to the Directors of Anaesthesia Group who represent the employing jurisdiction and is supported by Queensland Health.

QARTS is coordinated by a coordinating committee comprised of the QARTS Rotational Coordinator, Rotational Supervisors (ROT), Interview Coordinator, ANZCA QRC Representative, DoA Group Representative and the ANZCA QLD Education Officer. A Queensland Health representative is also invited to join this committee. The committee has oversight of accredited training positions during introductory, basic, and advanced training.[40]

The Northern Rotation in Northern Queensland is an entirely regional training pathway with all hospitals located in MM2.

Northern Rotation

Core - Townsville University Hospital
Metropolitan - Cairns and Royal Darwin Hospitals
Regional - Mackay Hospital

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40 Queensland Health, Queensland Anaesthetic Rotational Training Scheme (QARTS), https://www.health.qld.gov.au/employment/work-for-us/clinical/medical/recruitment/training/qarts

Current Network Arrangements Supporting Rural Training

RACS General Surgery – South West Regional Hub, Victorian Surgical Program

Developed over three years by the Victorian-Tasmanian Training Committee, the South West Regional Hub comprises 14 training posts across six regional health services supplemented by rotations to metropolitan health services for subspecialty training, e.g. Trauma, Neurosurgery.

The primary site is Barwon Health Geelong (MM1) that employs and takes on the administration of trainees, with rotations to Ballarat Health Service, Epworth Geelong, Colac Area Health, South West Healthcare – Warrnambool and Hamilton Base Hospital. There are opportunities for Surgical Education and Training (SET) 4 and 5 trainees to rotate to metropolitan health services for additional training, such as Alfred Health for trauma. In the last two years of the program, it has become easier to swap the rural trainees with metropolitan trainees who wish to go to rural health services to access 'primary operator' experience for logbooks that they are not always accessing in metropolitan sites. All trainees that rotate through the South West Regional Hub are selected by the Board in General Surgery and trained under the SET Program in General Surgery Regulations. The South West Regional Hub operates under the auspices of the Victorian-Tasmanian Training Committee, which reports to the Board in General Surgery.

Currently in its eighth year of operation, the first of the trainees to complete the program was employed in December 2019 as a consultant at Ballarat Health Service. Exam pass rates are high, and the program has become so popular it is annually oversubscribed. There are six monthly meetings of all training supervisors in the program to discuss trainees and training progress.

There were no new posts established to develop the program, General Surgery posts were moved from other health services. St Vincent's Hospital Melbourne and other Melbourne metropolitan sites agreed to relinquish posts to the rural l health services with negotiation to do this taking three years. RACS and General Surgeons Australia (GSA) are fully supportive of the model and would like to establish more rural and regional networks with surgical Specialty Training Boards. A network model in North/North East Victoria is to be developed where there is a shortage of training posts.

RANZCP – Psychiatry at Whyalla Hospital and Health Service

A psychiatry training post was approved to commence in 2020 at Whyalla Hospital and Health Service as part of a network training arrangement. The trainee will start in Adelaide for the first three months of training then rotate to Whyalla. The benefits of being part of this network arrangement is that the metropolitan tertiary health service will conduct centralised recruitment and send the trainee to Whyalla. From experience, if Whyalla Hospital and Health Service conduct recruitment they have difficulty attracting applicants. Centralised recruitment ensures all applicants are aware they have a guaranteed connection with metropolitan sites.

RACP Queensland Rural Training Networks

The Queensland Paediatric Training Network has three different training pathways with three-year training contracts. It includes the Queensland Children's Hospital (QCH) a metropolitan pathway with trainees rotating to rural health services such as Bundaberg and Rockhampton. Another pathway has the Gold Coast University Hospital as the central site, and the other pathway has trainees commence at Townsville Hospital and Health Service. Although there is a compulsory rotation into QCH, trainees can be based for two years in Townsville then they go to Brisbane to finish off their training. This pathway also allows trainees to commence in QCH and rotate to Townsville for two years and finish training in Townsville. The Townsville network includes a rotation to Royal Darwin Hospital for one year as an option. Trainees can rotate for six to 12 months to linked sites, such as outer-metro, rural, regional and may include private health services. Trainee recruitment is centralised through the Children's Paediatric Network and all placements are guaranteed. There is investigation into accreditation of other sites to include in these rotations within North Queensland.

Mount Isa Hospital has been supported to enable STP trainees to rotate there from Townsville and other locations for their training. They were awarded accreditation for a rotational term of six months, with the focus of training on Aboriginal and Torres Strait Islander health.

RACP Victoria Rural Training Networks

One health service in Victoria identified that for the health service to be successful in rural training they needed to start with one of the Advanced Physician Training programs and work as a network. They successfully accredited an advanced trainee in general medicine in partnership with another site so that the trainee could complete dual specialty training in respiratory and general medicine. The health service has developed a further two positions using this model, one in medical oncology and one in geriatric medicine. These trainees are based in rural and going into metropolitan sites for whatever training is required, in a flipped model of training.

ACEM – ACT / NSW Emergency Medicine Network Training

There is a strong emphasis on growing the workforce locally in the ACT, providing high quality, well supported training experiences for trainees throughout their training until they become specialists. Sometimes the ACT health services work with local NSW health services to create a 0.5 FTE specialist position in one health service and another fractional appointment in another health service to build up the local workforce and create accredited training opportunities. For example, there are a few FACEMs in the region, including Batemans Bay, Bega and Queanbeyan. All were local trainees who have come through the Southern NSW training pathways and are now FACEM's. This has only occurred in the last five years by reaching out into the local area to actively build small networks to achieve critical mass for establishment of accredited training posts.

A clinical champion needs to initiate the process with the support of a health service and a region to build workforce sustainability. There needs to be the integration of networks so that the workforce feels supported in rural areas, not just trainees.

The EMET Program has supported doctors to build their own rural, regional and remote professional networks to increase emergency medicine education and professional development and networking in those locations. Through these networks there is a greater awareness of service delivery in the region and medical workforce contacts when a situation arises, or assistance is required. The ACEM ACT Faculty invite Southern NSW faculty members from Wagga, Goulbourn, Batemans Bay and Queanbeyan to faculty meetings provided an opportunity to build non-training professional networks to help build and support training networks over time.

Networks in Development or Proposed

RACP – Victorian Basic Paediatric Training Consortium

The VIC Department of Health established the Victorian Basic Paediatric Training Consortium (VBPTC) in January 2021 to enable a state-wide networked training model for Victoria.

VBPTC includes the establishment of a rural training stream. This will allow the majority of basic paediatric training to be completed in rural and regional health services state-wide supervised by rural paediatricians with rotations to metropolitan tertiary sites to meet additional training requirements. This will enable employment in a rural or regional area for a minimum of 18 months of the three years of training. The pilot of the rural training stream was due to commence in 2022. The RACP is committed to the pathway and is regularly consulting with the VIC Department of Health on implementation to ensure the support and success of the program. The RACP will ensure the accreditation committees enable the accreditation of the rural training stream that recognises the majority of training rurally and still ensures trainee access to paediatric tertiary sites.

RANZCO – Rurally Enhanced Training Networks

RANZCO is developing Rurally Enhanced Training Networks to support the expansion of rural ophthalmology training. The network will enable seventy-five per cent of training in Years 1–4 to be supported in rural health services to aid the retention of specialists in rural areas. Sites include Broome, Bunbury, Tamworth, North West Tasmania (Burnie), Dubbo and Darwin (Top End Health Service). Rollout was to commence 2020 with Goulburn Valley Health in Shepparton and other training posts will join the network at a later date.

6.4 Private rural health service context

Although there are rural, private health services that are near or co-located with public health services, they are not always involved in specialty training. Some network arrangements do include rural private sites such as the Western Victoria Surgical Program and other surgical networks, anaesthetic rotational programs, dermatology and radiology (as examples) often include the private sector to not only provide a broader casemix but sometimes to support caseload numbers required for training.

There are many factors that impact on public and private sector engagement in specialty training, however, there is an opportunity to capitalise on geographical proximity and the sharing of the specialist workforce in supporting the expansion of rural training.

One private rural health service lost accreditation for surgical training as surgical trainees could not be provided with primary operator experience required for surgical training. The unaccredited position was then filled by service registrars. During the time the position was accredited, it was funded through the STP and trainees performed ward duties at the private health service then primary operator experience at the co-located public health service. Many surgical admissions were through the public emergency department (if admitted as private patient then the consultant would need to attend calls in evenings if needed). The public health service is able to provide trainees with support and coverage for on-call rosters, something that the private health service does not have.

Where public and private health services are co-located in rural areas, there is an opportunity to consider 'campus' accreditation models. Perhaps the biggest challenge for this proposal is developing working practices between public and private that are mutually synergistic. Trainees need to be doing some primary operator surgical training however, there could be a shared role in public, acute in both and assisting in private. Consultants often work both in private and public, and in one example, there is the opportunity to investigate campus accreditation models for palliative care, radiation oncology, cardiology, and renal medicine.

In clinical radiology, the private sector has been servicing many regional communities. However, private entities are not necessarily structured nor financially able to support training. Training is seen as a 'public good' proposition, so it has been important for RANZCR to provide as much support as possible to ensure the success of any private rurally based training post.

Most of the new accreditation applications for anaesthesia specialty training are often 'satellite' sites, for example, a private health service in a regional centre as a satellite off the parent regional centre. The purpose of satellite arrangements is to provide additional subspecialty training in clinical work that is not available at a regional, public health service. It also enhances the quality of training as in most of the regional centres as it is usually the same anaesthetists and the same surgeons that work publicly and privately so there is consistency of supervision. An example of where this occurs well is in Townsville where the health service has a long-established relationship with the Mater Private in Townsville and the anaesthesia trainees rotate to the Mater Private for three months. There is excellent quality and quantity of experience at the private health service and both organisations support the training arrangement.

6.5 Collaboration

Many times over, feedback indicated that collaboration across the health sector between specialty groups, broader medical workforce, local health regions, metropolitan health services, jurisdictions and Colleges is key to supporting the expansion of training beyond traditional metropolitan health services.

College accreditation committees consist of specialists who understand the health service environment and often have a professional relationship with Fellows from sites being accredited through other College committees and other professional interactions. At this level, even with the policies of accreditation and those to manage independence of assessment, any issues can usually be discussed and resolved more easily. For example, in the case of establishing new training posts, the Director of Training (or similar role) for a specialty can contact another Fellow in the network or jurisdiction to discuss the role and seek support for the position before it reaches the College to ensure all accreditation standards and criteria are met. This increases the likelihood of a successfully accredited and supported training post. These are often informal networks of specialists who are champions of training.

> In one example of a national training program with small numbers of Fellows, most, if not all, know each other. The membership is such a strong collegial network that when conducting site visits, they are particularly mindful of managing conflict of interest but also holding each other to account for providing the best possible quality training experience and support for trainees. So much so, that the specialty felt that its size is a strength and benefit in ensuring the high levels of quality training.

Stakeholders advised there have been situations where supervisors leave a health service, reducing the critical mass of supervisors to support training and risking the health service's accreditation status. Some Colleges reported providing additional support to health services when this occurs, however, that was not always the case which resulted in broader workforce and service delivery issues.

It is particularly important in areas of medical workforce shortage that there is greater support and collaboration with Colleges, health services and jurisdictions to enable temporary locum or other supervision arrangements while recruitment is conducted to potentially maintain the level of accreditation and trainee workforce.

Jurisdictions advised that specialist medical workforce and training targets should be set at a jurisdictional level with a greater collaborative focus with health services and specialties to determine targets, accreditation and the resourcing of the administration of accreditation.

> QLD Health and NSW Health hold regular meetings with College regional committees. These meetings are aimed at increasing collaboration with Colleges and improving not only transparency of specialty training, accreditation and any training issues, but for jurisdictions to provide support to the specialty groups.

6.6 College support

Support provided by Colleges to rural trainees, supervisors and health services is vital.

For accredited network training arrangements, RANZCR has embedded in conditions of accreditation that all participating training sites sign agreements with each other as part of the network. These 'Memorandum of Understanding' agreements clearly articulate expectations from each training site, linked site and main site in relation to training and trainee responsibilities, including trainee entitlements and can include travel and accommodation.

> One of the objectives of RANZCR is to be more inclusive, collaborative, and consultative of the hierarchy of health services and jurisdictions. For example, the College has worked to build relationships with rural health services to support training. When assessing an application submitted for accreditation and conducting a site visit, the College speaks with the specialists who have submitted the application on what being a training site involves, including support and resources required for trainees and supervisors. Often when a post is being established for the first time, health services require additional support from the College to understand their role and responsibilities in specialty training to ensure that appropriate supervision, teaching and training structure and support exist to be able to provide a quality training experience across the breadth and depth of the training program.
>
> The College also goes through accreditation standards and requirements with the health services. Although they are clearly defined, the College has found that the dedicated time and engagement in training results in a virtuous cycle, with a good experience for the trainee from day one. Many rural sites are private providers, and this is particularly important for a new regional site. The aim is that the first trainee who rotates to a new site enjoys their time there and provides positive feedback so that the next trainee wants to go there.

The RCPA has increased stakeholder engagement and collaboration with health services and jurisdictions to support a continuous quality improvement model and early notification of any issues that may impact training and accreditation. The College has an annual accreditation audit to capture any changes in supervision, trainees, caseload and casemix and College staff members visit all sites on an annual basis as part of College engagement to provide direct support to trainees and supervisors. Often there are informal visits to sites by the College which has been found to improve support of training and early notification of issues.

> RACMA provides support to health services via the JCT whose primary role is to support and coordinate training as well as participate on accreditation panels. JCTs provide direct support to trainees within their jurisdiction by monitoring progress and access to training experiences, organising, and supporting training rotations, supporting health services in meeting any accreditation recommendations and reporting any emerging accreditation issues to the College accreditation committee.

Other Colleges advised that there has been a significant shift in recent years to increased collaborative support with health services in relation to accreditation and training rather than the traditional 'regulator' approach. This has seen improvements in engagement of supervisors and trainees and quality of training.

Recommendations:

No.	College Support
30.	Increased collaboration between jurisdictions, Colleges and health services to improve medical workforce planning alignment with accreditation and specialty training outcomes.
31.	Increased stakeholder engagement and collaboration between Colleges, health services and jurisdictions to support a continuous quality improvement accreditation model and early notification of any issues that impact accreditation.

6.7 Increasing high quality rural specialty medical training

There is a need for all Australians to be able to access a full range of health services. A sustainable specialist medical workforce to support access to health care is imperative for equitable access to health care for all Australians.

To support increasing training in rural areas, within the existing College accreditation systems and enable accredited training there needs to be a workforce to support trainees. There needs to be a concentrated effort by health services to plan, build and support that workforce to ensure a high-quality training environment for trainees. Understanding different service models for service delivery and to build the local workforce is important. Understanding who the health service is training, the aims of training and what the health service is trying to achieve are also critical in determining what workforce will best fill service need and which specialties are the focus of accredited training.

Once specialists are trained as supervisors and supported to engage in training, there are trainees embedded in the workforce and capacity has grown to develop business cases, health services can put forward recommendations for more accredited positions. It is important to note that there may never be a sustainable workforce in a particular speciality if the population is not big enough, or there is limited service need with little or no service delivery.

To sustain service delivery, a health service needs a well-supported and quality trained future medical workforce. Health services need a cultural shift to improve medical training with executive engagement. Training and supervision must also be viewed as core business with a culture of allocated time for supervisors and trainees to do training. There should not be competition between service delivery and supervision and training. Health services need to be able to manage this conflict and ensure both are equally important. Supervisors should not have to choose between time spent on service delivery and time spent on supervising and training trainees, with greater integration of Senior Medical Officers supporting supervision and training.

Improving focus and resources to support training at a state and territory level was identified as important for medical workforce planning. There is a need for better systemic structures that allow specialty training to be constantly on the radar of jurisdictions and across health services to build training capacity.

To drive quality improvements in accreditation, there needs to be consideration of training programs, the delivery and evaluation of training and the whole training framework. A health service must have the appropriate mechanisms to reach trainees who are feeling unsupported, deliver curriculum in a way that's easily accessible and provide the opportunities for trainees to network amongst peers, and more broadly, the health workforce. A critical component is ensuring that specialists implementing training are appropriate educators and having a workforce with the right skill set necessary to attract and retain doctors into rural training.

Many rural hospitals in SA have used a fully GP based service model with many now transitioning to a salaried staff model. This is being explored further under *South Australia's Rural Medical Workforce Plan 2019-2024*[41]. The aim is a rural generalist and specialist model to build training capacity in rural areas. LHNs will need to engage in workforce planning to deliver more high-quality regional training including identifying rural health services that have the capacity to support training with a base of a core number of specialists (such as general medicine physicians, general surgeons, anaesthetists) and ensure there are GPs with advanced skills to support the service. There will be a review in SA of service provision and the ability of the Activity Based Funding model to employ specialists to provide services. Training positions will be LHN decisions based on the service delivery model and availability of specialist supervisors and must be considered in accordance with Enterprise Bargaining Agreement conditions.

> In Victoria, a group of health services are establishing clinical networks across the whole of the Grampians (Western Victoria) region to ensure all the health services that are serving the same community, have seamless transition of care between health services. This will be at the clinical director level and across different clinical specialities, which lends itself to 'whole of region' training experiences.
>
> Ballarat Health Service identified the activities required to start from a position of no specialty training to becoming an accredited training facility. There were two main barriers to getting to a position of being accredited for training, the capacity to have supervisors trained and enough service registrars to be practising supervision and getting trained and accredited as supervisors. The health service has created capacity for additional service registrars to start working with the current consultant / specialist workforce and to attract additional consultants to gain the critical mass of supervisors required. Over time the department will train the consultants to become supervisors and collect data on casemix, volume, etc. required for an accreditation application.

Townsville Hospital and Health Service advised it has capacity to be a resource for outer regions such as Cairns, Mackay, and Mount Isa, and is looking to expand network training. As Townsville has been successful in expanding accredited training positions, and there is a critical mass of supervisors and infrastructure, there are opportunities to leverage to better support training across Far North Queensland in cases of health services not being able to meet accreditation standards on their own. As part of a network, Townsville Hospital and Health Service already facilitates trainees to go to smaller rural sites in Far North Queensland.

Recommendation:

No.	Increasing high quality rural and regional specialty medical training
32.	Support for rural health services to build training capability and capacity including training specialist supervisors, medical education officer and training infrastructure support.

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41 South Australia's Rural Medical Workforce Plan 2019–2024 https://www.sahealth.sa.gov.au/wps/wcm/connect/3bd067a6-7bc3-4eef-b2d2-e5d1305d52d5/SA+Health+Rural+Medical+Workforce+Plan+FIN.pdf

6.8 Barriers to the inclusion of more accredited rural specialty training posts

For some specialties and sub-specialties, accreditation is not an enabler for the expansion of specialty training in rural areas.

Not all rural health services have the full suite or range of services to be able to train. Sometimes service need does not exist, it does not exist in enough volume, infrastructure to provide the service is not available, the specialist workforce is not present, or the broader health workforce required to support the delivery of the service does not exist. This applies to pathology, dermatology, some radiology, neurosurgery and paediatric surgery, to name a few.

There is a risk that requirements for accredited specialty training posts are becoming so demanding in delivering training and what trainees are required to do, that the value of having trainees in rural areas is questionable for some health services. This includes requirements for time away for training, exams, specific rostering requirements and other non-clinical training and the ability of health services to backfill positions and maintain service continuity.

As identified in the NMWS, not all specialties can practise outside of metropolitan centres.[42] If mandatory requirements were introduced to include rural rotations in specialty training programs, some programs would have difficulty in accommodating this partly for the reasons listed above, partly due to insufficient rural sites to accommodate rotations, some rural sites may be unable to meet accreditation requirements, and some programs that do not currently formally support network training arrangements.

In addition to having appropriate infrastructure, there are interdependencies for some specialties. ICU training depends on the Department of Medicine and the Department of Anaesthesia, and to attract trainees to health services, there needs to be assurance that there are other elective terms available in anaesthesia and medicine.

For the RACS, the main reasons for accreditation not being supported more recently were low general anaesthetic surgical lists, unallocated time on the roster was too high, and trainees need protected hours for education, training and research and supervision requirements could not be met, for example, three consultants are required in urology. In some cases, there was a lack of involvement in the after-care of patients related to outpatient clinics, on-call issues and logbook data concerns.

The distinction between public and private is important to note as trainee involvement is generally as an assistant rather than a primary operator in the private sector. In one case, a site had the Head of Department as the Designated Training Supervisor which was not in accordance with standards due to the conflicting demands of the two roles. A Designated Training Supervisor must have protected supervisor time to be able to meet the needs of the trainee and if a specialist is trying to do both and provide a service, there is insufficient time for adequate supervision.

Smaller specialties and surgical specialties like cardiothoracic surgery, paediatric surgery and neurosurgery are unable to expand further into rural areas.

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42 Australian Government, Department of Health, *National Medical Workforce Strategy 2021–2031*

6.9 Accreditation data management

6.9.1 Colleges

All Colleges collect and manage accreditation data in some form. In recent years Colleges have become better informed and have a better quantitative and qualitative mix of information when undertaking accreditation assessments. Accreditation data can provide points for positive engagement and drive focussed discussion during site visits. Data is collected from multiple sources including electronic logbooks, purpose-built software programs for tracking health service casemix and caseload, College surveys of trainees and supervisors that are de-identified and aggregated to contribute to the overall accreditation assessment of a site or post.

There are still many situations of Colleges not having a full picture of their accreditation system. This adds to the administrative burden of accreditation.

Each College has its own method of data management. Accreditation data management varies from a combination of paper-based and basic database records such as 'off-the-shelf' Microsoft Excel databases to bespoke software programs tailored per specialty i.e., RANZCO, CICM and RACP. There is no data sharing between specialties and subspecialties and each specialty collects a common set of information from health settings such as HR policies, training support requirements, professional development, etc.

> The CICM has moved to an online accreditation web-based platform for the College with a program called Kentico. The Hospital Accreditation System (HAS) has become the main communication tool with a dashboard for the Intensive Care Unit Director and facilitates and manages the entire accreditation workflow on the platform. Governance workflow has been built into the HAS so that accreditation reports can be completed online by a lead accreditation assessor, reviewed by other accreditation team members and College staff before being finalised and recommendations submitted to the HAC and Board for endorsement or approval and / or noting.
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> Health services upload caseload and casemix data into the accreditation system on a regular basis from another hospital system. The HAS assisted the College in providing greater transparency with previous accreditation inspection history and other historical data uploaded and retained in the system. The system has been built to be more mobile responsive in terms of accessible anywhere with internet access. As the system is used, continuous improvements will be made over time to drive further efficiencies and be a more effective tool to support training.

RANZCO has recently integrated a system called Zoho, a customised customer relationship management database to capture accreditation information and improve automation and online interactivity. This platform is heavily customised for the needs of RANZCO and features the ability to pre-fill forms for accreditation, map ophthalmology training experiences, level of training, rotation length, FTE supervision, casemix and subspecialty training in the curriculum that can be covered at each accredited training post across Australia and New Zealand. The system also captures information on prior knowledge required or recommended to trainees before they go to that training post. Accreditation data dating back to 2005 has been integrated into the new system to ensure full accreditation history and the integrity of accreditation data reporting. The aim is for the system to also assist in rotation planning for supervisors and trainees to identify particular training posts against training requirements.

ANZCA has a data system that has been developed and implemented for the capture of accreditation data by all users called the ANZCA Training Site Accreditation system. This database holds information from past accreditation inspections and recommendations and any documentation uploaded to support accreditation outcomes including organisational policies and data sets. Users include health services, members of the TAC and College staff. Health services can access, upload and input data required for accreditation as well as completed a self-evaluation assessment of performance against accreditation standards and criteria. The database assists health services to understand their own performance and identify any areas that may require further review or follow up by the accreditation team prior to an accreditation site visit.

The RANZCP collects accreditation data manually and electronically. Some Branch Training Committees undertake the accreditation process via an online platform and conduct the accreditation process electronically, some conduct paper-based accreditation of training posts. Electronically accreditation data of the training posts (not training programs) is captured in the college training management system called InTrain. InTrain records each accredited training post with a unique reference number so training posts can be easily identified. Each training post has a supervisor or supervisors for that post allocated in the system.

The accreditation of training programs is a manual process with records maintained in spreadsheet format that the College is reviewing to improve over the next 12–18 months with the recent changes to the accreditation standards to have better oversight of accreditation assessments.

RACP and RACMA are progressing the development of purpose-built software through an organisation called BPAC. For RACMA, this will integrate accreditation within a training management system which also supports CPD maintenance and tracking for members. For both Colleges, the system will create efficiencies allowing for the management of the accreditation workflow and monitoring in one location with accreditation data online and accessible from anywhere.

Further specific information can be found on Colleges in Appendices A-L.

6.9.2 AMC

The AMC does not collect data on College accreditation of training posts unless a College is undergoing re-accreditation or there are specific reporting requirements that require a College to provide accreditation data.

In May 2017, the AMC made a submission to the National Registration and Accreditation Scheme, the Independent Review of Accreditation Systems[43] on data management and creating efficiencies in the accreditation system. The AMC provided feedback on 'what changes could be made to current accreditation processes (selection, training composition and remuneration of assessment teams) to increase efficiency, consistency and collaboration'.

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43 AMC Submission to the Independent Review of Accreditation Systems within the National Registration and Accreditation Scheme for health professions, May 2017, https://amc.org.au/wp-content/uploads/2018/10/AMC-Submission-to-the-Independent-Review-of-Accreditation-Systems-within-the-National-Registration-and-Accreditation-Scheme-for-health-professions-May-2017.pdf, page 10

The AMC advised that it was planning to 'invest in information technology, replacing the existing bespoke accreditation management system, with an application developed by a vendor specialising in accreditation systems, features of which are new web-based software to streamline tasks for the AMC and education providers through increased document and process automation and workflow management, aiming to create internal and external efficiencies and enhance consistency'.

The AMC engaged an American vendor of accreditation management systems to develop the software and over time, changes have been implemented to develop a system that largely manages AMC accreditation workflows. For example, the AMC can send emails to Colleges with a template to complete and upload back into the system. The system enables engagement with AMC reviewers to review the College process through the online portal.

The Royal College of Physicians and Surgeons of Canada uses the same provider as the AMC and have extended the system to accredit training posts in health services. They have set it up for health services to use the system and set up pages where information about training programs can be stored making it a useful data source for a range of stakeholders and the administration of accreditation.

6.9.3 State and territory accreditation data management

As workforce planners with the Australian Government, state and territory health departments require data in relation to specialty training to enable not only workforce planning but to support health services to deliver quality, safe training and build sustainable future capacity in the medical workforce.

The data required by state and territory medical workforce planners includes how many doctors are progressing through the pipeline in each medical specialty, where they are training, attrition from programs, returning to programs and the length of time a trainee may delay and/or extend training. Jurisdictions reported that it is very difficult to provide effective support or improvement in specialty training without training pipeline information and training outcomes.

QLD Health has developed a website portal called Medi-Nav that currently focusses on medical workforce careers and planning. However, it does not yet capture accreditation data. The intention over time is that the platform collects such information to better inform trainees and potential trainees of training and career options in relation to accredited specialty training.

NSW Health has been collecting accreditation data from health services since the beginning of 2019. Data is collected on training posts, health services and training programs and can identify when accreditation is due to expire, and any conditions or requirements placed on organisations in relation to accreditation. The focus is also on the sharing of accreditation data with Colleges. During this process, NSW Health has also identified that there is room for improvement for health services in accreditation.

South Australia Health has recently developed the Virtual Accreditation Manager System online portal for prevocational accreditation. The system is currently for managing pre-vocational accreditation, however there is the possibility of integrating vocational training accreditation data in future. LHN users will be able to submit accreditation documentation and data online, allow for the entire accreditation workflow to be facilitated online, except for the site visit. The outcome of accreditation decisions will be provided via the system to the LHN and enable granular reporting.

The Tasmanian Department of Health (TDH) collects accreditation data directly from health services rather than Colleges. The responsibility for co-ordinating information on accreditation has changed over time and will move to a more central collection point within the Office of the Chief Medical Officer. The information provided changes regularly and this sometimes means that it loses relevance very quickly. In terms of tracking in the system, the TDH reviews trainee head counts identified through the Medical Education and Training dataset provided by the Colleges, and also as needed, via surveys.

In Victoria, accredited training posts and the number of accredited trainees data predominantly comes from health services. However, the VIC Department of Health does not receive enough timely information on specialty training to understand how to influence and support effective training.

WA is working with Colleges to improve access to data to better inform the process of data management and analysis. Colleges have committed to improving their data and access to information on accredited positions but there is no one source of information for all specialty training posts. In WA the health services are responsible for accreditation processes related to vocational training and maintain individual databases.

Prevocational trainee positions in WA are accredited by the Postgraduate Medical Council of Western Australia (PMCWA) which provide data for accredited postgraduate year (PGY) 1-4 sites. There is a record of interns and pre-vocational Resident Medical Officer (RMO) accredited positions with traffic light codes used for each site and accredited post. This provides details on whether health services and individual units are meeting accreditation standards.

NT Health and ACT Health do not currently collect accreditation data for specialty medical training.

Stakeholders in accreditation need technology driven systems to enable improvements, create clarity on the capability and capacity of the specialty training system, reduce administrative burden and drive efficiencies in accreditation practices such as data management, applications, accreditation workflow management, reporting and monitoring.

Recommendation 19 can positively impact the issues identified in this section and bring together Colleges under one technological solution enabling greater consistency and transparency.

Recommendation 19 – Design and develop a common online accreditation portal to create efficiencies, reduce the administrative accreditation burden and create a synergistic approach to specialty medical training accreditation aiming to provide insight into health care system training capability and capacity for medical workforce planning and distribution.

6.10   Review of accreditation frameworks

Under the AMC Standards, Colleges are required to undertake periodic review of specialty training programs including curriculum and accreditation frameworks. There is variation between Colleges when a review of an accreditation framework may occur. Some undertake reviews every three years, others as required. There are several triggers that may impact on when a review may take place, including:

- regulatory – AMC driven either through changes in the AMC standards and requirements or as a result of an accreditation condition or recommendation by the AMC or as a result of the assessment of the AMC of a College progress report
- curriculum change

- training program change
- health care system and service delivery model changes that impact specialty training
- contemporary changes in specialist service delivery, and
- government programs – such as the STP and any requirements to support specialty training.

The AMC advised that there is a greater focus by Colleges on the governance of accreditation and the application of accreditation standards to a variety of settings. There are some Colleges that have been highly commended by the AMC for their work in this area. For example, ACEM has embedded a degree of flexibility in relation to linked accreditation sites where small health services can be linked to larger sites to increase specialty training capability and capacity, and the development of networks. Networked training is also something that Colleges are embracing.

> ANZCA undertakes a review of the accreditation framework every three years. The main drivers of change in the accreditation framework will be specialty training program changes, curriculum changes, supervision arrangements, and regulatory changes through the AMC or government programs.

An Accreditation Working Group was convened by RANZCOG in 2019 to develop a model of accreditation that supports a quality improvement approach. The working group will also review the existing accreditation, quality assurance and improvement processes to develop efficiencies, increasing transparency and improving the effectiveness of the accreditation processes across the FRANZCOG training programs. Under the review there will be consideration on moving away from four yearly cycles of accreditation with formal visits to more contemporaneous accreditation with a risk based, data-driven accreditation approach and visits as required.

Further details on College review of accreditation can be found in Appendices A-L.

6.11 Evaluating college accreditation systems

Most Colleges undertake continuous improvement measures in relation to the accreditation process and the broader framework, however, many have not evaluated their accreditation performance and systems and are not actively engaging with external stakeholders to participate in such evaluations.

> The RACP is taking a proactive approach to accreditation currently evaluating performance in several different areas that feed into accreditation. The physician training survey includes a number of questions that are targeted to issues on accreditation that would raise concerns. Questions in the survey are linked to the new accreditation standards and grouped in indicators reflecting the new standards to assist the RACP in the transition to the new accreditation standards. The results are analysed and de-identified by the leads of accreditation across all subspecialties. A range of issues have been identified across health services that required action, particularly around workload, patient safety and bullying. Health services are divided into groups in terms of actions and the accreditation leads determine the level and nature of response by the RACP for each group. Two of the groups received letters indicating accreditation concerns requesting a response from the hospital with an action plan for remediation.

RACMA monitors accreditation practices through an online evaluation survey sent to health settings, trainees and supervisors who have been involved in an accreditation site inspection during the previous 12 months. The results of this survey contribute to continuous improvement activities in the accreditation framework.

For ANZCA, audit, evaluation and quality improvement measures have been integrated into the accreditation process and ANZCA takes feedback from sites after visits via an online survey to assess the College on the quality of the process and inspection. The survey includes whether the site received enough information, assistance and support in preparing for the accreditation inspection, communication, etc. There is also an accreditation 'Visitor Survey' that accreditation team members complete to provide feedback to the College on process and possible improvements. The results of these surveys are presented to every Training Accreditation Committee meeting as part of continuous quality improvement.

Although there currently is no evaluation by RACS of the accreditation process and how Specialty Training Boards operationalise the RACS accreditation framework, the College is currently undertaking an accreditation project with the scope including improved collaboration and transparency between the Specialty Training Boards and the College. The aim is for the College to provide more guidance and support to Specialty Training Boards in making decisions on accreditation.

6.11.1   Improvements to accreditation frameworks

Colleges advised that changes in accreditation have evolved over time to meet the changing specialist training environment. Changes have been made to improve support for supervisors, trainees and to promote increased transparency, consistency, expertise and responsiveness in accreditation.

These changes include increased review of accredited sites, accreditation team composition, introduction of trainees and community representatives to accreditation governance and assessment process, updated data collection and integration in accreditation, updated policies, guidelines, standards and criteria.

An increased focus on trainee wellbeing has also seen an introduction of private conversations with trainees as part of the assessment process to capture feedback that trainees may not wish to share with supervisors or employers.

Supervisor training has been introduced by Colleges to improve support of supervisors of specialty training. Many Colleges are also progressing the introduction of formal accreditation assessor training.

Some Colleges have improved accreditation standards to provide better guidance and understanding for health services to support and deliver high quality training with evidence guides to demonstrate compliance with standards.

Survey tools have been employed by Colleges to seek feedback on training experience and supervision on a regular basis. This information also contributes to the review of accreditation of training posts as a well as the overall training program.

Recommendation 19 has the ability to positively impact the issues identified in this section.

Recommendation 19 – Design and develop a common online accreditation portal to create efficiencies, reduce the administrative accreditation burden and create a synergistic approach to specialty medical training accreditation aiming to provide insight into health care system training capability and capacity for medical workforce planning and distribution.

Further details on College improvements in accreditation frameworks can be found in Appendices A-L.

Recommendations:

No.	Improvements to Accreditation Frameworks
33.	Review of AHMAC National Accreditation Framework for Medical Specialty Training 2015. Standardising terminology and having a standard agreement on assessment with overarching standards and criteria may drive further efficiencies. Maintain specialty specific criteria and requirements and share common data.
34.	Improve feedback mechanisms for trainees, supervisors and health services to raise and address issues related to accreditation.
35.	Leverage the AMC Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs for system level reform.
36.	Leverage the National Safety and Quality Health Service Standards, the current health service regulatory framework.

6.12 Lessons from other medical education and training accreditation models to streamline specialty medical training accreditation practices

The project explored with stakeholders if there were other accreditation frameworks that could potentially provide innovative solutions for greater efficiency and effectiveness in College accreditation. Predominantly, the feedback received throughout the consultation indicated that accreditation in all forms has some level of positives and negatives. Rather than adopting methods or elements of other accreditation frameworks, stakeholders provided solutions for consideration in current College accreditation frameworks.

There seemed to be a greater focus for health services and jurisdictions on prevocational training accreditation as this group of medical practitioners are the main workforce of a health service. Greater involvement and engagement of the health service executive in specialty medical training accreditation would enable a greater focus on strategic workforce objectives, including the capacity building and sustainability of the medical workforce as well as the focus on a medical workforce for the service delivery model.

The AMC has a powerful role as the regulator of training and to effect change, the AMC is the ultimate lever to set and reset key policy and structural issues in specialty medical training. There were some views that the AMC should take a stronger role and enforce the implementation of accreditation reform.

There are possible lessons to be learnt from within the health sector and externally in other industries. Health is a complex, multi-layered regulatory system with no common oversight and 'pulling together' to improve efficiency and effectiveness and reduce the regulatory burden on the health system.

6.13 Evaluating and monitoring the performance of specialty medical training posts

Evaluating the performance of specialty medical training posts can often be an early indicator of any issues that may arise that may impact the accreditation of a site. Evaluation can take many forms and be carried out at various intervals by various stakeholders to gain an overall view of the quality of training either across sites, networks, jurisdictions, training cohorts or entire training programs. On occasion, accreditation issues arise that require attention by many stakeholders, the level of attention required is determined by the risk it poses at many different levels.

Colleges seek feedback from trainees and supervisors at regular intervals, such as at the end of rotations, at key milestones during the training program and some conduct annual surveys. Surveys cover a range of topics directly related to training experiences, supervision and support provided during training at various levels, as well as present an opportunity to raise issues. Some Colleges aggregate feedback received, particularly in the case of large health services, and provide this feedback to health services as part of accreditation assessments or if issues are raised, to address and remediate issues with a health service.

Evaluation occurs at local and jurisdictional level and may be specialty specific. For example, in Queensland physician training posts are evaluated for physician training via trainee surveys to seek feedback on training experience. If there are any negative results, the Network Rotation Coordinators or Network Directors of Physician Education may investigate further to remediate any issues, particularly if it is a repetitive complaint.

> One health service advised that they had started evaluating the performance of training posts by piloting a peer review process across departments. For example, a surgical department reviews a medical department against a set of training standards developed by the health service, based loosely around the RACP training standards. These standards have been accepted across the clinical departments in the health service. There is also an exit survey of trainees once they complete a rotation, and some feedback comes from Colleges during the accreditation process. That is of positive value to organisations to improve training, particularly when trainees provide honest and open feedback about a health service to an external entity.

Another health service reviews 'End of Term' supervision exit interview data on how effective a training position was for that term. This also assists the health service to understand if newly established training posts are meeting expectations, standards, training experience, supervision and support requirements including how much training is covered, numbers of patients, caseload, casemix, etc. All the data collected becomes part of the accreditation documentation provided to Colleges.

Some health services conduct quarterly surgery casemix comparison with consultants, trainees and Junior Medical Officers to assess health service training performance and ensure fair and equitable distribution of training experience and exposure. Logbook data to review cases is provided monthly and there are quarterly, mid-term and end of term interviews and assessments between supervisors and trainees to review any problems trainees might be having to rectify issues and provide support as early as possible.

A regional health service advised that evaluation of training posts and training experience depends on the specialty group and what they're doing at College level. This review of training helps with performance and productivity from the perspective of a 360-degree feedback model. This is largely driven by Colleges rather than a health service specific model. The Chief Medical Officer/ Director of Medical Services meets

with the clinical heads of departments monthly as a group and on a one-on-one basis to keep abreast of what is happening in each department, including in relation to training.

> A private rural health service actively seeks feedback from trainees on a regular basis to ensure they are having a positive learning experience and environment locally rather than formally through Colleges. The Director of Medical Services also has direct involvement with trainees and a strong focus on building a positive culture and training environment in the organisation.

6.14 Regional Training Hubs

One of the roles of a Hub is to assist health services in accreditation processes for new posts under the IRTP measure of the STP. The consultation sought feedback from the Hubs on their involvement and experiences in accreditation with respect to this role as well as feedback from stakeholders on the role of the Hubs in support of establishing new training posts in rural areas.

Feedback varied in terms of the level of involvement with Colleges and health services and was also dependent on whether the Hub teams included local specialists or clinicians. In some cases, there was a strong disconnect and misalignment between what the Hub was hoping to achieve in supporting accreditation and the expansion of specialist training posts, and the level of support provided to health services to achieve this. In other cases, the Hubs provided significant support to health services with direct engagement at clinical level and providing value-add support for specialty training. This was also reflected in the RHMT Program Evaluation in that half the Hubs are supporting local health services with accreditation processes.

> There had been value gained from the Hubs such as promotion of specialty training, recruitment, and retention strategies in rural areas, particularly videos and visual information to support career progression and retention of junior doctors.
>
> The presence of the Hubs encourages health services to talk on a more regular basis about specialty training to share ideas and opportunities to try and attract people to rural areas.
>
> In one example, meetings are scheduled once a quarter and resourced through the Hub for health services in the region and the Hub is helping to track and manage accreditation processes via a central database for health services in the region. Within the main health service's education unit, there has been use of some of the Hub's resources to build in career counselling for junior doctors.

A Hub provided an example of direct assistance to a health service for accreditation as the health service was very close to losing accreditation in anaesthetics. The Hub put resources into supporting the anaesthetic department and ensured they had the required resources, including a trainee survey to collect anonymous feedback from trainees, support for the supervisors of training, setting up a mentoring system to ensure that the health service could meet accreditation requirements. In addition, the Hub supported the orthopaedic department and intensive care units to work towards accreditation and further work is underway to develop jurisdictional level network training models.

However, there is concern amongst stakeholders regarding the involvement of Hubs in accreditation. Various stakeholders do not support the involvement of Hubs in accreditation. Accreditation is the role and responsibility of health services to ensure that it meets the standards. Having an external person or body involved who has no prior history of working in health service delivery and specialty medical training is a risk for the health service, medical workforce, and Colleges. Accreditation is part of a continuous improvement

cycle, accreditation administration can be onerous, but health services and each specialty department must own the responsibility and any associated risk across the accreditation cycle, not just in the lead up to an accreditation assessment.

Feedback on the role of Hubs, not specific to accreditation, was that their integration in the IRTP has been problematic for health services and Colleges. In line with the findings of the RHMT Program Evaluation, there needs to be greater clarity on their role in supporting specialty training which has impacted on engagement with stakeholders. Many Hub staff are not involved in service delivery or specialty training and therefore have limited knowledge to contribute to specialist medical workforce planning and capacity building in health services and the broader support of specialty training and accreditation.

6.15   Additional case studies of rural specialty training and good practice

One suggestion provided was there could be consideration for accrediting places where people are and want to stay where they can serve their communities. The Remote Vocational Training Scheme (RVTS) identifies doctors in primary care working mostly in rural, remote and Aboriginal and Torres Strait Islander communities and supports them to undertake much of general practice training in place. There is a focus on virtual training, targeted in-service training and offsite training workshops. A doctor could do most of their training in these areas with structured distance education, remote supervisors and regular supervisor visits for face-to-face training and support. The RVTS source a remote supervisor to support the trainee. However, a model such as this may only be suited to trainees in the later stages of training who have acquired a certain level of competency.

6.15.1   Queensland

An example of a successful rural training post in psychiatry is in Central Queensland where a trainee can undertake the whole training pathway in **Rockhampton**, access the breadth of training and meet the training program requirements across the region. This post is supported under the IRTP.

Cairns has an outreach model of sending physician trainees into small Aboriginal communities in Cape York, with their training centre as Cairns Base Hospital, a Level 3 accredited teaching hospital for RACP training.

Whilst driven by members of a College, sometimes rural training pathways have been a response to workforce issues and in Queensland this led to the development of the Rural Generalist Pathway. What that and other pathways since have demonstrated is that providing junior doctors with a vision of an articulated, supported training pathway during the tenure of training, is that there is a higher probability they will remain in the communities in which they have trained.

What also evolves is the 'community of practice' and the QLD Rural Generalist alumni are strongly connected. They have regular meetings and an annual conference as part of the Rural Doctors Association of Queensland (RDAQ) and it is a very well supported network.

In Queensland, there has been an increase in numbers of trainees in physician training pathways. The advanced training pathways have recognised the benefits of integration with the Basic Physician Training pathway, and this is a way for QLD Health to provide support and a way for the trainees to get the experiences they need in an efficient timeframe across the duration of training.

Queensland Rural Medical Service advised that the challenge for distribution in Queensland will continue to be the selection of rurally orientated people who are then provided with the opportunity to go through the settings that will reinforce that orientation and the support they will need post-Fellowship with RDAQ to upskill or to retain those professional networks that they have developed.

O&G trainees in Queensland enter the specialty training program and have their placements identified for the full length of the four-year program. This increases stability for trainees over a longer period knowing where they will be training for the full term of training and they can plan their life. Stakeholders reported that this initiative makes significant progress in supporting trainee wellbeing.

Townsville is the only site in Queensland where an intensive care trainee can do most ICU training without going to Brisbane. Outside of Townsville, Cairns and Rockhampton are suitable for a certain amount of ICU training, however, there is still the requirement to rotate to metropolitan sites in Brisbane for cardiac, neurocritical care and trauma training.

6.15.2 New South Wales

There are two O&G training posts which are specifically rural under the Provincial Integrated Training Program (PITP). The trainees spend three out of four years in a rural setting. **Dubbo Base Hospital** and **Orange Health Service** participate in this program with plans to further expand the PITP.

Dubbo Base Hospital has also been successful in accrediting a paediatric training post and joined a training network with the trainee rotating to the Children's Hospital at Westmead.

Psychiatry in Orange, NSW, has been part of a very successful network training program. One of the reasons for the success is the mental health service in Orange is a dedicated, stand-alone psychiatric hospital that has had a critical mass of psychiatrists for many years. Eleven years ago, one psychiatry trainee commenced at the facility and over the last ten years the training program pathway has been expanded to ten trainees. The program has graduated six psychiatrists who undertook the entirety of their training program based in Orange. All of which are reportedly still practising in rural NSW. The psychiatry training program is part of a network with a metropolitan district and outer metropolitan district health services. As a smaller network they were always able to select and recruit to fill training posts while a larger network was fifteen to twenty per cent undersubscribed and could not fill positions. Despite having a smaller network program around Orange, the region is still dependent on seconded trainees from a metropolitan service within the network. When the metropolitan health service has not been able to fill all of their positions, the rural area is often the one that does not receive a trainee or additional trainees if service need requires it.

6.15.3   Northern Territory

Royal Darwin Hospital has been identified as a 'centre of excellence' for paediatrics and child health training and was accredited as part of the Queensland Paediatric Basic Physician Training Network for one of the three basic training years. There are multiple trainees applying to rotate to Darwin, however, there is currently only one position, with the health service hoping that over time this will increase to two positions.

At Royal Darwin Hospital, there are ten trainees, five in accredited training posts. The health service does not have enough general surgery for more accredited training. In emergency medicine, there are 35 trainees, half are in advanced training, across two EDs and two service registrars. There are also a number of rural generalists providing an emergency service. Overall, there are seven SET trainees and seven service registrars in surgery, with two orthopaedic trainees and two service registrars to provide the orthopaedic service. For O&G, to get more trainees the health services need to offer advanced training and in areas like Indigenous health or in sexual reproductive health or rural medicine. There is not the volume of work, even with Darwin Private Hospital as part of a network, to provide more training for O&G.

In **Katherine**, there is a paediatric training post that has been accredited and accommodated in a flexible and innovative way to support training. There are also two advanced general medicine trainees, one funded under STP and one jurisdictionally funded.

In **Gove** the health service has been accredited for some Basic Physician Training and is also accredited to deliver the emergency medicine certificate. This has been a good incentive for recruitment and retention of staff, for improving levels of care and training pathways to embark on formal training by developing more training opportunities and accredited training posts.

Alice Springs Hospital indicated that training is well supported in the region including basic physicians for 12 months, advanced training positions and up to 18 months in some areas of advanced training. The site has 24 months in emergency medicine, and in the emergency department, there are eight FACEMs with a retrieval team and services led by the Royal Flying Doctors Service (RFDS). The RFDS provide the plane and nursing staff, and the Alice Springs Hospital provide the medical support to the service. There are also general surgery, ICU and anaesthetic accredited positions.

There are 26 different specialities at the Alice Springs Hospital undertaking telehealth on a regular basis doing approximately 220 consultations a month of outpatient service via telehealth. There is a FIFO radiologist, one each week from Monday lunchtime to Friday lunchtime, all other radiology services are via tele-radiology.

6.15.4   Tasmania

The **North West Regional Hospital in Tasmania** was first accredited for 12 months for O&G training in 2013. Following a review in 2014, the health service was accredited for a further three years. The health service has actively worked to build the O&G department attracting enough specialists and combining two units. Despite multiple workforce challenges over the years impacting accreditation, the health service now has full accreditation.

6.15.5 Victoria

Latrobe Regional Hospital supports training in Basic and Advanced Physician Training (general medicine, oncology, geriatric and palliative), paediatric, general surgery, anaesthesia, foundation training in intensive care, emergency medicine, orthopaedic surgery, obstetrics and gynaecology and psychiatry.

At the **Ballarat Health Service**, the respiratory medicine post has been varied to meet the needs of service delivery as well as training. The trainees participate in a rapid access lung clinic Monday morning, early diagnosis for cancer to suspected cancer in the afternoon, they undertake endoscopy training, participate on Thursday morning in an advanced complex respiratory clinic and a general clinic in the afternoon. The rest of the week the trainees support the existing medicine team and participate in some respiratory medicine consults. A similar model has been adopted and supported for advanced renal physician training.

Ballarat Health Service advised it has had very good support to expand specialist physician training. The health service capacity has grown from three to eight advanced medicine posts, six subspecialty posts and two general medicine posts. Basic Physician trainees can now do two out of three years of training in Ballarat. The health service also secured funding for renal physician training posts based in Ballarat with trainees going to Royal Melbourne Hospital one day a week in an outreach model for clinic and teaching. This is currently a trial remote supervision program with a supervisor an hour away.

6.15.6 Western Australia

The WACHS offers several programs for junior doctors:

- The Applied Surgical Pathway in Rural Environments (ASPIRE) is a two-year program for PGY3 or above who are interested in pursuing a career as a Rural General Surgeon. Upon completion of the program candidates will be well placed to apply for the General Surgery Training Program with RACS.

- The Rural Adult Physician Training, Opportunities and Rotations (RAPTOR) One is a 12-month program for PGY2+ who are interested in physician training. The program aims to provide the successful candidate with relevant term rotations at Albany Health Campus and professional development to help prepare them to apply for Basic Physician Training.

The WACHS would like to expand training capacity and opportunities and is proposing a potential model with conjoint appointments where trainees are assigned to **WACHS** and could work in accredited training positions in Bunbury, Broome or Geraldton. For example, existing rotations from metropolitan hospitals to regions (e.g. North Metropolitan Health Service to Broome) could be accredited as a network. This would broaden the clinical experience for the junior and consultant workforces. The model could include a six-month attachment per region in WACHS, within a 12 to 36 month contract.

7.0 Out of Scope Feedback

7.1 Trainee selection

Trainee selection was raised on a number of occasions by stakeholders, particularly in relation to centralised selection. The variation of process and criteria for trainee selection per College, per specialty and per jurisdiction is difficult for many to navigate. Some Colleges select centrally, some provide the guidelines and allow this to occur per jurisdictional committee, some programs are national so there is a national approach. This was closely linked to the requirements for applications with positive feedback on affirmative action for rural applicants but conversely negative feedback with respect to the criteria in an application which disadvantages rurally based junior doctors, for example, requiring a certain number of references from specialists which is more difficult to achieve in rural areas due to the size and nature of the workforce.

For Colleges, trainee selection was at times impacted by the numbers of available training posts. In some specialties there are limited training posts around Australia and New Zealand, and they can only accept a certain number each year. This particularly impacts national programs such as dermatology and neurosurgery. For ANZCA, there were 250 applicants in Queensland in 2019 with only 120 interviewed for 45 new positions. The number of new training posts goes up slightly each year, but this is solely reliant on the increase in service provision.

> Every ophthalmology training post is filled and the RANZCO selects for that purpose, so they know exactly how many trainees they have for the next year and how many first years they can accept. If there is a training post where someone is going on maternity leave for six months, the College has a program called the Temporary Training Registrar which is for service registrars hoping to be accepted into the specialty training program. They occupy the training post for a six-month period to fill that vacancy. If they are eventually selected, they can then apply for Recognition of Prior Learning (RPL) for that time and any assessments they've completed. If the College has vacant training posts, there is flexibility to conduct a mid-year intake.

7.2 Trainee recruitment

Trainee recruitment is not conducted by Colleges. It is conducted by specialists for their specialty in individual health services, as a group for health regions or rotational programs or centrally with support of the jurisdiction or other bodies. For example, in Queensland there is a central recruitment model. Queensland Health has invested in the pathways and ensure that they have mapped out the future specialist workforce for the state throughout all the specialties. There can be someone from the Queensland Health Medical Workforce Unit participating on recruitment committees. There is a similar application process for everyone under the Resident Medical Officer (RMO) Campaign with an online application that tailors questions once a specialty has been selected and applicants upload documents to the site. Queensland Health funds administrative support to enable the training pathways to function and undertake recruitment and selection activities. For example, depending on what a health service's physician education program is, there could be elements of the local level funding that supports hosting educational events.

RCPA has a training network with centralised recruitment. Trainees submit their preferences and laboratories submit their preferences and they're matched as closely as possible to preferences.

7.3 Trainee allocation and rotations

Allocations or rotations of trainees are a requirement of almost all specialty training programs. They are sometimes centralised and carried out by jurisdictional College Fellows or a 'primary' health service (often metropolitan tertiary health service) in a 'hub and spoke model', depending on the specialty. Sometimes the timing of allocations via metropolitan sites is an issue not always aligning with rural health service workforce needs.

Rural health services reported a lack of consideration when trainee numbers are reduced, with network hubs pulling trainees back to metropolitan sites or not allocating to rural sites when there are not enough trainees to fill positions in metropolitan sites leaving them without any trainees. This impacts on both service delivery and training capacity, and occasionally also impacts training posts funded under the STP. On one occasion, a health service reported that an STP funded post was vacant for 2019 and was earmarked to be vacant again in 2020 due to trainee shortages, unrelated to accreditation of the training post.

> In NSW, all psychiatry trainees are required as a condition of their employment to do at least a three-month rural rotation during their training, with most psychiatry networks requiring six months. The state implemented this change when RANZCP removed the mandatory rural rotation requirement from the specialty training program.

RACMA has no formal requirement for rural rotations, however, do require a breadth and depth of training experience to meet training requirements and it is recommended that trainees seek this in various health services rather than in one location. Should a post be identified as having gaps against RACMA's curriculum and core competencies, the College will facilitate access through professional networks to another health service to gain training exposure to fulfil requirements.

> CICM requires all trainees to undertake a three-month rural rotation. This is not centrally coordinated. Trainees determine where they go to train, and there are more accredited training posts and units than there are trainees. Trainees self-manage their training requirements and progress with supervisors and determine their own rotations based on training needs and available posts.

RANZCOG requires that six months of the six-year training program is in a rural area. The rotation to a rural training site is determined and coordinated by the Integrated Training Program Coordinator at a central point, often a metropolitan health service.

> For general paediatric training in Queensland, almost all regional health services have accredited positions, however, regional health services always need to compete to attract trainees to fill accredited positions with the metropolitan and outer metropolitan health services. If there are accredited positions available in metropolitan health services, rural health services will always have difficulty attracting trainees.

ANZCA allocates trainees per rotational program or in collaboration with other jurisdictional programs in a very transparent process per jurisdiction. If a trainee is accepted and agrees to be on the Queensland Anaesthetic Rotation Training Scheme, one of the agreements is that the trainee agrees to accept any rotation that is offered as part of the training. If a trainee refuses, they are effectively resigning

from the rotation and the training program. There is consideration and flexibility for special requests to accommodate leave, family, etc.

> RACS rotations vary by specialty. Urology rotations, for example, are coordinated by jurisdictional committees. Sometimes rotations are quarterly or six monthly. Some of the rotation periods can be influenced by supervisors, and network supervisors in the case of GSA, and regional training committees. For orthopaedic surgery, rosters are planned 12 months in advance in almost every jurisdiction. Each AOA Regional Training Committee is responsible for the distribution of the trainees through the accredited posts. Rural training is 12 months, and that may be 12 months in one centre or six months in one rural centre and six months in another rural health service.

RANZCP rotations are six months, and the allocation of rotations is by the Director of Training in consultation with the local training committee. For example, in SA, the Director of Training receives rotation preferences from trainees twice a year. The Director of Training meets with the SA training subcommittee and allocates the rotations.

> RANZCR trainees are recruited to a network. Under the network contract they need to rotate for at least 12 months away from their home sites.

Stakeholders advised that when a trainee is seconded from a metropolitan service, the rural health service is often obligated to provide trainees free housing, pay them more than local trainees and provide them with free travel to and from cities several times during their term. There is not the reverse requirement for rural trainees rotating to metropolitan sites which disadvantages rural trainees and can generate problems within trainee cohorts.

When health services are only accredited for Year 1 of training, or 12 months, rural sites reported often receiving the least experienced trainees who need the highest level of supervision rather than the most experienced who need the least supervision.

A final year trainee with a high level of competence requires a lower level of supervision, and rather than be training in a tertiary inner metropolitan site, these trainees could be rurally based. Junior trainees commencing training require a higher level of supervision which aligns more with metropolitan service delivery and supervision capacity.

7.4 Supervision, supervisors, and support

Not all specialists wish to be involved in supervising specialist medical training. Supervision demands a significant commitment of time and College engagement in education.

Supervisors of training generally undertake their roles without any additional financial support. As a supervisor of training, the cost to a health service is lost clinical activity. Health services pay a wage for a doctor who is not providing a clinical activity, but they are providing an essential education service which therefore supports trainees who provide significant clinical benefits to health services. In Queensland, the health services pay for supervisors of training to meet two or three times a year in Brisbane which includes time away, flights and accommodation.

Some grants are also available in Victoria to support supervisors in specialist training and education, however, for the most part, there is very little additional funding jurisdictionally or locally to support tutorials, journal clubs, education meetings and other related activities outside of direct clinical supervision and service delivery.

There is also a missed opportunity in not considering the involvement of SIMGs in educational supervision either formally appointed or informally. Some have been academics or senior consultants in their countries of training and may have to undertake training or supervised practice longer than the trainees before they can be recognised as a supervisor. This can be a real detriment for rural health services as SIMGs often have had years of experience in areas more broadly than their specialty.

7.5 Workforce data

There is a significant gap for Colleges on medical workforce data and for jurisdictions on specialty training data.

Jurisdictions have a vested interest in Colleges providing regular and accurate data on their workforce and training pipeline to inform jurisdictional workforce plans. Jurisdictions felt they had no visibility of where there are peaks and troughs in phases of training, challenges around selection, quality of experience, numbers applying for training programs, etc. This was identified as key for jurisdictions when they work together at a national level on workforce distribution, supply and demand.

The mission statement for Queensland Rural Medical Service is 'to build a fit for purpose rural and regional workforce'. Overall, this is made more difficult by the decentralised health service model with each health service considering their own needs as paramount, including metropolitan hospitals which also have service and training needs.

> Additional funding provided outside of specialist medical training under the Emergency Medicine and Education Training (EMET) has assisted health services to be creative about how they can train to build capability and capacity in emergency medicine. Central Australia Health Service had some negative outcomes at Tennant Creek Hospital in emergency medicine services. The EMET funding facilitated a FACEM to go to the hospital to train staff and work with Fellows of the Australian College of Rural and Remote Medicine (ACRRM). The hospital was not a training site; however, the funding has supported the development and expansion of training with a FACEM visiting once a fortnight in a supernumerary capacity. Their role is to train, not treat patients. The hospital has now become a training site for ACRRM trainees and medical students from the Rural Clinical School.

Feedback from stakeholders indicated the need for a more holistic view about rural areas and that the conversations about the expansion of training are often isolated from the real world. There needs to be consideration of changing demographics and changing expectations. Specialists in the past qualified at an earlier age, the social environment is changing, and country towns are closing down for many other reasons, and specialists were on call for private patients 24 hours a day, seven days a week. There is a shift towards improved work-life balance options and rural specialists often need to be on-call for lengthy periods of time without someone else assisting. Some doctors are no longer happy to do that, particularly those with family commitments. Looking at how to train more specialists in rural areas must consider the whole health and medical workforce that contribute to delivering a service.

7.6 Service demands versus training versus cost (including benchmarks for elective surgery and patient waitlists)

The health system's primary focus is patient care and decisions are made to ensure continuity of care and service delivery. A balance must be reached in determining the composition of the workforce to deliver a service as a priority.

More than one example provided during consultation indicated that elective surgery benchmarks were a contributing factor to whether a health service would commit to specialty training, and then if so, how many posts or trainees could be accommodated. Training takes significant time and some health services advised that there were decisions based on the need to progress and meet service delivery targets to meet national benchmarks rather than fall behind. This can mean no training and only service registrars or very limited training, to continue to allow specialists to progress through case lists at an appropriate rate with limited workforce. In one case, a health service reported it needed to reduce the numbers booked on surgical lists to allow trainee access to patients.

On occasion when a health service has a limited budget it may wish to redirect funds allocated to a specialist training post to another service area in need of extra staffing. This will mean that although an accredited post is vacant, the health service will not provide funds to enable the rotation or engagement of a trainee to fill the position. It may also indicate a drop in service demand in one department and increase in service demand in another department. This is also a cost saving measure in some cases whereby training positions are filled with service registrars instead.

There can be a mismatch between service delivery and training requirements. If there are several people working in a specialty area to deliver a particular service level, it may be detrimental to a health service to have more of the workforce as accredited trainees because of the limitations on work hours set by Colleges rather than the way a health service needs to use them as a workforce. There is little incentive for health services to do that if it means there will be a negative service impact.

In some cases, if health services did increase accredited training posts, it may impact their ability to deliver service 24 hours a day, seven days a week and compromise their obligations for quality training, accreditation, and safety.

If a health service determined particular services were required, this is determined with the finance department of the health service and / or health region. The model of care is determined and then hopefully they can hire enough staff in the different speciality areas or across professions to create that service. Stakeholders advised that there is not a lot of jurisdictional level planning or co-ordination to support health services. For example, if a new health service opens that requires staffing, there is no consideration for where staff will come from for the new service nor consideration to fill gaps left in other health services when staff leave to go to the new service, whether nursing, junior doctors or specialists. In one jurisdiction, stakeholders advised that universally across health services and the jurisdictional health department, the workforce plans at a local level do not necessarily align with what is happening at a state-wide level.

7.7 Service registrars (unaccredited trainees)

Service registrars are extremely important, not only to support service delivery, but to support specialty training and accredited trainees. These are sometimes identified as 'middle grade' roles that 'usually perform the same tasks as training registrars, but without the same college requirements for supervision, education and limits on overtime and on-call work'.[44]

These roles are often seen as a pathway to specialty training by some doctors, and without them, specialty training capacity would be further limited.

Accreditation requirements include accreditation teams reviewing rosters or timetables for all trainees and training schedules as part of the assessment against trainee wellbeing standards.

Service registrar roles assist a health service without specialty training to gather evidence and data on clinical casemix and caseload required for accreditation. They provide an opportunity for a health service to start to build supervisor capacity and capability with the oversight of service registrars.

In terms of RPL for service registrars, some specialties take into consideration logbook evidence, however, there is no formalised training and supervision, so most RPL is limited. For example, one year of work as a service registrar may not equal one year of training RPL.

There may be selection points for prior experience in specialty service and some may have accelerated learning plans once they commence specialty training that acknowledges time in practice.

7.8 Scope of practice and credentialing

Health services need to ensure there are supportive legal and credentialing frameworks for medical practitioners in rural areas to operate across the full breadth of their scope organisationally as well as to meet community service need. This includes credentialing, safe practice protocols and a clinical governance framework. Strong collaborative relationships between narrow scope specialists and broad or extended scope of practice specialists are required, particularly where there are good lines of communication, agreed clinical guidelines and share clinical responsibility.

Regulation does not incorporate scope of practice; that is organisationally based and health services have the ability to consider this from a benefit approach rather than risk and be able to support the medical workforce through credentialing with a strong clinical governance framework to operate the full breadth of their scope of practice.

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7.9 Fiscal environment

There is constant tension between service delivery, workforce and budget which impacts more broadly than specialty training. In one example, a health service has nine operating theatres but can only operate five due to budget restrictions, so cannot attract the specialists, cannot accredit training posts and cannot get trainees.

It was reported that sometimes there is no clarity of budgets by individual sites to be able to make local decisions on workforce and training.

RANZCR identified that barriers to training development and expansion have been created for some sectors, particularly in regional settings, by privatising specific areas of practice within public hospitals, such as medical imaging. This impacts training opportunities and workforce growth as costs incurred by private sites, including the on costs to join a training network and supervision, which are considerable. Private sites are often not funded, or underfunded, to support training and therefore it can be unappealing to invest in the provision of training.

In some jurisdictions, the awards are lower which impacts attracting and retaining specialists and trainees.

Many rural, and in particular remote health services, face significantly higher costs for specialist training. The costs include industrial agreement rates, which is often higher in remote areas (including mandating the need for accommodation, car, travel and higher wages), and also the added costs to service departments of having a trainee. For instance, in Kimberly, WA, taking two trainees each year is a significant cost impost on the local health system, hence, the absence of trainees in many rural hospitals in WA.

In one jurisdiction, various stakeholders advised of significant challenges with a 'secondment fee' which is a percentage of on-costs that must be paid for every seconded trainee which can be so prohibitive to health services with fiscal constraints, such that those in rural areas, are sometimes reluctant to accept trainees on rotation. This fee can be variable in terms of percentage charged and feedback indicated that private health services may attract a higher percentage rate.

Feedback from other stakeholders indicated that there were occasions where there was limited funding available in the health region to support beyond the 'end of the training pipeline' and to establish specialist positions for the retention of trainees once they achieved Fellowship.

7.10 Portability and recognition of entitlements including leave

Much was discussed in relation to the portability and recognition of entitlements when trainees move between jurisdictions and health services. It is more problematic in some specialties with interstate training pathways and national training programs but can also present issues within jurisdictions moving from one health service to another, including between public and private sectors.

Queensland Health has embarked on a plan for the Queensland Department of Health to be the employer for all junior doctors, including specialty trainees.

Health service boards maintain responsibility for service delivery and patient outcomes, they are legally employed by the Department, but all the relevant functions are delegated to the health services. Intern and RMO campaigns will continue to function as usual with health services picking up candidates from the campaign. Health services are responsible for the issuing of the contract to doing all of the criminal history checks, credentialing, engaging and managing them from a HR perspective on a day-to-day basis. Senior medical officers are employed directly by the health service that they work for.

In Queensland, there are already provisions and mechanisms for people to move between health services seamlessly and have their service and entitlements recognised. There have been problems where those mechanisms are not used very effectively, or the timing has not worked, or people were unwilling to engage in the process.

NSW Health has provided length of training contracts for trainees so that when they go to the private sector they remain on contract. They take leave without pay and maintain entitlements and are paid directly by the private health service. Another model where trainees stay on the NSW Health payroll and then the LHD will invoice the private hospital for the salary, sometimes hospitals charge an administration fee on top of that.

In Tasmania, if a trainee in an accredited training program has a requirement to do 12 months in another jurisdiction, the state may agree to recognise service and entitlements. This is on a case-by-case arrangement.

7.11   Reputational and cultural issues

Some rural health services have had the stigma of a sentinel or adverse event which then means that a particular site linked to an event is not seen as an attractive placement opportunity for medical students or for vocational doctors. Apart from the assurance of safety and quality in health service delivery, there can be many cultural and other reputational issues that a health service needs to overcome to attract a workforce back to an area and to embed specialty medical training. This may take years to overcome.

7.12   STP feedback

Much of the feedback on the STP and IRTP centred on funding, length of agreement, administration, health service capability to support training, and program rules being at times too limiting or misaligning with College delivery of specialty training programs, impacting successful outcomes. There was also feedback on the length of time it takes to establish new training posts which makes being responsive to government programs difficult for Colleges and health services. Sometimes, by the time a post has been established and accredited, funding has been withdrawn and re-allocated because it has taken so long to accredit and fill the post.

The immediate problem for some smaller jurisdictions and participation in the STP is that they are unable to leverage the program significantly because of the limited available workforce. There are only so many training places they can deliver with the specialist workforce available, the demands already on the workforce for service delivery and sustainability of the workforce.

Although the concept of funding following a trainee under the IRTP supports continuity of support for a trainee in a rural area, this presents service and financial issues related to when trainees move away to undertake further training. In addition, rural sites are often not accredited for long periods of time and a trainee will need to rotate to other sites to complete requirements, which can be other rural sites, depending on the training requirements.

8.0 Conclusion

The specialist medical college accreditation system has a significant role in setting and maintaining standards for quality and safe specialty training in Australia. Although there are challenges to address, there are also opportunities to embrace to support specialty training beyond metropolitan and urban settings to meet the specialist health care needs of Australian regional, rural and remote communities.

Recognising the need for change in specialist medical education, training and accreditation is critical. This imperative has been articulated most recently in the NMWS with some Colleges already making progress in developing and implementing rural health strategies and actions aligned with the NMWS.

Collaboration and partnerships with and amongst key stakeholders in specialty training such as governments, peak bodes and specialist medical colleges, will be vital to effectuating and supporting change in the non-GP specialist training and accreditation system. This will ensure successful and sustainable long-term outcomes that improve distribution of specialist medical training and the specialist workforce.

System level strategies and actions in training and accreditation should consider increasing flexibility in training accreditation systems to accommodate training in a variety of settings, greater support for network training with the inclusion of rural public and private sector training opportunities, models of supervision to improve access to and support for rural training, formalising rural representation in education, training and accreditation decision making and improving data capability and management to reduce regulatory burden and support specialist medical workforce planning.

Effectuating change in such a complex system is not a simple matter requiring significant commitment of time and resources with much consultation, engagement and collaboration along the change journey.

Drawing upon lessons learnt and opportunities as a result of the COVID pandemic will also be an important factor in strengthening specialist medical training and accreditation systems.

COVID presented an unprecedented opportunity for health stakeholders to be responsive and agile in a rapidly changing environment. Colleges responded quickly during this time to support members, trainees, governments and the health sector. Colleges continued to support local education and training delivery, where possible, and enhanced learning opportunities through virtual technology methods. Innovation in education, training, supervision and assessment were also developed to ensure the continuity of the training pipeline and supply of the specialist medical workforce. There is an opportunity to take advantage of this momentum of change to engage in system-wide reform in specialist training and accreditation to deliver better health outcomes for regional, rural, and remote Australian communities.

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All information in this publication is correct as at May 2022.