Australian Government

Department of Health and Aged Care

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

SUMMARY REPORT

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

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The Department would like to acknowledge the engagement of Colleges in continuous quality improvement in specialty training and accreditation, particularly in supporting and enabling the integration and expansion of specialty training in rural areas to meet the needs of rural health services and the communities they serve.

A full list of acknowledgements is listed at *How Accreditation Practices Impact Building a Non-GP Rural Specialist Medical Workforce*, Report Appendices – Appendix M.

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Acronyms

ACD	Australasian College of Dermatologists
ACT	Australian Capital Territory
ACEM	Australasian College for Emergency Medicine
AHMAC	Australian Health Ministers' Advisory Council
Ahpra	Australian Health Practitioner Regulation Authority
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
BPT	Basic Physician Training
CHO	Chief Health Officer
CICM	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
EDMS	Executive Director Medical Services
EMET	Emergency Medicine Education and Training Program
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
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
ICU	Intensive Care Unit
IRTP	Integrated Rural Training Pipeline
JCT	Jurisdictional Coordinator of Training
LHD	Local Health District
LHN	Local Health Network

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

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

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 World Health Organization. (2010). Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations. World Health Organization. https://apps.who.int/iris/handle/10665/44369

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

in specialist medical training via rural rotations. Evidence demonstrates that rural training experience aids in attracting trainees to rural areas, providing for the development of rural practice skills through service provision and training. In Canada and the United States, trainees indicated that exposure to rural practice had influenced their decision to enter rural practice.[6] [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 practicing 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.

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 alone.

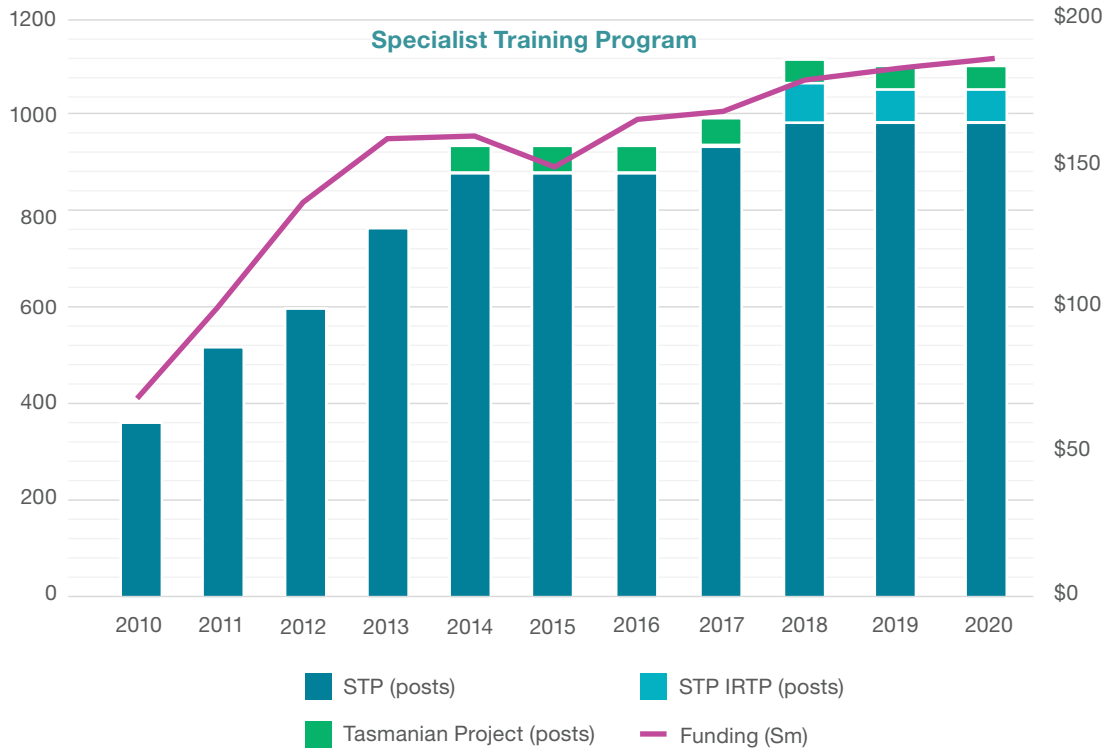
6 Jamieson J, Kernahan J, Calam B, Sivertz (the Late) KS. One program, multiple training sites: does site of family medicine training influence professional practice location? Rural and Remote Health 2013; 13: 2496. https://doi.org/10.22605/RRH2496

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.



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 Integrated Rural Training Pipeline (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 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]

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.

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 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 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 specialist medical training 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.

Colleges were invited to participate in an initial online survey to gather preliminary qualitative data on accreditation practices and feedback ahead of face-to-face meetings. The survey results further informed interview questions for College meetings. Interview questions were developed for stakeholder groups based on their level of involvement in specialist medical training accreditation practices.

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.

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

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.

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 with evidence that these rural training experiences are often highly valued and sought after by trainees. The requirement for trainees to access unique and complex specialist cases in metropolitan, urban or large regional centres remains.

Accreditation frameworks, standards and requirements are derived from the requirements of specialty training programs and curricula. It is specialty training programs and curricula that must also consider broader health contexts, including the rural context.

It is important to note that the themes that emerged from consultation were interwoven with other components of specialty training, out-of-scope for this project. As such, accreditation cannot be considered in isolation when determining potential changes to improve the distribution of training in rural areas of Australia. 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 the rural or 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 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** 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 trainees which sometimes is misaligned with service needs.

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, 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.

Out of Scope Feedback

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 simply cross-jurisdictional.

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

Good Practices

The following table represents examples of good practice by specialist medical colleges to support rural training. Further details of these practices can be found in Appendices A to 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

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[12], the body of work on specialist medical college accreditation auspiced by Australian Health Ministers' Advisory Council (AHMAC) in 2015, the AMC Standards and recommendations made in the 2005 Review of Australian Specialist Medical Colleges.

Based on the reoccurring themes, 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 further 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,
- 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'[13], the mechanism the 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.

12 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

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

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).
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 4.3.2).	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.

Recommendation	Rationale
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.
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.

Recommendation	Rationale
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.
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.

Recommendation	Rationale
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.
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.

Recommendation	Rationale
22. Increased collaboration between Colleges, jurisdictions and local health areas (inc. 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.
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.

Recommendation	Rationale
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.
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.

Recommendation	Rationale
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, 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.
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.

Recommendation	Rationale
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).	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).	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).	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.

2.0 What works well in specialist medical college accreditation

2.1 Quality Assurance and Quality Improvement

- The primary functions of the accreditation system are quality assurance, regulatory and quality improvement.
- There are set accreditation standards with specialty training responsibilities and cyclical assessment providing an opportunity for reflection on what they health services are doing well to support specialty training and areas of focus for continuous quality improvement for both training and service delivery.
- The key principles of college accreditation must maintain focus on quality care, ensuring that patients and the trainees are safe and that there is adequate support for trainees and supervisors.

2.2 Setting the Parameters for Quality Training

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

2.3 Opportunity for engagement

- Accreditation is a form of strategic engagement between Colleges and health services. It is an opportunity to empower trainees, supervisors, and Fellows, and empowers health service executives in relation to the medical workforce, training system and health system. The involvement of health service executives in accreditation visits has the ability to influence improvements in the support of specialty training more broadly than just one specialty in a health service.

2.4 Peer Review

- Accreditation is predicated primarily on a peer review system. Having specialists who understand the system, and the challenges of balancing the trainee versus employee and training versus service paradigm, is critical, compared to professional accreditors that accredit sites. The accreditation system peer-review component ensures connections between health services, Colleges, trainee groups and supervisors in support of specialty training.

2.5 Trainee Wellbeing

- The increased focus on trainee wellbeing, experience and patient safety has stimulated positive change for health services in training and the health workforce more broadly.
- There is a stronger focus on anti-bullying, improvement in training policies and practice, 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 assists everyone involved in specialty training to understand what the parameters and requirements are for quality, well supported and safe specialty training.
- The increased involvement of trainees in accreditation is positive, both from an interview during accreditation assessment and the inclusion of trainees on accreditation teams.

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

The following challenges emerged within the current specialist medical 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, metropolitan, rural, health service size, jurisdiction and service delivery.
- Accreditation frameworks can be rigid and allow little adaptation or consideration that rural posts or pathways are any different. However, there is progress towards integration of flexibility by some Colleges.
- Decision-makers in Colleges are often metropolitan experienced, based in metropolitan areas and as a result, there are predominantly metro-centric decisions made in the specialty training system.
- It is difficult for rural and regional 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 detail of some accreditation criteria, for example, required case numbers, casemix, etc.
- Accreditation data management systems are extremely 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 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 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 time, process and numbers-based education to achieve training requirements and competency. Although many Colleges either have or are progressing towards competency-based training, 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.
- State and territory medical workforce units have limited visibility and involvement in specialty medical training and accreditation.

3.1 State and Territory Summary

- **States and territories reported limited engagement with Colleges**. Some jurisdictions meet regularly with local college members on matters of mutual interest, this includes matters related to training and accreditation. There is a need for building and strengthening partnerships between Colleges and jurisdictions in medical workforce planning and training.
- Most jurisdictions **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.
- Three states **support specialist training through targeted medical workforce programs**. These are designed to meet the needs of public health settings in rural, regional and metropolitan areas based on jurisdictional workforce plans and priority areas, such as specialties in undersupply in the state. There is no formal link between state-based programs and the STP, although priorities align closely with Australian Government priorities.
- Reaching appropriate caseload, casemix and the **critical mass of supervisors in rural areas** was identified by all jurisdictions as problematic for most specialties that are able to practice in rural areas. This is further impacted by recruitment and retention challenges of the specialist and trainee workforce.
- **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 accredited training.
- Geography, population and health service sizes are key challenges affecting the ability to meet accreditation standards and sustain specialty training.
- Jurisdictional **industrial arrangements vary** particularly in relation to trainee wellbeing, conditions of employment, allowances, entitlements such as professional development and leave for training which can all impact the ability of a health service to achieve accreditation to support training. This also creates complexity for Colleges to navigate when developing and applying accreditation frameworks.
- **Training infrastructure in rural areas** can be limited or even non-existent, including limited ability for trainees to attend weekend exam practice, trial exams and tutorials often held in metropolitan or regional health services.
- Most jurisdictions have a strategic medical and / or health workforce plan incorporating a focus on supporting medical workforce needs in rural areas.

3.2 Specialty Specific Accreditation Challenges

Specialty specific issues and examples were provided by all 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. These issues were identified by specialists at health services and Colleges.

Specialty by College	Accreditation Process – timeline, administrative burden, requirements	Supervision	Network Rotations	Service Delivery and Training – inc. 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	Bottle necks for mandated training terms				
Clinical Radiology	Yes		Bottle necks 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

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 supervision by Fellows to curricula that are largely metropolitan experience-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.
- The majority of College policies and processes for specialty training are decided upon and administered through central offices and members with metropolitan experience with little consideration of the context of rural and regional health care, service delivery and what can be achieved in rural training. A 'one size fits all' model may not be appropriate for rural health services.
- Consultation or engagement with rural representatives or committees to inform policy and process is not always evident in College policy or practice.
- Most accreditation frameworks do not incorporate criteria or elements to explicitly consider or support rural and regional context.
- Training orientated to metropolitan hospitals can imply bias and has the potential to predetermine outcomes on whether a rural site can support a good training experience. This potentially impacts the ability of the rural health service to achieve accreditation and attract trainees with preconceived views on the rural training experience.
- Accreditation does not consider organisational scope of practice and some Colleges are not sufficiently flexible to adjust assessment against accreditation standards for the Indigenous, rural and remote health environment. Context is significantly important for training and accreditation. Frameworks should be flexible enough to apply different ways of measuring quality and outcomes.
- Rural positions need to be recognised and accredited as valuable training experiences suited to rural settings for the purposes of training outcomes in a rural area. Training experiences are more general, varied and comprise multidisciplinary teams in a range of settings.
- Some accreditation criteria could be viewed as covertly metro-centric making it more difficult for rural health services to comply with accreditation requirements such as particular roster arrangements, workforce, sufficient accommodation, and infrastructure such as internet access areas.
- It is not common for accreditation teams to include special expertise such as rural members when assessing rural sites and any negative perception of rural facilities and training can impact an accreditation assessment.
- There is the need to support having a greater rural voice in determining what specialty training programs can and should be supporting in rural areas and enabling rural representatives to have greater input in College decision making.

4.2 Flexibility in Accreditation Frameworks

- The absence of flexibility in many College accreditation frameworks does not support improvements in geographical distribution of specialty training.
- There needs to be greater flexibility to value rural and other varied training opportunities for well-rounded specialty training experiences and focused on outcomes, rather than numbers or standards when assessing rural health services
- Greater flexibility is apparent in some specialties due to the reduced requirement for physical infrastructure.

4.3 Supervision of Specialty Training

- Colleges require a certain FTE and structure of onsite, direct specialist supervision that may not always align with contemporary health service delivery models, particularly for rural areas.
- Most Colleges require that trainees can only be supervised by Fellows of that particular specialty. This becomes a challenge in rural areas with limited numbers of local staff specialists to meet accreditation standards.
- Flexible supervision models have been developed by some Colleges that include enabling remote supervision and support for non-Fellows and locums (where appropriate) in becoming accredited supervisors. For one College, substantially comparable SIMG specialists are able to supervise trainees during the final year of supervised practice, prior to their admission to Fellowship.
- Models of supervision to further support rural training are required with consideration given to supervision arrangements that focus on clinical skills rather than a profession as well as increased support for more networked supervision models to support trainees.
- Models of remote supervision and better enabling of technologies need to be incorporated and supported through accreditation frameworks. This is particularly important where achieving the critical mass of onsite supervisors is difficult to achieve or will never be achievable for some rural sites impacting the ability to expand training.
- Many Colleges require potential supervisors to be at least three years post-Fellowship. Some Colleges have applied greater flexibility with the pre-requisite time from Fellowship to becoming a supervisor.
- There is some flexibility regarding the level of supervision required in the senior or advanced years of specialty training with the increase in experience and competency of a trainee.
- Health services need to better enable and support the development of training infrastructure which includes required resourcing and workforce, such as specialists and service delivery teams for training delivery.

4.3.1 Locums

- Locums are excluded from supervision by many Colleges.
- A heavy reliance on locums can compromise training accreditation. Some Colleges consider on a case-by-case basis, locums becoming accredited supervisors to support continuity of accredited training in rural areas.

4.3.2 Alternative Supervision Models

- There has not been extensive exploration of alternate models of supervision in specialty training. With many Colleges integrating Entrustable Professional Activities (EPAs), this is forming the basis for improvements in determining competency of trainees and levels of supervision required.
- There is some support of non-Fellow local or direct line supervisors in a model of supervision that has the secondary supervisor who is a Fellow. Other options include less physical onsite supervision with telesupervision support, particularly for advanced trainees with a higher level of competence.
- Local supervision has been supplemented in some cases with Visiting Medical Officers ensuring trainees are appropriately supervised and in accordance with accreditation standards.
- To enable alternative supervision models, supervisor training and additional support mechanisms may need to be provided either through network training or professional arrangements with the integration of technological supports.

4.4 Casemix Breadth, Depth, and Caseload

- Rural health services often have difficulty meeting caseload and casemix numbers due to the nature and volume of service delivery relative to the needs of the communities they serve. This may be due to limitations on health service scope of practice which impacts not only caseload and casemix but specialties that practice in these areas. Often there is not the volume of work available to employ a specialist full time let alone build a department of specialists to build training capacity.
- Some casemix and caseload issues have arisen for health services when there is a need to reduce overtime and fatigue in trainees. Alterations to rosters to try to reduce this can sometimes jeopardise the accreditation of the training posts because trainees would not access sufficient case volume for training requirements.
- In some cases, clinical case volumes, particularly in regional areas, are excellent, allowing trainees to be primary operators.
- Online training portfolios record training experiences for trainees to demonstrate that they have completed the minimum volume of practice including caseload and casemix training requirements, however, logbooks may not always reflect true caseload and casemix. Some trainees enter time in training to meet requirements and once they have met requirements, additional work is no longer recorded. This can be an issue from an accreditation perspective to be able to accurately identify caseload and casemix at each accredited site and to ensure trainee safety.
- When a health service wishes to establish a new training post, service registrar logbook data is critical information to demonstrate that a health service has the specialty caseload and casemix available to support an accredited training post.

4.5 Infrastructure Issues

- Rural health services may only have infrastructure based on the health service scope of practice and limitation of resources. When there is growth and need for increased or expanded service provision and the health service needs to build infrastructure, there can still be limitations on what can be accommodated which can impact rural health service compliance with infrastructure accreditation standards and criteria.
- For some specialties, infrastructure does not exist in rural areas because it is not the way service is delivered. This is also reflected in the specialist workforce that are not present in rural areas.
- The need for particular infrastructure, or equipment at every accredited site does not recognise that sites can still provide a health service, valuable training experience and good training outcomes.
- Networked training models are vital to recognise that rural sites that may not meet all the requirements still have a valuable training experience. They can link with larger sites with the ability to provide exposure to particular equipment and training experiences for a rotational term.
- 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 whilst many trainees are interested in academic positions, these are frequently less available in rural areas.

4.6 Impartiality, Transparency and Consistency

- 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 equally. There is standardisation where possible in practices and documentation, accreditation and specialty specific expertise employed in governance structures, accreditation committees and teams, policies, regulation, and process to drive consistency and underpin frameworks to ensure quality and safe specialty training.
- Colleges apply guiding and governing principles for accreditation assessments, particularly that all accredited health services and training posts have a positive learning environment with appropriate supervision, support, resources and an adequate volume and diversity of experience to meet the requirements of training programs.
- Accreditation assessment teams often have two Fellows, one staff member and occasionally a trainee and/or jurisdictional representative with peer review throughout the governance process. Despite such measures, accreditation practices and assessments are not always transparent, consistent or independent.

4.6.1 Transparency

- Over time the accreditation frameworks and processes of Colleges have become fairer and more transparent.
- Greater clarity and transparency are required in the requirements a health service must meet to comply with standards and decision making in relation to accreditation. Publicly available information on websites can be very high level and often does not provide sufficient detail required for health services to be able to make decisions on medical workforce and training prior to applying for accreditation.
- Conflict of interest and biases can negatively influence the accreditation assessment of a health service and approach of an accreditation assessment team.
- It may be preferred that trainees access certain procedures to meet core training requirements during a rotation in a rural health service as there is less competition with other trainees than in metropolitan settings. This is not always aligned with rural health service delivery.

4.6.2 Consistency

- There is inconsistency in the assessment of health services against accreditation standards and inconsistency of accreditation requirements within Colleges.
- There is no common terminology, language or definitions creating inconsistency in assessment across Colleges for similar standards.
- Inconsistency in setting accreditation standards is problematic for health services, for example, setting requirements that are outside the employer award or agreement.

4.7 Accreditation standards and industrial arrangements

- Accreditation requirements outside the employer award or agreement creates inconsistency across specialties and workforce and stakeholders indicated that they are unfair expectations to place on rural health services which are often unable to meet these requirements the way metropolitan and larger sites can.
- 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 hoping to be selected in specialty training program. This directly impacts accreditation in relation to support provided to all trainees for welfare and safety.
- Some accreditation standards have increased requirements relative to changes in industrial arrangements or changes that misalign with industrial arrangements under awards. This may be out of the control of health services to address and difficult to manage with fiscal constraints, such as inter-jurisdictional rotations paid under different agreements and state or territory awards.
- There is a degree of artificiality with some accreditation criteria, particularly in a rural setting where service demand has significant training value in experiencing real-world stresses 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. Sometimes having the capacity to train is not the workforce solution to meet service delivery needs for some rural health services.
- Health services need to determine the capability of the organisation to accommodate and support specialty training within the organisation's scope of practice, with a clear goal and direction about the purpose of their training system. This may be to build, stabilise and sustain their local workforce so the health service can reduce their reliance on Fly In Fly Out and locum doctors.
- The vulnerability and fragility of specialty training within small departments in rural areas is an ongoing concern. Rural areas that can often be reliant on one specialist to provide all the volume of practice for a specialty or subspecialty to meet accreditation requirements. These training systems can be very fragile and reliant on too few people; 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 inflexibility by some Colleges of supervision models, duration of training rotations and construct of training experiences makes it difficult for rural health services to engage in training with a mix of both Australian Fellows and SIMGs staffing health services. This can be impractical and hard to manage in addition to difficulties in attracting specialists without a trainee workforce.
- There are limitations accreditation can place on rural health services including service delivery and workforce in relation to casemix, rostering and staffing structures to support accredited training.
- Rural health services welcome the opportunity for trainees to work across specialty areas to provide additional medical workforce support and expose trainees to other relevant training experiences that can be offered in a rural area.
- Some health services in a 'local district' health care model can leverage the district health services in meeting some requirements to support training such as tutorials, study groups, and technological support. In some cases, rural health services may not be a part of a larger district or region and reliant on the ability to join networks to participate in training.
- 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 with smaller workforce numbers are particularly impacted which can limit numbers of accredited positions.
- 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.

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 and should explore capacity to train globally across a health service, region, or network to determine accreditation.
- Significant changes in health service delivery that result in changes in caseload and casemix numbers can impact the accreditation status of a health service or training posts.
- 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 decisions and minimise the impacts on training and service delivery.
- Collaborative engagement between Colleges and health services to address any deficiencies and ensure trainees are supported to achieve training requirements may produce mutually beneficial outcomes.
- Opportunities exist to explore networked training and jointly accredit public and private health services in rural areas with many 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.
- Innovative models for specialty training in rural areas have been developed but stakeholders hesitated to submit these to Colleges as they did not fully meet accreditation standards. Some proposals included tele-supervision arrangements not supported by many Colleges.
- 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.
- Sometimes the biggest challenge to overcome is the attachment to a training network and sharing training with metropolitan sites who are sometimes unwilling to accommodate a rural training rotation.

4.11 Withdrawal of Accreditation

- Accreditation withdrawal decisions are often approved at the most senior levels of a College.
- The matter of withdrawal of accreditation is 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 after remedial action was unsuccessful or there are concerns for trainee safety.
- The basis for the withdrawal of accreditation is not always clear for health services or jurisdictions. Jurisdictional health departments advised that frequently they were not advised early enough to provide critical assistance and support to both health services and Colleges.
- Withdrawal of accreditation can be extremely problematic for health services to continue to meet service delivery needs. Trainee safety and support is paramount; however, health services would like to be able to continue to deliver health services and support traning with the sopport of Colleges and jurisdictions whilst remediating any issues.
- There is significant reputational risk associated with the loss of accreditation and this can have a far greater impact on the ability of a health service to attract trainees and workforce long term. With a reduction of accredited training experiences, a rural health service can appear much less attractive.
- When Colleges provide support to health services and work with them to support remediation, there are improved remediation outcomes and compliance with accreditation standards.
- Sometimes the loss of accreditation can be a positive experience strengthening the relationship with Colleges, increasing collaboration between Colleges and health service and improving support for training. It can also support a health service to turnaround the workforce and make significant improvements in specialty departments and for the support of training.
- Loss of accreditation can often be due to lack of staff and supervisors to provide the training or to demonstrate the capacity to train as well as rostering issues related to workforce shortages.
- College mechanisms need to be in place to support health services to minimise risk and impact on workforce and delivery of specialist services for rural and regional communities.

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

Challenges with the accreditation system sometimes impact more in rural health services due to size but are common across the sector whether it is accreditation of metropolitan, private, rural, community or other settings.

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 get it to the accreditation stage.
- The volume of paperwork, data collection, time commitment and the burden of administration related to the accreditation process can be prohibitive for the establishment of new training posts. Re-accreditation often still requires significant data and the production of documentation associated with supporting training.
- It can take health services anywhere from 40 hours to twelve months to prepare, gather and collate data and information for accreditation site visits, often outside of service delivery. The total data set requires a significant amount of specialist time coordinating input from many different people involved in training, often without administrative support.
- There is significant administrative burden associated with multiple specialty accreditation assessments, each with a separate and different process, particularly within short timeframes.
- Health services must accommodate College accreditation assessments with altered rosters to enable specialist staff to meet with College assessors which impacts service delivery due to the availability of workforce.
- There are common training infrastructure requirements and information, such as generic policies, that every college asks for from health services in accreditation standards and criteria to support trainees that are not specialty specific.
- Larger regional centres may have medical education officers and a medical workforce unit to provide education and training coordination and administrative support. This includes oversight of accreditation to ensure that accreditation standards are met, early warnings about issues and potential problems are raised and dealt with. Specialists often coordinate specialty specific accreditation requirements, including site assessments.
- In smaller rural health services, there is often not the ability to fund medical education officer positions leaving specialists to coordinate and support end-to-end local education, training and accreditation, in addition to provision of service.
- In some jurisdictions, there are medical education units at local health district level to support all surrounding health services with accreditation requirements and collating information and data for accreditation assessments.

5.2 The administrative and resource burden for specialist medical colleges

- The accreditation system is very burdensome in terms of administration and resources with sometimes large volumes of training posts or sites to accredit annually.
- The voluntary engagement of Fellows in College activities is critical to the function of Colleges. This engagement varies from approximately 20 to 60 per cent across Colleges. Specifically, for accreditation activities, there is often a limited pool of Fellows available either with accreditation expertise or an interest in accreditation.
- Practicing specialists have limited availability to engage in College activities, often requiring long lead times to plan leave cover. Availability can sometimes be one day at a time impacting logistics of travel across a large geographical area. Some accreditation visits take several days, depending on the location, specialty, the size of the health service and any other linked sites under network arrangements that also require accreditation.
- Availability of specialists impacts the construct of well-balanced accreditation teams with appropriate expertise, knowledge, and the consideration of conflict of interest.
- Not all Colleges have the financial resources, or the volume of Fellows required to support accreditation activities.

5.3 Data management

- All Colleges collect and manage accreditation data in some form. Many have transitioned from paper-based models to technology-based solutions from Excel spreadsheets to purpose-built online platforms to manage data, workflow, and decision making.
- There are still many sector stakeholders who do not have a full picture of the specialist medical training accreditation system. This in itself adds to the administrative burden of accreditation.

5.4 Dealing with issues associated with accreditation

- When issues arise that impact accreditation in one specialty, this can sometimes impact across other specialties, for example, in complex situations related to culture, bullying and harassment.
- Colleges have all developed training policies and statements about wellbeing with a ‘zero tolerance’ on bad behaviour that has also been integrated into most accreditation processes and standards.
- The AMC receives feedback where things go wrong in accreditation relationships between health services and Colleges, particularly when there is a decision to withdraw accreditation. Health services sometimes do not agree with College decisions.
- There are particular issues about confidentiality and safety when raising issues about culture where trainees and supervisors are in close contact, in a small health setting. This can mean that raising issues can be difficult with the impact felt more widely with training, workforce and service delivery all potentially affected. In addition, there is further complexity in small rural areas as the community is often interwoven with the health service and issues can have a greater reach and impact across the community.
- The size of a health service can present challenges in the visibility of issues, particularly larger health settings. In large settings with many trainees and supervisors, there is a greater likelihood of trainees

and supervisors feeling they can speak up anonymously and there is a greater likelihood of the ability of the health service to support the continuation of training whilst responding to the situation and remediating issues.

- The current timing of accreditation cycles are designed to find a balance in compliance and monitoring to ensure that quality, safe and supportive training is occurring and accreditation standards continue to be met.

5.5 Accreditation Process Timeline

- The accreditation of training process is led by Colleges which have accountability for the coordination, administration, and timeframe.
- The administration and coordination of the accreditation process is lengthy and onerous including administration and coordination across the accreditation workflow, particularly for smaller specialties with fewer Fellows supporting the process and limited resources.
- The accreditation process timeline does not always align with College or health service priorities. The time it takes to establish a new accredited training post impacts health services and Colleges' ability to be responsive to workforce needs and government priorities.
- Some accreditation timelines have been implemented to accommodate the lead time for trainee selection, recruitment, and allocation to rotations.
- It can take six to 18 months, in some cases up to two years, to establish a new accredited training post. This omits the enormous amount of background work, negotiation, and data collection to develop a business case for a health service and/or network to support the establishment of a new training post or to accredit a unit.
- Re-accreditation can take approximately three to six months with data and information collection, submission to college, accreditation team site visit, reporting and finalisation of the accreditation outcomes.
- When issues occur at a health service that impact accreditation, it can take 12 months or more for accreditation non-compliances to be rectified by a health service.
- The establishment of new training posts is mainly driven by health service demand.
- Clarity of accreditation criteria and requirements is required to enable health services to plan, develop training capacity and self-assess prior to an accreditation application and assessment.

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

6.1 Valuing the rural training experience

- Colleges need rural specialists to provide rural context for specialties and training. There must be engagement with rural clinical leaders and champions who can drive change locally and across networks, who work in rural areas and engage in rural training and put themselves forward to contribute to college governance committees.
- Recognition and genuinely valuing rural training and regionally based specialty training programs is required to enable and support the expansion of accredited training beyond metropolitan settings. This aligns with the *2010 World Health Organisation* global policy recommendations on *'Increasing access to health workers in remote and rural areas through improved retention'*. Particularly 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'.[14]
- Inclusion of elements of rural, remote and metropolitan practice in the AMC Standards for Assessment and Accreditation of Specialist Medical Program and Professional Development Programs' accreditation standards for specialty training programs may further encourage the development of more training pathways in rural areas.

6.2 Clinical Leadership

- The success of expansion of training in rural and regional areas can be highly variable and dependent on clinical leaders or champions; those specialists with enthusiasm, expertise, reputation, influence, and a willingness to impart knowledge and support the next generation of rural doctors.
- Often the success of a rural training post or health service to support training delivery relies heavily on the advocacy of clinical and medical leaders in a region. It may take years to negotiate the establishment of new training posts and networked training pathways.

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

6.3 Networks

- 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.
- The recognition by Colleges that not all health services can provide the full depth and breadth of training but could participate in a training network to provide a component of training, is positive. This has led to more network training arrangements to ensure that trainees have access to training experiences to complete specialty training across a network of health services.
- Some accreditation standards provide flexibility to accredit smaller health services that may not meet all accreditation requirements as standalone facilities but can participate in training networks. These arrangements support building specialty training capacity and medical workforce in rural areas.
- Not all specialties have formalised training rotations or networks, and for some specialties, there is no centralisation of rotation allocation with local recruitment of trainees required.
- 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.
- Centralised network training arrangements that coordinate trainee rotations sometimes do not allow smaller health services or jurisdictions to select which trainees they receive for rotations to meet service need. This means that rural health services can receive trainees with low level competence that require high levels of support, something which can be challenging in rural areas with limited workforce. This also limits the ability of the receiving jurisdiction, region, or health service to effectively plan and build the workforce it needs.
- Sometimes trainees are not sent to rural training posts at all if there is a shortage of trainees.
- Sometimes trainees are withdrawn mid-term from rural health services to fill positions in metropolitan health services.
- Cross-jurisdictional networks can be problematic with varying pay levels, lack of continuity of entitlements as well as many engineered for trainees to return to their original jurisdiction to complete training requirements.
- Understanding and collaborating within a consortium of stakeholders requires significant time and effort to influence and build relationships and professional networks to establish and maintain training networks.
- Rural health services in network arrangements rely on larger health services to coordinate trainee rotations, for supervisor support, training support including tutorials and educational activities, exam practice and the provision of support for backfilling leave arrangements.

6.4 Private Rural and Regional Health Service Context

- Rural, private health services that are near or co-located with public health services are not always involved in specialty training. Some specialty network arrangements include rural private sites to provide a broader casemix and sometimes to support caseload numbers required for training.
- There is an opportunity to capitalise on geographical proximity and the sharing of specialist workforce between rural public and private health settings to support the expansion of rural specialty training.
- 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.

6.5 Collaboration

- 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 consisting of specialists who understand how to deliver training programs in rural health service environments can support health services in building training capacity, improving training delivery and remediate any identified issues. This is often also supported via informal professional networks of specialists.
- In areas of medical workforce shortage greater support and collaboration is required between Colleges, health services and jurisdictions to enable the support of temporary locum or other supervision arrangements while workforce matters are resolved to maintain accreditation and the trainee workforce.
- A stronger focus at jurisdictional level is required to set and support medical workforce and training targets with greater collaboration with health services and specialties in relation to achieving targets, accreditation and resourcing the administration of accreditation and training.

6.6 College support

- Support provided by College accreditation schemes and training programs to rural trainees, supervisors and health services is vital.
- 'Memorandum of Understanding' agreements have been implemented for some network training arrangements to articulate expectations from each of the training sites, linked sites and main sites in relation to training and trainee responsibilities, including trainee entitlements such as travel and accommodation.
- There has been a significant shift in recent years to Colleges providing more collaborative support to health services for accreditation and training rather than the traditional 'regulator' approach. This has seen quality improvements in supervisor and trainee engagement.

6.7 Increasing high quality rural and regional specialty medical training

- To support increasing accredited training in rural areas, there needs to be a concentrated effort by health services to engage in workforce planning to build a workforce to support trainees and ensure a high-quality training environment. 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 is 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 in the workforce, and capacity has grown to develop business cases for training, health services can submit applications for accredited positions.
- There needs to be a cultural shift to improve medical training with health service executives to ensure training and supervision are core business with allocated time to engage in training. There needs to be management of the tension between service delivery and training to ensure both are equally important.
- There is a need for better systemic structures, resources and support that allow specialty training to be a priority of jurisdictions and across health services to build training capacity and reduce risk.
- Health services must have appropriate mechanisms to drive quality improvements in training frameworks to meet college accreditation standards, deliver curriculum in a way that is easily accessible, support trainees and supervisors and provide the opportunities for trainees to network amongst peers and the broader workforce.

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

- Not all rural and regional services have the full range of services to be able to support accredited specialty training. Sometimes service need does not exist or is limited with insufficient volume, infrastructure to provide the service is not available, the specialist workforce is not present, and the broader health workforce required to support the delivery of the service does not exist.
- There is a risk that requirements for accredited specialty training posts are too onerous for rural sites to accommodate such as time away for training, exams, specific rostering requirements and other non-clinical training impacting the ability of health services to backfill positions and maintain service continuity.
- There are interdependencies for some specialties. ICU training depends on the Department of Medicine and the Department of Anaesthetics and to attract trainees to health services, there needs to be assurance that there are other elective terms available in anaesthesia and medicine.
- Smaller specialties and surgical specialties such as cardiothoracic surgery, paediatric surgery and neurosurgery are unable to expand further into rural areas due to service delivery models and infrastructure centralised in metropolitan settings.

6.9 Accreditation Data Management

6.9.1 Colleges

- 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.
- Each College has its own method of data management varying 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.
- 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.

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.
- The AMC made a submission to the National Registration and Accreditation Scheme, the Independent Review of Accreditation Systems in May 2017[15] on potential changes to current accreditation processes (selection, training composition and remuneration of assessment teams) to increase efficiency, consistency and collaboration'.
- The AMC has upgraded 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'. Such a system can be extended to accredit training posts in health services with health services using the system for training programs making it a useful data source for a range of stakeholders and the administration of accreditation.

15 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

6.9.3 Jurisdictions

- Commonwealth and jurisdictional health departments require data in relation to specialty training to enable not only workforce planning but support to health services to deliver quality training and build sustainable future capacity in the medical workforce.
- Jurisdictions reported that it is very difficult to provide effective support or improvement in specialty training without training pipeline information, accreditation and training outcomes.
- Some jurisdictions collect accreditation data directly from health services with variable results. Data is collected on training posts, health services and training programs, accreditation expiry and any accreditation conditions or requirements placed on organisations.
- Jurisdictions collect data on prevocational training accreditation with some developing technological systems to manage pre-vocational accreditation that may accommodate vocational training accreditation in future.
- Technology driven systems are needed 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.

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. Some Colleges undertake review 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 particular requirements to support specialty training.

6.11 Evaluating College accreditation systems

- Majority of Colleges undertake continuous improvement measures in relation to the accreditation process and broader framework, however, many have not evaluated accreditation performance and are not actively engaging with external stakeholders to participate in such evaluations.
- Changes in College 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.
- There has also been an increase in review of accredited sites, accreditation team composition amendments, 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 changes to 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.

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

- Accreditation in all forms has some positive and negative aspects. Rather than adopting methods or elements of other accreditation frameworks, solutions have been developed for consideration in current College accreditation frameworks.
- There is 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.
- Medicine is a complex regulatory system with no 'pulling together' to improve efficiency and effectiveness and reduce the 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.
- Colleges survey trainees and supervisors at regular intervals covering topics directly related to training experience, supervision and support provided during training. Some Colleges aggregate feedback, 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 of training posts also occurs at local health service and jurisdictional levels and may be specialty specific. This may include peer review and end of term supervision exit interview data on how effective a training position is 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.
- Some health services conduct quarterly surgery casemix comparison with consultants, registrars, and the Junior Medical Officers to assess health service training performance and ensure fair and equitable distribution of training experience and exposure.

6.14 Regional Training Hubs

- Regional Training Hubs (Hubs) provided significant support to health services with direct engagement at clinical level and provide value-add support for specialty training. This was also reflected in the RHMT Program Evaluation in that half of the Hubs are supporting local health services with accreditation processes.
- The support of Hubs in assisting health services in accreditation processes for new posts under the IRTP measure of the STP has been variable.
- Various stakeholders do not support the involvement of Hubs in accreditation. Accreditation is the role and responsibility of the health services to ensure that they meet accreditation standards. An external person or body involved without experience working in health service delivery and specialty medical training is a risk for the health service, medical workforce, and Colleges.

7.0 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 towards 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 the distribution of specialist medical training and workforce 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.