College Discussion Paper
May 2021

# Transition of ACRRM Training Program from Australian General Practice Training by 2023

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

Version 1.5

# Contents

# 1. Introduction

The purpose of this document is to seek feedback from the Department of Health about the College's proposed model of delivery for the ACRRM Fellowship Program following transition of the Australian General Practice Training Program (AGPT) to a College-led system in 2023, this paper does not intend to create an operational plan.

## 1.1. General

The Commonwealth Government has made a clear commitment to build a sustainable, high quality medical workforce that is well distributed across the country to respond to community need.

A wide range of policy decisions and investments have been made over many years to support this outcome, especially for general practice. Substantial academic infrastructure and support has been made through undergraduate medical programs (e.g. Rural Clinical Schools, University Departments of Rural Health), vocational training, retention incentives and, more intermittently, in prevocational training. These workforce initiatives and education programs are currently managed by a plethora of agencies, with little transparency or collaboration in governance, objectives, activities or outcomes.

The Australian General Practice Training Program (AGPT) and the Remote Vocational Training Scheme (RVTS) have been key government responses to GP workforce development since 2001 and 1998 respectively. These programs were designed to deliver enhanced support for Australian College of Rural and Remote Medicine (ACRRM) and Royal Australian College of General Practitioners (RACGP) Fellowship Programs using a delegated network of accredited training providers. Regional Training Organisations (RTOs) were funded and managed directly by General Practice Education and Training from 2001-2016 when this responsibility was assumed by the Commonwealth Department of Health. RVTS has been funded directly by the Department of Health since its inception.

Performance indicators, core policies and funding arrangements for RTOs (including RVTS) were designed by the Commonwealth prior to ACRRM's Fellowship Program being fully accredited in 2007. RTO business models were therefore founded on RACGP Fellowship Program standards and Commonwealth policy requirements. ACRRM's Fellowship Program requirements were later incorporated through ancillary considerations and exceptions. Specific outcomes for ACRRM training were not measured at all until the College assumed responsibility for recruitment to a small quota of training positions in 2017. Neither the AGPT nor RVTS have been comprehensively evaluated at any time.

Transition of the management of the AGPT and RVTS to ACRRM and RACGP was announced by the Federal Minister for Health, the Honourable Greg Hunt, in 2017. The decision was welcomed by the Colleges and widely supported as a positive step by registrars, RTOs and the profession.

This decision provides an important opportunity for the profession to co-design and guide specialist education and training pathways for General Practice (GP) and Rural Generalist Medicine (RG) in Australia.

## 1.2. Consultation

It has been difficult to determine a clear and consistent path for the transition of AGPT to the Colleges since the announcement in late 2017. Australia is moving through a process of health system reform that is likely to see far greater focus on overcoming the geographic maldistribution of our medical workforce as well as rebalancing generalist and specialist disciplines within the workforce. COVID-19 has also significantly interrupted the usual health workforce supply, policy priorities and planning processes in Australia in 2020 and 2021. Additionally it has disrupted and slowed the type and level of engagement that has been possible within the sector.

Despite these factors, ACRRM has undertaken a wide range of informal and formal consultation mechanisms about the transition to College-led Training, including:

- regular conversations with students and registrars;
- meetings with RTOs to increase ACRRM's operational understanding of their delivery models and systems;
- regular meetings between ACRRM and government, ACRRM and RACGP, as well as ACRRM, RACGP and the Department; and
- formal mechanisms such as the Transition to College-led Training Committee and General Practice Training Advisory Committees.

A wide range of engagement has also been held between 2018 and 2021 with key stakeholders and potential partners, including: National Rural Health Commissioner, RG Coordination Units, Rural Doctors Association of Australia, Australian Medical Association, Australian Indigenous Doctors Association, National Aboriginal Community Controlled Health Organisations, GP Supervisors Association, GP Registrars Association, rural workforce agencies, specialist medical colleges, universities, local governments and community groups.

The College has also consistently contributed to wider policy forums on medical workforce planning, National RG Program development, Primary Health Care Reform etc. to ensure policy and decision milestones for transition are informed and aligned as much as possible with future primary care policy directions.

The proposed College-led model of ACRRM training from 2023 is informed heavily by the strategic imperative and opportunity to strengthen the effectiveness and efficiency of ACRRM's program by consolidating the four current program pathways (AGPT, RVTS, Independent Pathway and Rural Generalist Training Scheme) into one.

It is clear there are opportunities to build on the success of the current systems and provide more streamlined and consistent training experiences for registrars, deep and meaningful engagement with supervisors and practices, as well as greater vertical integration across undergraduate and postgraduate medical training. Better links with other specialist medical workforce programs and those of wider health disciplines will strengthen opportunities to deliver systems of comprehensive care to the complex needs of our remote, rural and Indigenous communities.

## 1.3. Building on Success

Over the past 20 years the AGPT and its RTO network have achieved a range of success against the standards and performance indicators that had been set for them. There are now well organised and supported structures for training delivery with skilled educators, trainers and supervisors, as well as program policies, that do not exist to such an extent within non-GP specialist training. There is much to be proud of, particularly against a complex set of systemic problems that are impacting the attraction and retention of the primary care workforce.

The College intends to build on the evidence and success of the AGPT and blend this with its own experience and success in delivering training through Independent Pathway to ensure the ACRRM Fellowship Program remains fit for purpose for the future needs of rural doctors and their communities.

ACRRM manages the Independent Pathway directly. It is a fully accredited training pathway to Fellowship that currently trains approximately 400 RG registrars under a full fee-paying agreement. In the second half of 2021, the Independent Pathway will be enhanced by a new stream of up to 100 Commonwealth-supported training places each year.

The full transition of ACRRM AGPT training to the College in the first semester 2023 will afford ACRRM the opportunity to manage its largest Commonwealth-supported pathway to Fellowship which currently supports nearly 600 registrars through the RTO network.

Transition will provide an opportunity to establish direct training relationships with the majority of ACRRM's registrars, supervisors and training practices/posts for the first time. Removing third-party program management will allow the College to be more accountable and responsive to our training network and vocational learners. Feedback from ACRRM registrars indicate this change is likely to make a significant difference to their satisfaction and experience during training. Many supervisors and practices have also told ACRRM they would welcome a deeper and more engaged relationship with the College to recognise and guide their teaching and training contributions.

The increased flexibility that will be created when the College is responsible for managing the delivery of its own program will allow for reframing existing relationships with experienced training providers as well as forming new partnerships.

ACRRM will build on its existing strategic and operational relationships with key stakeholders across the full continuum of learning (i.e. undergraduate, prevocational, vocational and post-Fellowship) to ensure rural training resources and opportunities are maximised at all levels. It will enable innovative models that are specifically tailored to support an ACRRM Fellowship Program in local communities to emerge and, in collaboration with the RACGP and other specialist medical training programs, form a sustainable part of the rural and remote medical workforce that Australia needs and deserves.

## 1.4. ACRRM Fellowship Program

ACRRM was established by rural doctors in 1996 with the primary objective of improving the quality and safety of care for rural and remote communities by setting fit-for-purpose professional standards for practice, and delivering lifelong education, support and advocacy for the profession. ACRRM training aims to redress the short and long-term problems of attracting suitably skilled medical practitioners to rural and remote regions. The College has grown from a founding membership of 600 rural doctors to a thriving profession of over 5000 including nearly 1000 registrars in training.

ACRRM's standards, training and continuing professional development programs have been fully accredited by the Australian Medical Council (AMC) and are free of conditions (one of only a few colleges in Australia to hold such status). AMC accreditation is a regular and robust external process that ensures that specialist medical college programs are using contemporary, evidence based, best practice in all aspects of their education, training, assessment and registrar support.

Like the RACGP, ACRRM is accredited to set independent training and professional standards for the specialty of GP. And together with the RACGP, the College is also part way through a new AMC accreditation application to have RG recognised as a specialised field of general practice.

The impact that ACRRM's graduates (Fellows) are making on the access to quality care in rural and remote communities during training and over time is significant.

The Fellowship Program provides comprehensive education, curriculum, assessment and support that is focused on the RG scope of practice and provides doctors with the confidence and competence to work in rural and remote communities for significant periods of time. All ACRRM registrars undertake their training in rural towns (MMM2-7) unless there are extenuating training or personal reasons to train in a metropolitan centre for a fixed time.

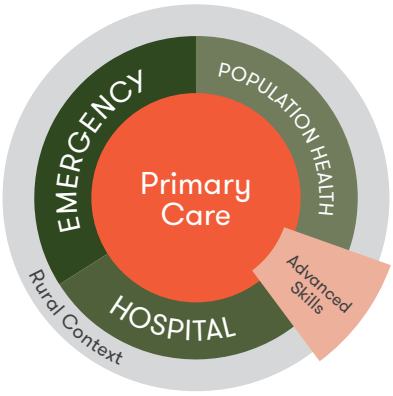
Enrolment in ACRRM programs is the strongest possible predictor that a registrar will become a long-term rural doctor. Eighty-two per cent (82%) of graduates continue to be based in rural or remote towns five years after achieving Fellowship and 49% of those are in small rural or remote locations[1].

Independent analysis has found ACRRM Fellows compared to GP Fellows without FACRRM are 3.24 times more likely to be working rurally, and 4 times more likely to be working remotely[2]. More recent analysis has found FACRRMs are also significantly more likely to be based rural and remotely than doctors with FRACGP and FARGP[3].

## 1.5. RG Medicine

At the core of great RG practice is an excellent foundation in GP. Comprehensive primary care skills which have always been the forte of the GP form the essential platform of rural practice, as in city practice. However, absence or limited access to specialist services in rural areas (relative professional isolation) means that RG practice must also be highly skilled in providing secondary and emergency care services as well as at least one area of extended specialised skills. It is the combination of these competencies, framed by a deep understanding of rural and remote community context and the population health approach, that differentiates the RG learning needs from those of GPs.

**Figure 1: ACRRM RG Medicine Scope of Practice**




The ACRRM Fellowship Program embraces these elements of RG Practice.

1 ACRRM membership database as at Apr 2021. Percentage given of total Fellows 5+years from Fellowship that are based in RA(2-5), and RA(3-5) respectively.

2 Islam A. (2017) What are FACRRM's doing now? A look at the 2014 MABEL data. Conference Proceedings. 5th MABEL Research Forum, May 2017, Melbourne

3 McGrail M et al. (2020) *Faculties to Support General Practitioners Working Rurally at Broader Scope: A National Cross-sectional Study of their value*. International Journal of Environment Research and Public Health.

Internationally, RG has been defined as the provision of a broad scope of medical care by a doctor in the rural context that encompasses the following:

- Comprehensive primary care for individuals, families and communities
- Hospital in-patient care and/or related secondary medical care in the institutional, home or ambulatory setting
- Emergency care
- Extended and evolving service in one or more areas of focused cognitive and/or procedural practice as required to sustain needed health services locally among a network of colleagues
- A population health approach that is relevant to the community
- Working as part of a multi-professional and multidisciplinary team of colleagues, both local and distant, to provide services within a 'system of care' that is aligned and responsive to community needs.

*Ref: Cairns Consensus Statement on Rural Generalist Medicine, 2014 (Clause 7).*

Within Australia, ACRRM and RACGP have defined RG as follows:

> **Consistent with the Cairns Consensus Statement on Rural Generalist Medicine and acknowledging the contextual position statements on Rural Generalism by ACRRM and the RACGP respectively, the two Colleges propose that a Rural Generalist (RG) is a medical practitioner who is trained to meet the specific current and future health care needs of Australian rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care, and required components of other medical specialist care in hospital and community settings as part of a rural healthcare team.**

*Ref: ACRRM and RACGP Collingrove Agreement (2018)*

## 1.6. ACRRM Training

ACRRM's Fellowship Program is deliberately designed to develop a skilled RG medical workforce that meets the needs of the people of remote and rural Australia. It operates at two levels; Core Generalist and Advanced Specialised training and employs an apprenticeship-based approach using a number of learning contexts and education delivery techniques.

ACRRM training often occurs seamlessly across primary and secondary care, with a registrar's experience tailored to the availability of accredited posts at the local and regional level i.e. moving away from the concept of silos of "hospital-based "or "practice-based" training towards a focus on a more integrated learning experience that reflects contemporary models of care and therefore the job of a RG.

Core Generalist Training (36 months) is designed for doctors entering training in their second or third postgraduate years. These registrars fulfil the requirements of the ACRRM RG Curriculum while rotating through accredited training placements in hospital and community practice settings. The practices/posts provide the registrar with a supported and graduated exposure

to the full scope of RG practice. Registrars who complete this part of training will at a minimum have attained skills in rural practice, primary care practice, secondary care practice, obstetrics, anaesthetics, emergency medicine, and paediatrics.

During Core Generalist training, registrars are required to participate in regular online education sessions which focus on the management of common conditions (acute and chronic) in the rural context and relies on the involvement of FACRRMs, other regional specialists and subject matter experts. Registrars also attend specific skills workshops run by the College and clinical education run locally by other education providers and hospital education staff.

Advanced Specialised Training (12-24 months) registrars undertake specifically accredited training placements in at least one of 12 approved disciplines. These training posts are negotiated between the registrar, College and other stakeholders (e.g. RGCUs, RTOs, hospital department heads) and take into account the registrar's career goals, any specific medical service needs for the intended community where the registrar wishes to practice (if known) and the priority health needs for the jurisdiction in which the registrar seeks to practice.

All training is underpinned by comprehensive curricula, learning resources and assessment that are regularly reviewed to ensure it reflects contemporary education and clinical best practice. These standards and requirements are consistent for all ACRRM registrars, irrespective of the training pathway provider.

The ACRRM Fellowship Program does not restrict training locations to any particular State, Territory or regional boundaries. It is a national program that sets requirements for training to be conducted in accredited training posts in rural and remote contexts (MMM 2-7).

ACRRM acknowledges that the government sets policy parameters for distribution of Commonwealth-supported training places. This policy has not been confirmed at the time of writing this discussion paper but it is anticipated such a policy will prioritise training in rural, remote, Indigenous and vulnerable communities.

## 1.7. Increasing ACRRM Training Opportunities

Registrars can currently undertake ACRRM Fellowship training via one of four accredited training pathways:

1. Australian General Practice Training (AGPT), cost of training is fully funded by government
2. Remote Vocational Training Scheme (RVTS), cost of training is fully funded by government
3. Independent Pathway (IP), cost of training is met by registrars themselves (NB: some IP registrars may be eligible to receive up to $15,000 subsidy under the Non-VR Fellowship Support Program between 2019-2022).
4. Rural Generalist Training Scheme (RGTS), cost of training will be fully funded by government (commences Q3 in 2021)

As of 17 May 2021, there are a total of 886 registrars in active training through one of the ACRRM Fellowship Program pathways:

| Region | Current Registrar Numbers* | | | |
|---|---|---|---|---|
| | AGPT | RVTS | IP | Total |
| ACT | 16 | 2 | 6 | 24 |
| NSW | 98 | 6 | 94 | 198 |
| NT | 31 | 3 | 15 | 49 |
| QLD | 233 | 5 | 101 | 339 |
| SA | 34 | 1 | 11 | 46 |
| TAS | 12 | 1 | 11 | 24 |
| VIC | 71 | 3 | 59 | 133 |
| WA | 41 | 3 | 29 | 73 |
| Total | 536 | 24 | 326 | 886 |

ACRRM's ability to attract and train more rural doctors has been hindered by a lack of government investment outside of AGPT and RVTS programs; and the lack of flexibility and/or incentive for the AGPT to produce specific targets for ACRRM graduates.

ACRRM has been limited to 150 funded training places annually on the AGPT since 2017. In contrast the RACGP Program has been able to offer 1350 funded training opportunities every year.

At the regional level this has meant applying for one of a very small number of ACRRM Fellowship places has represented a higher personal risk to aspiring applicants than applying to the considerably larger RACGP Program. ACRRM has not been allowed to compete for a larger number of funded places through the AGPT, despite steady interest in ACRRM training outside of AGPT and RACGP rural training places on the AGPT often remaining unfilled even with significant recruitment efforts.

There is every reason to believe that the move to College-led Training will increase confidence and interest in ACRRM training. A small example of the impact that College leadership can have is the change to College-led selection for AGPT in 2017. College intake targets and processes sparked an increase in ACRRM enrolments that year and subsequent years. This has matched an ongoing healthy demand for IP training, despite the costs for that program being significant and registrars receiving no government support until Q1 2019 when a small subsidy was offered to eligible candidates.

ACRRM is confident the transition to a full College-led Training model will create a positive impact on recruitment and support for registrars seeking careers in RG. The government has shown its trust and confidence in ACRRM to deliver results by awarding the College funding to support 100 RG training places outside of the AGPT or RVTS programs. There is already substantial interest and engagement to support the program. The partnerships and planning for the new Rural Generalist Training Scheme (due to commence Q3 2021) will provide a significant fillip to encourage new and innovative approaches to support ACRRM training in 2023.

Despite the success of RTOs in meeting AGPT requirements, there has been a longstanding perception by registrars that they are not sufficiently invested, or expert, in ACRRM training to provide a high-quality training experience. This perception has had a direct impact on recruitment and retention of ACRRM registrars through AGPT.

Evaluation data has indicated small increases in satisfaction levels from ACRRM registrars in AGPT over recent years, although there continues to be an appreciable gap in satisfaction between ACRRM and RACGP in AGPT. This sense of relative lack of support and understanding has also been demonstrated in exit surveys of ACRRM registrars from AGPT. Many have indicated they have decided to withdraw from ACRRM training on advice of their RTO educator or supervisor, often citing RTO problems in applying ACRRM policy to their own training plans, or simply referring questions to ACRRM for resolution rather than facilitating information or problem-solving themselves. Unfortunately, there also continues to be examples of RTO representatives at recruitment career days stating that they cannot speak to ACRRM training benefits or requirements, despite RTOs delivering the program for nearly 20 years.

The transition of AGPT to a College-led model will provide an opportunity for the ACRRM to oversee and manage all aspects of the registrar experience and administration processes. In doing so, the College will be able to remove past perceptions and increase the professional identity, communication and connection for all current and aspiring Fellows of ACRRM.

Key drivers for increasing demand for ACRRM training places will be:

- Improved workforce planning and programs to incentivise and encourage generalist, and in particular, RG and GP careers;
- Reform of GP training allocations methodology to reflect future workforce needs for both RG and rural GP places, rather than using historic patterns of demand;
- Maximising integration and alignment of marketing, curriculum, assessment and selection processes across the medical education continuum;
- Strength of College-led model in providing a single source of advice and support for training and assessment requirements;
- Authentic RG teaching, mentoring and support by experienced ACRRM Fellows and educators;
- Consolidation of ACRRM training pathways into a single, high quality, well supported program to remove confusion caused by multiple marketing campaigns, training providers, different costs and supports, processes and requirements;

Success of the program will lead to increased confidence and enthusiasm for the program by future candidates.

# 2. ACRRM Fellowship Program Vision

## 2.1. Vision

ACRRM's vision for its Fellowship Program is to:

> "Deliver world-class, culturally appropriate Fellowship training that inspires and enables specialist RGs to deliver excellent healthcare to people in rural and remote areas and Aboriginal and Torres Strait Islander communities."

The ACRRM Fellowship Program will stand alone by providing:

- Dedicated focus on the end-goal model RG practitioner – this approach is highly attractive to a particular national cohort of emerging medical graduates drawn to the model in its purest form and the opportunity to train with peers with this same professional identity and focus. Without this pathway option, these doctors may well be drawn to consultant specialties and forgo the opportunity to gain primary care scope and to undertake an entirely rurally-oriented training experience.
- Dedicated focus on rural workforce outcomes – all elements of the ACRRM program design support the outcome of providing skilled doctors for rural and remote communities. This unity of purpose enables the program design to intrinsically select, motivate and support doctors toward a rural career. This obviates the need for the Department to impose deficit policies to force doctors into rural and remote areas with all the negative outcomes this typically engenders.
- Bespoke design which is directed entirely toward the gold standard RG model outcome but incorporates the facility for registrars to take other GP career paths rather than vice versa. This approach enables the College to design all aspects of its curriculum, program structures and assessment toward attaining excellence in practice as RGs.

## 2.2. Key Principles

The ACRRM Fellowship Program is guided by the following key principles:

- **Registrar-centred**
  Provides flexible, individualised and supportive learning experiences
- **Quality in Training**
  Inspires and promotes quality and safe training practice
- **Healthy Training Environment**
  Ensuring a collaborative and respectful training environment
- **Community-engaged**
  Is contextualised to community needs, responding to the dynamics of healthcare in rural and remote Australia
- **Workforce Development**
  Builds, supports and enables sustainable long-term rural and remote health workforce solutions

**Figure 2: ACRRM Fellowship Program Key Principles**

## 2.3. Goals and Objectives

**2.3.1.** That the overarching framework for delivery of College-led Training is developed in close cooperation with the profession and governments to maximise leadership, collaboration and confidence in achieving better outcomes for communities using scarce resources.

**2.3.2.** That all training pathways (i.e. AGPT, Independent Pathway, RGTS and RVTS) be progressively transitioned into a single, equitable, integrated, flexible College-led Training Program.

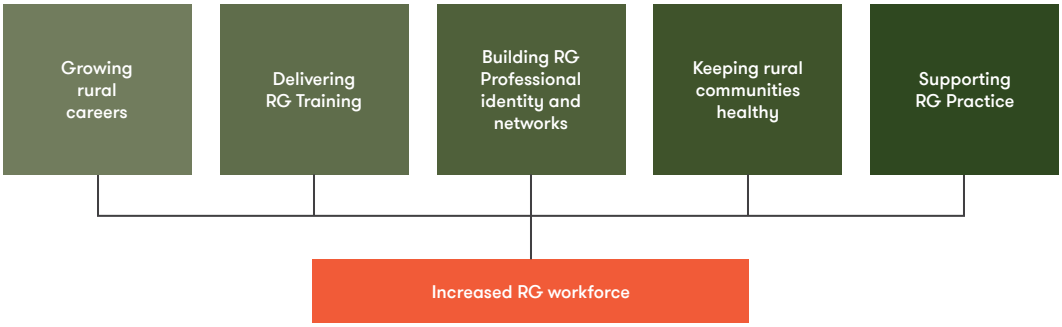
**2.3.3.** The ACRRM Fellowship Program will address the imbalance in medical generalist workforce between rural/remote and urban communities and support Aboriginal and Torres Strait Islander doctor numbers to reach population parity.

**2.3.4.** That the ACRRM Fellowship Program continues to deliver excellence in contemporary medical education in the field of RG with high levels of satisfaction by registrars and supervisors.

**2.3.5.** That research programs are facilitated to support the Fellowship Program to respond to evolving RG skills requirements and rural education methodologies.

**2.3.6.** That vocational training arrangements build rural training capacity and align with strategies to assist national RG and GP career paths and workforce programs across the spectrum of undergraduate, prevocational and postgraduate education.

**Figure 3: ACRRM role in RG Workforce Development**



# 3. Transition of AGPT to College-led Training Model

## 3.1. College Transition Charter

ACRRM commits to:

- Strive to ensure there is no or minimal disruption to the training progression for current ACRRM AGPT registrars, supervisors and training posts.
- Apply a "no disadvantage" approach to all decisions that are within the College's control.
- Maximise continuity of relationships, plans and supports for registrars, supervisors, and training posts.
- Respect and maximise opportunities for leadership, delivery, decision making and innovation at a regional level.
- Develop deeper levels of engagement with our supervisors and training posts and practices.
- Work in collaboration (not competition) with others to coordinate, support and build continuity for registrar training placements.
- Ensure training information, data, systems and processes are transitioned to ACRRM systems in ways that are as safe, seamless and as effective as possible for all parties.

ACRRM also commits to work closely with the RACGP, GP peak bodies, Aboriginal Community Controlled Sector, Commonwealth and State governments and community stakeholders to:

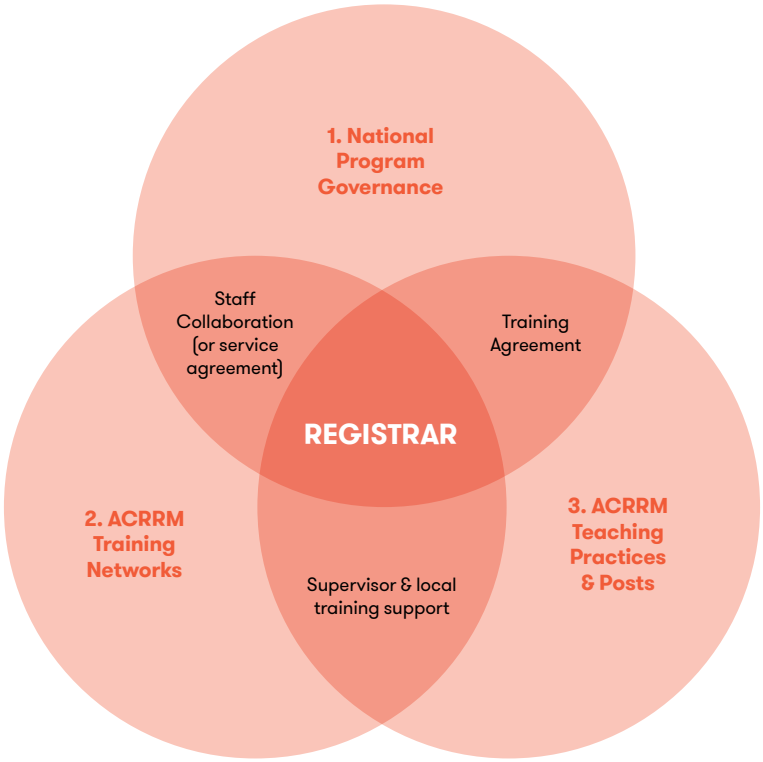
- Attract and train more GPs and RGs to improve access to quality primary care across Australia.
- Strengthen the promotion of RG and GP careers to medical students and junior doctors.
- Increase the supply of GPs and equip them with the knowledge and skills to address the needs of Australia's diverse communities.
- Increase support for cultural education and training with Aboriginal and Torres Strait Islander communities to help close the gap in health outcomes.
- Invest in the training workforce and put in place better training/education support for registrars, supervisors and practices/posts.
- Apply a nationally consistent training and education program that is delivered locally and is contextually relevant and responsive to the community.
- Address workforce shortages and support community needs, by introducing new solutions to training across communities.
- Provide personalised case management and individually tailored support for registrars.

*Ref: RACGP Profession-led Community-based Training, outcomes, April 2020*

## 3.2. Conceptual Model

The conceptual design of ACRRM's delivery model for College-led Training is presented in Figure 4.

**Figure 4: Fellowship Program Delivery Model**




### 3.2.1. National Program Governance

The College will build on its existing operational infrastructure and expertise to ensure that all Fellowship Program requirements are appropriately governed, managed, delivered and supported. These functions include but are not limited to:

- Recruitment and selection systems
- Fellowship Program curriculum and assessment
- Clinical and cultural education and teaching support
- Supervisor engagement, training and support
- Practice and post accreditation
- Registrar training progression and remediation
- Medicare Provider Numbers, data and reporting
- Research and evaluation

The College will continue to work with key partners and stakeholders to define, deliver and monitor these outcomes.

### 3.2.2. ACRRM Training Networks

ACRRM Training Networks (ATNs) will be established to provide context specific expertise and leadership to the program and its outcomes. They will build on the foundations established through the RGTS that will commence in Quarter 3, 2021.

These networks will provide a pivotal point for coordination, promotion and implementation of the delivery of the program. They will drive local marketing, recruitment, registrar and supervisor support for in-practice training, clinical skills teaching and problem solving. They will collaborate with rural training and workforce organisations such as RACGP training systems, Rural Clinical Schools, Rural Generalist Coordination Units (RGCUs) and Health and Hospital Networks.

ATN funding will be weighted to invest in expertise and education services, not physical facilities or major infrastructure. Each network will establish an operational presence through co-location of staff and resources with existing like-minded organisations in rural or regional locations. Technology enabled networks and partnerships will also be employed to deliver contemporary, high quality, models of blended learning and support for doctors training in rural and remote communities. Attention will be given to opportunities to create efficiencies in delivery through targeted resourcing and shared models.

It is anticipated that the ATNs will be capable of rapidly extending the focus of their activities into prevocational recruitment and postgraduate retention activities once the AGPT has transitioned. These might include trainer training, upskilling and skills maintenance, and peer support, mentoring and networking opportunities.

The networks will be managed by a Regional Manager with expertise in education and administration, and will employ a Regional Clinical Director, Training Officer/s, Registrar and Supervisor Liaison Officers, local Medical Educators and administration support. The College will seek to employ staff with experience in ACRRM training who will bring significant expertise and continuity of support where possible. Their work will include engagement with the local Aboriginal and Torres Strait Islander health services and the local community.

A number of Regional Advisory Committees will be formed with medical education partners in each region to inform and plan the development of educational packages, clinical skills workshops, mentoring and peer support networks.

### 3.2.3. ACRRM Training Posts

A key benefit of College-led Training is the opportunity for ACRRM to strengthen its connection to the supervisors and training posts who provide the foundation of the training program. ACRRM will build on its existing national network of accredited training practices and supervisors. It will take a proactive approach to engaging supervisors and posts to support quality teaching and support for registrars on all Fellowship Pathways. This includes incorporation of supervisor input at governance levels and education design as well as in informing the ongoing accreditation model.

Underpinned by a strong accreditation framework in which skills, resources and capacity to teach are key outcomes, the College is currently investing in system design to support an integrated mechanism for supervisor resources, reporting and payment oversight ensuring that in-practice teaching is a priority and recognised appropriately.

The College will also provide resources, mentoring and support to supervisors and training teams in community, hospital and other accredited settings and supervisors will be individually supported through the College case management model providing context to registrar teaching and progression in training.

ACRRM will, through partnerships and collaboration with RGCUs and Local Health Districts ensure capacity building occurs in hospital posts with a focus on skills acquisition and establishing clinical systems of care with other medical and health professionals with a focus on the RG skill set. Hospital-based and non-GP specialist supervisors will be encouraged to be part of the local supervisor networks, including professional development activities.

Training agreements will be established to ensure the teaching expectations are clearly understood and remuneration terms and conditions transparent.

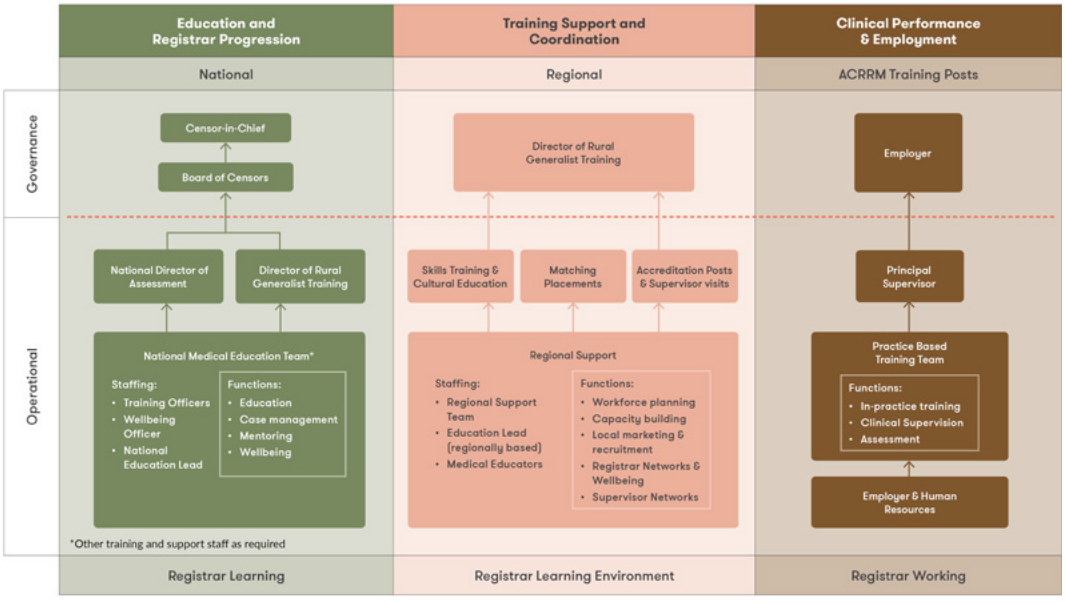
Where posts and training placements are to occur within an ACCHO, the College will leverage relationships with existing cultural education and support networks to ensure training can be appropriately supported and meets both the needs of the community and of the RG training curriculum. Where appropriate, salary support will be facilitated.

## 3.3. Operational Priorities

### 3.3.1. Registrar Support

The proposed delivery model from an ACRRM registrar's perspective is outlined in Figure 5.

**Figure 5: Proposed Delivery Model from Registrar Perspective**




Current as of 31st May 2021

### 3.3.2. Distribution of Training Places

Consistent with ACRRM Training Standards, all training places will be in MMM 2-7 locations, with priority to MMM 3-7 placements where possible.

It is intended that all regions will have a target allocation of registrars. Targets will be determined in consultation with the Commonwealth Department of Health and key regional organisations to ensure adequate distribution of trainees, viable peer learning networks and utilisation of program resources.

### 3.3.3. Consistent Medical Education and Policies

The ACRRM Fellowship Program is a fully integrated RG pathway – its selection, curriculum, education, training and assessment are all purpose designed to lead doctors to the end point qualification for FACRRM and certified RG practice. Accordingly, registrars will undertake ACRRM's existing comprehensive, structured national education package. They will undertake this with ACRRM medical educators and other registrars. The program is mapped to cover all requisite aspects of the ACRRM RG Curriculum standards for Fellowship.

It is delivered using a range of modalities comprising of:

- ACRRM online courses supported by individual project work, assessments and medical educator- facilitated group discussions;
- Linked series of face-to-face workshops and group networking events;
- Emergency medicine skills face to face workshops;
- ACRRM assessment preparation programs and online courses; and
- Supplementation of identified learning gaps using ACRRM Online Learning resource library.

The components of the program are modular allowing localised or national delivery as required. The program is supported and delivered by ACRRM's team of medical educators who participate via remote delivery or travel for face-to- face delivery. Local delivery of face-to-face workshops will be done in conjunction with the regional support team.

The program will operate in accordance with a single set of comprehensive national ACRRM policies with clear processes. These policies are already in place and in use for the ACRRM Fellowship Program and cross-reference specific AGPT policy requirements where relevant.

From 2023, the College will assume direct accountability as the point of contact, advice and decision making for registrars, supervisors and practices in all matters related to its program policy, assessment and curricula. This will improve the consistency of application of the program regulations for all registrars. It will also provide the College with a wider perspective about the application of its policies and procedures and therefore opportunities for continual improvement of the program.

### 3.3.4. Cultural Education and Support

Aboriginal and Torres Strait Islander healthcare represents a much greater proportion of rural and remote practice than it typically does in cities and the College views cultural education and support as an especially important aspect of its Fellowship Program.

It is recognised that many aspects of the funding and requirements to support Aboriginal and Torres Strait Islander health training continue to be subject to discussion and negotiation.

The College recognises the importance of taking a strong partnership approach. It will aim to deliver this education and support in a manner which is aligned to our Fellowship Program and which also enables Aboriginal and Torres Strait Islander peoples and their representative organisations, to exert leadership in its content and delivery.

The College recognises the expertise and the important role that peak organisations including NACCHO, AIDA, IGPRN, LIME and the Cultural Mentors Network all have to play in this area.

The College will continue to progress discussions regarding the detail of how this will be achieved and is open to taking a collaborative, national approach.

### 3.3.5. ACRRM Accredited Training Posts and Supervisors

Accreditation standards for training posts and supervisors are set nationally to ensure high quality training, providing a clear framework for development of training posts but accommodating the varied contexts of regions and the considerable diversity of training settings.

ACRRM accreditation will continue to be managed nationally and be supported regionally using a range of models and partnerships as appropriate to each context and in light of the emerging roles of RGCUs in each jurisdiction.

It is noted that the government has recently announced an upcoming review of GP practice accreditation, including GP teaching post accreditation. ACRRM looks forward to contributing to that review in detail to ensure that future accreditation models and processes appropriately meet the needs of ACRRM's training program and teaching network.

### 3.3.6. Fit-for-purpose Regional Partnership Models

The ACRRM Fellowship Program is uniquely positioned to take a flexible approach to its delivery and implement the regional models most appropriate to the needs of each regional context.

ACRRM intends to establish operations that build on existing regional capacity and address the needs and circumstances particular to each region where training occurs.

In seeking to achieve this, the College has the following key priorities:

- to build training capacity in areas of RG workforce need;
- to leverage existing training resources appropriate for ACRRM training;
- to collaborate with like-minded partners to build an integrated and mutually-supportive approach to training and workforce for rural and remote communities;
- to ensure that state RG Coordination Units and health and hospital networks are integrally involved in shaping training opportunities and models of care in rural towns; and
- to directly engage local doctors, practices, ACCHOs and staff within communities.

ACRRM will build on successful models of regional delivery providing continuity to partnerships and outcomes where they exist. A stepped process will be applied in other communities to determine appropriate models for those regions.

The College will employ regional staff to facilitate and strengthen collaborative arrangements with RGCUs, state health departments and local posts, ACCHOs and other health services. Strategic partnerships will be strengthened with other organisations that play key roles in the architecture for rural medical education and workforce, for example, RTOS, rural student networks, universities, regional clinical schools, regional training hubs, rural workforce agencies, and primary healthcare networks.

### 3.3.7. Funding that Addresses the Costs of Training in Remote and Rural Communities

ACRRM wishes to increase the attraction and value proposition of both training and supervision in rural and remote locations by appropriately remunerating training costs.

Ideally, funding structures will be tailored to ensure that training practices and posts are sufficiently supported to meet the additional private and systems costs for participating in training from rural and remote locations.

This strategic enabler recognises the challenges associated with rural and remote practices, including limited patient catchments, low socio-economic demographics, high bulk-billing rates, and recurring workforce shortages; as well as the expectation that ACRRM registrars undertake hospital and afterhours practice.

### 3.3.8. Sustainable, Low Overhead, Administration Costs

ACRRM's business case will be shaped to realise cost efficiencies across the sector wherever possible but especially by avoiding investment in facilities where partnership approaches can be negotiated.

The reduction of some administration systems and the consolidation of management systems across College pathways will allow ACRRM to establish economies of scale alongside data and operational systems efficiencies.

Business systems integration in particular will allow the College to deliver more consistent approaches to evidence and accountability of the program outcomes.

# 4. Investment, Infrastructure and Funding

The Department of Health has suggested a number of important proposals for reforms to try to better align the education and training needs of the ACRRM and RACGP Fellowship Programs with the medical workforce priorities of the government, in particular the need to increase the number of GP rather than non-GP specialists, and to increase the distribution of medical practitioners in rural, remote and vulnerable communities.

These investment, infrastructure and funding arrangement proposals for GP Training are under active consideration by the Department and the government as part of their expectations of the AGPT transition process. While these are outlined and discussed briefly below, it is important to note that none of these proposals have been fully developed or decided at the time of writing this paper.

Each proposal represents a significant change. Each provides both opportunities and risks for the future GP training system and each would have a significant impact on the transition activities and development work that ACRRM and RACGP need to undertake to successfully transition AGPT to College-led arrangements by 2023. Therefore, the timing of any significant reforms would need to be carefully understood and balanced by the risks of the work being completed in the relatively short timeframe remaining to transition between systems before 2023.

## 4.1. Workforce Organisation Networks

The Colleges and Department of Health are jointly considering the best approaches to deliver workforce planning and distribution support for the Colleges, practices and other settings involved in training GPs, and to the communities which benefit from health services delivered during training and beyond.

The Department of Health has proposed that a new Workforce Organisation Network (WON) could be created to provide a comprehensive, multidisciplinary approach to health workforce planning, analysis and prioritisation. This new health system infrastructure would potentially see GP Colleges, other specialist medical colleges, nursing and allied health professional associations, government departments and agencies all interacting with and through WONs to create an integrated approach to data, planning and distribution of health care workforce at all stages of their career continuums.

Indicative functions a WON might provide to ACRRM and RACGP training programs have been suggested as follows:

- Advice to Colleges on priority registrar placements
- Practice engagement and needs assessment and provision of advice to Colleges regarding gaps and issues
- Advice on the prioritisation of training locations to the Department and Colleges
- Workforce planning and community needs mapping
- Other functions as per health workforce requirements.

Producing the sufficient number and distribution of skilled medical workforce is embedded in the College vision statement for 'the right doctors, in the right places, with the right skills providing rural people with excellent healthcare" and is thus the primary outcome of the ACRRM Fellowship Program. ACRRM is therefore supportive in principle of any additional resource that could improve the provision of data, evidence, expertise, and support to guide our decisions and training outcomes.

That said, the integrity and performance of the College Fellowship Program and its relationships with its learners, teachers and training contexts must remain central to ensure the ongoing credibility, success and quality of our graduates. Strong profession-based relationships and trust are always critical foundations for any apprenticeship-based training system. They will continue to remain crucial in future to build the attractiveness of generalist careers paths and the confidence of the current profession in the Program. The risks to small rural practices in needing to engage and respond to new workforce organisations could be significant, particularly if the type of engagement crossed over with College engagement on training support, registrar placements or planning.

ACRRM's support or otherwise for WONs within the context of GP/RG training will depend entirely on the demonstrated ability for this new structure to provide better information to support decision making and aligned investment in rural health workforce teams. Considerable discussions and co-design would need to occur to map business rules, systems integration and effective operational roles and relationships.

Under no circumstances would ACRRM support the introduction of WONs if it was contingent on significant amounts of current AGPT training resources being diverted to fund the establishment of new workforce infrastructure.

ACRRM believes it would not be feasible to build WONs into the planning for transition of AGPT in 2023. There is no detail available about scope or functions of the WON/s at this time, no understanding of the operational intelligence and linkages that would be required across all specialties, no confirmed budget for the WONs and insufficient time to develop and test these prior to the transition of AGPT to the Colleges.

If government were to support a WON as part of future workforce support, ACRRM would be pleased to contribute to planning and design of the Network, particularly as it applies in the rural medicine and rural heath context.

## 4.2. Nationally Consistent Payment Benchmarks

ACRRM strongly supports the proposal to introduce a nationally consistent remuneration benchmark for financial support for Registrars, Supervisors and Practices. The College believes this will bring much-needed transparency and equity to GP training across the country and prevent the risk of competition and uneven playing fields evolving between ACRRM and RACGP in their engagement of supervisors, practices and training environments.

It is understood the Department of Health has committed to explore this option as a priority so that it can assessed and potentially implemented as part of transition in 2023. ACRRM looks forward to participating in this consultation process.

## 4.3. National Funding Pool for Training Payments

It has been proposed by the Department of Health that financial allocations for payments to registrars, supervisors and training practices/posts will be held centrally by the department/government rather than paid to the Colleges up front on the basis of the number of individual registrars enrolled. It is understood that these funds could then be drawn down by each College according to actual training service provision (e.g. six monthly or annually) or paid directly to the recipients by the government on authorisation from the respective College (see 4.6 below).

ACRRM is supportive of this proposal in principle as it has the potential to provide greater flexibility in the investment of GP training funds when there are variations in registrar enrolments, or early completion of training etc. However, this support would be contingent on mechanisms also being developed to provide opportunities for business cases to be funded to equalise or incentivise training practices in remote, rural or vulnerable communities (examples are discussed in 4.4 and 4.5 below).

College support for this concept is strictly conditional on the process being designed to reinforce rather than fracture the primary relationship between the College/s and their respective and shared registrars, supervisors and teaching posts.

## 4.4. Rural Loadings

ACRRM strongly recommends a consistent national approach to rural loadings across training payments to offset the additional work created through limited workforce capacity and the additional costs of delivering and participating in training and education in rural and remote communities compared to urban settings.

There is considerable evidence to demonstrate it costs more to run a community-based general practice in rural communities, and to undertake training requirement from a rural or remote base. It is important that this potential barrier to rural training is removed.

## 4.5. Investment in Building Capacity and Innovation

A Commonwealth funding pool for GP/RG innovation is strongly recommended to support additional investment in training capacity and targeted investment in building RG/GP training delivery for rural, remote and communities of special need.

Such a funding pool could potentially be used to support employment models and strategies for registrars during their training e.g. single employer models, salary top up models, and transferrable entitlements.

This funding mechanism would operate on a national merit-based system, with transparent criteria and assessment processes. It should rely on College support for any funded model and be evaluated to build evidence and case studies for education and workforce development more broadly.

## 4.6. Centralised Government Payment System

It has been proposed by the Department of Health that Services Australia would process all financial payments for training services and incentives on approval by the relevant College for the services/supports they are entitled to receive.

There has been insufficient detail shared with ACRRM to form a view about the potential of this reform. ACRRM would recommend considerable engagement and consultation with practices and supervisors before such a change was introduced to ensure it created desirable efficiencies or benefits to them.

Based on the limited information available and the likely scale of ACRRM's program in the short to medium term, ACRRM does not believe this reform would create any significant level of saving to the College's administrative time or costs. We would also be concerned if the approvals and auditing processes for payments was onerous or unconnected to other training program data and reporting processes.

Significant business systems integration systems would need to be developed and tested between practices, Colleges and the relevant government payment agency/s before this was implemented. It is ACRRM's firm view that this could not be achieved before 2023 but could be developed over a longer period if the decision was made to proceed with this change.

## 4.7. Aboriginal Salary Support Program

ACRRM supports the proposal that investment in the Aboriginal Salary Support Program (ASSP) continue and that it be based on a single national process, rather than splitting the total investment between the two Colleges. This will maximise the collaboration and funding available to improve outcomes for the Aboriginal health sector.

It is understood the Department of Health will lead consultation about the administration of the ASSP in the near future.

# 5. Key Risks

The transition of a mature program of this scale, complexity and nature of the AGPT brings a considerable range of risks. The College considers the following risks as key.

## 5.1. Training Delivery or Progression being Disrupted

There is a major risk that current registrars, supervisors, and practices will have their training plans and systems significantly disrupted if the transition process is not managed effectively. In the worst case a critical failure in transition of information could lead to registrars' being unable to work, or their completion of training requirements for Fellowship being delayed. ACRRM takes this risk very seriously and has committed to make its approach to transition registrar-centric for this reason.

The College's track record of successfully delivering its Fellowship training program directly for the past two decades provides a major mitigation against this risk.

The College has strong and current education and administration capacity within its staff and resources.

College systems and authorities are in place to manage, record and approve critical aspects and decisions of the program implementation (e.g. issuing Medicare Provider Numbers). ACRRM has been systematically building on its established education delivery structures, and modifications to its administration and reporting systems have been informed by the Department of Health as necessary. Work toward scaling up and enhancing these systems is continuing and they will be user-tested prior to 2023.

Continuity for registrars and their training posts will benefit in particular from the established systems within the College to enable direct relationships and ongoing relationships with registrars, supervisors and administrators on the AGPT. These include designated training officers, and multi-level engagement systems with each RTO. To ensure the continuity of access to locally based staff, resources, and capacity the College is undertaking a systematic approach to identifying training services needs and establishing appropriate agreements and collaborations to support these.

## 5.2. Parallel Major Reforms

There are a range of major policy and program reviews and reforms in progress by the Commonwealth government (e.g. National Medical Workforce Strategy, Primary Health Care Review) all of which have the potential to impact the expectations and outcomes for GP training investment. The Department has also identified a range of potential reforms to the architecture of medical training infrastructure that is funded to support GP and RG workforce development. Needless to say, each major policy or investment change will have a significant impact on the design and resources of College-led Training models.

ACRRM considers there is now insufficient time to progress and resolve most of the GP training reform concepts in time to inform AGPT transition. Attempting to manage multiple reforms at this point will force the Colleges, RTOs and the Department to spend significant time and attention on informing and establishing new systems rather than transitioning current ones. This will compound the risks outlined in section 5.1.

The College recommends this risk is best mitigated by prioritising those reforms that must or ideally should be made before 2023 and continue to explore others over a longer timeframe with the benefit of operational College-led programs and clarity of the government's wider primary care policy directions.

## 5.3. Lack of Consistent Communication

There is significant and growing commentary in the public domain about the transition path and timeframes. This is exacerbating a sense of uncertainty in the sector and a lack of trust in the process going forward and is potentially discouraging general practice and rural general practice enrolments.

ACRRM has attempted to mitigate this risk by ensuring communication and consultation is accurate and consistent with the decisions of the Department of Health and Towards College-led Training Advisory Committee agreements.

ACRRM recommends that a shared understanding of communication and messaging be developed by the Department of Health and the Colleges as a priority.

# 6. Key Decision Timelines and Deliverables

This paper is presented in a context where a number of key variables remain undecided. The timelines and workplans should thus be viewed with recognition of the contingencies that have the potential to necessitate fundamental planning changes. Pending decisions around the scope of the College's responsibilities, their funding mechanisms, and timelines, the paper provides as much clarity as possible around the principles and approaches of its model, implementation, and risk management.

In particular it should be recognised that there is no confirmation of the range of deliverables for which the College will have responsibility, what funding or resources will be available for the delivery of these, nor what if any capacity the College will have to grow its program going forward through trainee allocations.

| ACRRM | Government |
| --- | --- |
| **Quarter 2, 2021** | |
| • Development of ACRRM MPN and data reporting systems<br>• RTO Accreditation reviews<br>• RTO engagement on selection, registrar management, education research grants, academic posts, policy, appeals and remediation<br>• RACGP and Dept collaboration on transition related information requirements<br>• ACRRM commences supervisor and practice support mapping<br>• ACRRM manages Intake 1 of AGPT 2022 selection | • Confirm training program outcomes<br>• Confirm investment in GP training delivery infrastructure and systems (i.e. WONs, centralised payment system, standardised payment levels for registrars supervisor and practices, Aboriginal Health Salary Support Program) |
| **Quarter 3, 2021** | |
| • Continue to develop MPN and data reporting systems<br>• Manage recruitment for Final Intake AGPT 2022<br>• Engage with RTOs for supervisors and practice support mapping<br>• Operational mapping of registrar and training data with RTOs<br>• ACRRM implements RGTS<br>• Participate in College assurance process as defined by Government<br>• Respond to Government Grant Opportunity Guidelines | • Confirm key policy parameters (i.e. distribution policy, pathway policy, training place allocations policy)<br>• Confirm College training models<br>• Confirm financial parameters<br>• Confirm Grant Opportunity requirements |

| ACRRM | Government |
| --- | --- |
| **Quarter 4, 2021** | |
| • Propose distribution models for CLT from 2023<br>• ACRRM commences operational mapping of registrar and training data with RTOs<br>• ACRRM to commence supervisor systems and accreditation support systems build on emerging projects | • Approval of distribution models for CLT from 2023<br>• Practice and supervisor recruitment campaign |
| **Quarter 1, 2022** | |
| • Oversee approval process for RTO System Development<br>• Oversee approval processes for RTO Education Research Grants<br>• Actively participate in the College assurance processes as defined by Government | |
| **Quarter 2, 2022** | |
| • Finalisation of College Grant opportunity as dictated by department timing<br>• Proactively work with RTOs for the transition of registrar data<br>• Proactively work with RTOs on key elements for transition to Colleges | |
| **Quarter 3, 2022** | |
| • Commence transfer of registrar and training data to College systems<br>• Recruit staff<br>• Finalise College assurance process<br>• Active accreditation of practices following national recruitment campaign | |

| ACRRM | Government |
| --- | --- |
| **Quarter 4, 2022** | |
| • Continue transfer of registrar and training data to College systems<br>• Establish contracts with subcontractors (if applicable)<br>• Recruit staff | |
| **Quarter 1, 2023** | |
| • Continue transfer of registrar and training data to College systems<br>• Begin Contractor compliance<br>• College provision of MPNs<br>• Full MDS Training and data reporting to department<br>• Liaison with new Aboriginal Health Training for salary support applications | |

# 7. Monitoring and Evaluation

Monitoring and evaluation will be an ongoing process. Key issues which will be monitored include:

- Strategy implementation;
- Extent interaction and collaboration with RTOs and other providers;
- Registrar, supervisor and training practice engagement/enrolment;
- Numbers of graduates;
- Retention outcomes over time;
- Educational performance indicators to determine the appropriateness and acceptability of methodologies used; and
- Health care needs of rural community.


## Contact

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