Position Statement: Integrated rural training hubs

Endorsed: November 2016

Preamble

In 2013, the Royal Australian College of General Practitioners (RACGP) was commissioned by the Commonwealth to develop national policy options for connecting and enabling an integrated rural training pathway for medical practitioners. The ensuing policy statement, *Final report: new approaches to integrated rural training for medical practitioners*, with its key recommendation to invest in integrated rural training hubs, helped shape the Australian Government's new *Integrated Rural Training Pipeline for Medicine (IRTP)* announced in December 2015.[i]

A key part of the Government's $225 million rural health workforce initiative, the new pipeline investment will commit $94 million for 30 new regional training hubs; support for rural based interns as part of a new Rural Junior Doctor Training Innovation Fund; and expansion of the Specialist Training Programme to provide 100 new training places in rural areas.[ii] The Department of Health request for proposal for the first component of the pipeline measure – regional training hub funding – was released on 11 October 2016.

Strategic objective

There is significant support for the creation of vertically and horizontally integrated rural learning hubs enabling longer and more effective rural placements. For policy success, it will be important to ensure a focus on the areas already functioning well, to build further capacity in these local areas by utilising established links and partnerships. Each developed hub must make use of strategically aligned partnerships at the local level, which include the many existing integrated RACGP Rural aligned teaching practices.

At this critical point in the policy cycle RACGP Rural is seeking to work collaboratively with each hub to guide implementation and support partnership discussions through:

(i) Facilitating access to our vast member base on the ground in training hub areas to mobilise support for these sites;
(ii) Links to our established GP-led multidisciplinary teaching teams to build local area capacity and provide opportunities for integration;
(iii) Providing expertise and implementation advice through participation on formal governance committees;
(iv) Bringing a national overview and perspective which can help to facilitate networks between the hubs in realising longer-term workforce goals.

Position summary

The RACGP welcomes the Australian Government's strategy to support rural medical training nationally through the creation of 30 regional training hub sites as part of its IRTP strategy.

For over 20 years RACGP Rural has called for system reform to enable stronger coordination to link the different stages of training in a rural setting, from medical school to rural practice, through a more integrated training approach. Each community is unique and presents a challenging setting for those providing healthcare and working to improve health outcomes. Community level investment is warranted to enable communities to develop localised training solutions, which match their healthcare needs and service construct.

It is envisaged that the regional hubs initiative will provide the required assistance for the learner to navigate the system and build training capacity at the local level. Allowing for flexibility and choice of placement for the learner is important. Therefore ensuring as many rural and remote locations are supported as possible will be vital to the success of the model so that training can be tailored to the community setting and against community need. The approach will help lift key barriers for both teacher and learner, overcoming past policy weaknesses, through providing an essential policy framework to enable integration across the full training continuum.

Key partner

A hub partnership

The coordination of medical training is compounded by structural arrangements that are presently complicated by variations in arrangements between jurisdictions. How well the hubs model can overcome these barriers to provide a comprehensive rural training experience and seamless transition from undergraduate training into rural practice remains untested. Structures will be required to ensure local solutions are found and implemented so that supports can be customised to local arrangements in order to meet variability across rural settings. A clear governance model which includes the specialist colleges and regional training providers is needed to guide comprehensive, aligned, evidence based action.

In facilitating policy implementation, RACGP Rural - as a key regional hub partner - can support hub sites meet program objectives through essential community links which can:

- Build that vital community connection for trainees through our extensive rural general practice base nationally;
- Enable a broad and varied training experience, supporting multidisciplinary training aims, meeting the needs of the learner and the learner's future community;
- Support rural streaming ensuring more community-based rural general practice experience for rural interns;
- Help harness existing teaching effort as well as support the hubs draw out untapped teaching capacity;
- Ensure training reach beyond regional centres through facilitating connections to enable participation of the more rural and remote based GP practices;
- Support local workforce needs analysis and essential skills planning through member informed input to help align training with community need;
- Informing processes to streamline training requirements, including accreditation, across the stages of training.

The following section expands on these important areas outlining how a strong partner based hub approach will support a national system of coordination for a more integrated and consistent strategy benefiting both teacher and learner.

Policy requirements

A number of key policy parameters to guide training hub development were formed during extensive consultation with our rural membership over a six month period to January 2014 to develop national policy options for the Department of Health. A policy consensus was reached by our membership on the rural hub model in facilitating training integration across the full training continuum. Reiterating the potential benefits and efficiencies through enabling a more integrated approach, as developed by our membership, is provided here to guide implementation.

Rural training hubs

The multidisciplinary rural training hub model supports a critical mass of students, facilitates a community connection that can continue throughout training and harnesses teaching effort to build sector capacity in a region. Supportive structures inherent to the hubs would encourage broad team-teaching and learning approach and help draw out untapped teaching workforce across a range of disciplines. It is envisaged that training hubs would enable the required connections encompassing the use of available expertise through community partnerships to ensure training can be tailored to the community setting to address need.

Key benefits:

A supportive framework

- Facilitates the supportive framework needed for a more viable and integrated rural training approach and experience, with governance structures that actively facilitate collaboration between medical training stakeholders, jurisdictions and the community. These structures need to recognise the responsibilities of all key stakeholders, including the teacher and learner, in ensuring that the relevant regulatory requirements, curricula and standards are being addressed.

Meeting community need

- Rural-based community education, aligning training needs with community need, linking medical workforce with patient outcomes data, to ensure that doctors are training where they are needed, thus meeting both the needs of the learner and the learner's future community;
- Builds capacity to support skill acquisition (advanced skills) training for practising GPs to meet patient need, recognising that attainment and maintenance of these skills needs to be contextually relevant and responsive to the community's needs.

Support of rural intention

- Replaces compulsion with choice and flexibility allowing for a broad and varied training experience including choice of quality training placements for the learner;
- Provides support across the full training continuum, enhances connectedness, support of rural intention and maintenance of links to community.

Stronger training integration

- Supports a critical mass of students (multidisciplinary) who make community connections that continue in intern, prevocational and vocational training years;
- Links the different stages of training in a rural setting offering a seamless transition from undergraduate training to rural general practice.

Coordination and connectedness

- Lifts administrative barriers of both teacher and learner through coordination support and streamlining of training requirements, including accreditation, across the stages of training from intern, prevocational and vocational training years;
- Harnesses locally available expertise better utilising the locations with capacity and networks, by encouraging team (multidisciplinary) teaching and learning approaches and identifying innovative solutions to address gaps where capacity and networks need to be developed.

Policy shifts

Navigating the system from medical school to rural practice is complex and currently unnecessarily inflexible, leaving little choice to truly empower career decisions. The training system requires a more **integrated strategy** to allow for a seamless transition through the training continuum. Several policy changes are required to enable this integrated training approach, which prioritises **broad generalist training** in a rural location throughout all years of medical training.

Policy responses must remove the current barriers for both teacher and learner, influence a strong teaching culture, provide for a quality training experience with seamless transition from undergraduate training to rural and remote general practice. It is through building local networks across disciplines that more sustainable training solutions can be found.

Enabling integration

To achieve integration the trainee should be able to easily navigate the system from medical school through to rural practice. They must be supported to make informed choices and access structures that facilitate a quality training experience. The negativity associated with rural training and rural general practice can be removed by quality early rural training experience, eliminating compulsory terms and allowing flexibility in the training continuum for skill acquisition.

For the learner

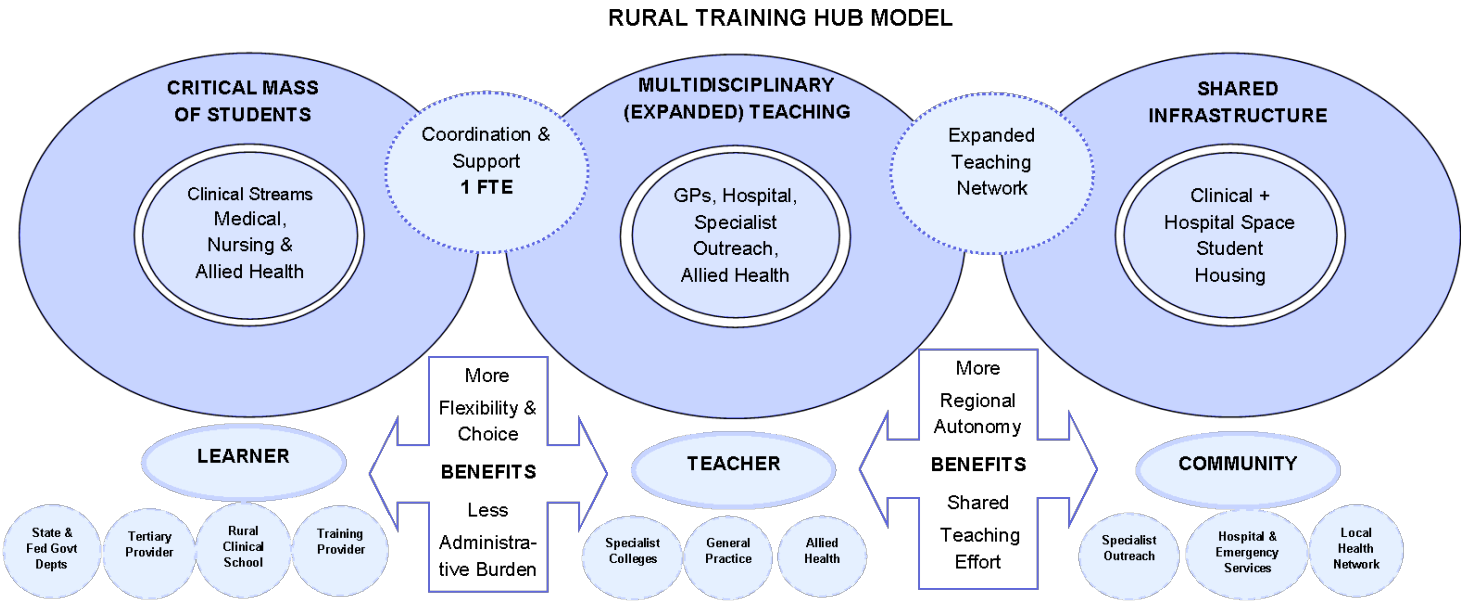
1. **Nurturing rural intention** by enabling learners to maintain a link to a specific rural community throughout their full training years. Members feel that sufficient rural exposure opportunities and providing more training certainty with appropriate flexibility and supports will work to support rural intention.
2. Providing **broad, varied training opportunities** with adequate balance between skill-specific training and broad generalist training will ensure learners are trained first and foremost as generalists with the broad skills needed to meet community need. Time spent training in hospital and community settings must be balanced and reflective of emerging service shifts which require new models of care with more emphasis on community based care.
3. **Support to navigate the system** from medical school through to rural practice. The provision of a community-based training coordinator (hubs diagram further below) would help to address the burden placed on the teacher supervisor.
4. **Flexibility** in the training system with multiple entry and exit points with structures to empower career decisions and added supports to nurture rural intention.

For the teacher/supervisor

1. **GPs work in teams and therefore should train in teams**. More flexible models of training are needed which support integrated and multidisciplinary team teaching. These approaches would reduce the administrative and teaching burden on supervisors, increase training capacity and produce more sustainable results for rural training.
2. **More flexible and innovative models of supervision** are needed to support on-site supervision in rural and remote areas, including models which enable broader community partners and professional expertise to provide niche teaching models (e.g. aged care or diabetes management).

Policy solution

An **integrated rural training hub** model brings each of these elements together, enabling the critical mass of learners and teachers needed for sustained rural training success. The model allows for longer rural placements to maintain learner connection to community, and provides the linkages and supports needed to navigate the training system which are currently lacking.



The model harnesses localised training effort, utilising locations with capacity and training networks to establish a supportive structure which encourages team teaching and learning. Significant, targeted investment is required to make it work. The appointment of a **training coordinator** is also an important feature, to support both the teacher and the learner and to help lift the administrative burden from teacher/supervisor.

The model relies on local autonomy, secured through flexible agreements between key training participants (shown in diagram) which are spread across education and training (pre- and post-graduate education, prevocational and vocational), specialties and levels of healthcare (primary, secondary and tertiary).

References

[i] The Royal Australian College of General Practitioners. Final report: New approaches to integrated rural training for medical practitioners. 2014. Available at http://www.racgp.org.au/yourracgp/faculties/rural/projects/nrtp/

[ii] Australian Government. Media release: Building a health workforce for rural Australia. 2015. Available at http://www.health.gov.au/internet/ministers/publishing.nsf/Content/40FEE0992461C3C9CA257F1C001DB8E5/$File/SL150.pdf