

Independent Evaluation of the Rural Health Multidisciplinary Training Program



Appendices to the Final Report
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Australia

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Appendix 1: Program Parameters

1. Deliver effective rural training experiences for medical, nursing, dental and allied health students (prior to gaining professional registration).

- i. Identify students to undertake rural training as part of the course curriculum requirements.
- ii. Provide structured rural residential clinical placements which contribute to the requirements of the relevant curriculum.
- iii. Ensure placements are of a length that supports genuine engagement with the community and are in line with available evidence on improved rural health workforce recruitment and retention.
- iv. Support opportunities for inter-disciplinary learning.

2. Ensure rural training experiences are of a high quality.

- i. Ensure student safety.
- ii. Work collaboratively with health service organisations to put in place processes to ensure patient safety.
- iii. Ensure students are well supported by rural academic staff, health professionals and community representatives.
- iv. Provide effective cultural safety training to students.
- v. Provide training to at least an equivalent standard to that delivered in metropolitan settings.
- vi. Provide relevant rural practice training to students.
- vii. Maintain internal evaluation mechanisms to assess the quality of placements and student satisfaction.

3. Student selection and rural student recruitment

- i. Increase the number of rural origin students selected for entry to the University's health courses (including those studying in health professions other than medicine).
- ii. Identify and support those students with a genuine interest in rural health practice and prioritise these students for long term rural placements and activities funded through the RHMT programme. Identification of students should be based on evidence to maximise rural health workforce outcomes e.g. time spent living in rural areas or previous engagement in rural training. This could be achieved by introducing:
 - ▶ a 'rural stream', with flexible entry and exit points; or
 - ▶ selection weightings to preference those students considered to be most likely to pursue an interest in rural health.

4. Engagement with key partners and the local community to support the delivery of

training to students

- i. Work collaboratively with the community, state/territory health bodies, non-government organisations, universities and other complementary organisations to support the delivery of positive training experiences for students.
- ii. Encourage local health professionals and community members to mentor and support students on long term placements.
- iii. Encourage academic and administrative staff to live in rural areas as part of their local community.
- iv. Encourage academic staff to undertake clinical practice in the community.
- v. Provide training for rural health practitioners to better support the delivery of rural clinical training to students.

5. Maintaining and progressing an evidence base and the rural health agenda.

- i. Support research into:
 - ▶ rural health workforce development (including recruitment and retention strategies)
 - ▶ rural training strategies
 - ▶ innovative rural service delivery models to enable the provision of health services to meet community needs
 - ▶ health issues directly impacting on rural people, with a focus on benefiting communities within the university's catchment area through the delivery of better health services; and
 - ▶ improving the health of Aboriginal and Torres Strait Islander people.
- ii. Universities should support rural research opportunities for their students in accordance with curriculum requirements.
- iii. Collect and maintain data on rural workforce outcomes resulting from rural training activity through the RHMT programme.
 - ▶ Establish tracking systems for graduates or utilise national data collections such as the Medical Schools Outcomes Database and the Australian Health Practitioner Regulation Agency, with a regional focus aligned to each university's operations within their rural communities.

6. Aboriginal and Torres Strait Islander Health.

- i. Facilitate improvement of Aboriginal and Torres Strait Islander health through activities such as:
 - ▶ Embedding Aboriginal and Torres Strait Islander health issues into the rural training curricula of health professionals, with reference to the Aboriginal and Torres

Strait Islander Health Curriculum Framework (when finalised); and

- ▶ Developing and implementing training and education courses about Aboriginal and Torres Strait Islander health and/or for Aboriginal and Torres Strait Islander people.
- ii. Increase the number of graduating Aboriginal and Torres Strait Islander health students. Strategies include:
- ▶ Targeted enrolment strategies for Aboriginal and Torres Strait Islander health students
 - ▶ Mentoring and support programmes to enhance the ability of students to complete their course of training; and
 - ▶ Recruitment of Aboriginal and Torres Strait Islander academics and staff.

7. Regional leadership in developing innovative training solutions to address rural workforce recruitment and retention

- i. Work collaboratively with other universities operating within the university's catchment, as well as within the RHMT network, to support the goals of the RHMT programme.
- ii. Work with relevant education, professional and health service stakeholders in the region to develop and maintain models such as:
- ▶ integrated rural training pathways for medical students interested in rural careers that support students through to postgraduate training; and
 - ▶ service-learning models that can increase local health service delivery while supporting high quality rural training experiences.

Appendix 2: Commonwealth Policy Initiatives

Key national policy and strategic initiatives associated with rural health workforce education and training, recruitment and retention (1990-2019)

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
1990	First rural health training unit: Cunningham centre established at Toowoomba, Queensland; RHTU program initiated by state and Commonwealth governments in response to rural health workforce shortage		
1993	Rural Undergraduate Support and Coordination Program (RUSC) established to promote rural general practice as a career. Funding to universities for rural placements, establish rural health clubs and increase rural health teaching through Australian medical schools. Participating universities required to provide 4 weeks of RUSC funded placements to all medical students		
1994	First national rural health strategy endorsed by Australian Health Ministers' Conference (AHMC) with key elements: resource allocation, accessible rural health service delivery and rural health workforce development		

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
1996	University Departments of Rural Health (UDRH) program announced by incoming coalition government, a key component of their Rural Workforce Strategy		
	Flinders University commences clinical training opportunities to medical students in the Northern Territory by delivering full Year 3 and Year 4 curriculum in Darwin		
1997	First UDRH program established in Broken Hill and Mt Isa	Commonwealth General Practice Strategy —aimed at addressing maldistribution between urban and rural areas	
	John Flynn Placement Program introduced as part of the General Practice Strategy (1996-97 Budget)		
1998		Rural Locum Relief Program introduced enabling doctors that are otherwise ineligible to access MBS to have temporary access when providing services through approved placements in rural areas. Administered by Rural Workforce Agencies	
1999	Healthy horizons framework (co-signed by the Australian Rural Health Alliance), endorsed by AHMC, bringing together primary health care, public health and community involvement, defining a collaborative approach to rural health.		

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
2000	<p>Regional Health Strategy – More doctors, Better Services 2000-2001 Budget - included funding for nine new RCSs and three UDRHs; establishment of the Rural Australia Medical Graduate Scholarship (RAMUS) Scheme; Medical Rural Bonded Scheme; HECS Reimbursement Scheme.</p>		<p>Rural Pharmacy Workforce Programs and Aboriginal and Torres Strait Islander Pharmacy Workforce Program introduced under the Third Community Pharmacy Agreement between the Commonwealth and Pharmacy Guild. Aims to improve access to community pharmacy services in rural communities and strengthen rural pharmacy workforce. The <i>Rural Pharmacy Liaison Officer</i> (RPLO) Program was established to implement local level projects that provide support to practising rural community pharmacies and pharmacy students undertaking placements in rural areas. The Rural Program also provides scholarships to students from rural and remote locations for undergraduate and postgraduate education and rural student placement allowance.</p>
	<p>First Rural Clinical School (RCS) established in Wagga Wagga and the Riverland. The RCS initiative provides at least 1 year of clinical training for 25% of Australian medical students in a rural community</p>		
	<p>First Regional Medical School founded by James Cook University at Townsville</p>		
	<p>Expansion of the UDRH program to include additional four departments</p>		

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
2000	Primary health care research evaluation and development (PHCRED) strategy established to build the primary health care research capacity and evidence base in Australia. The UDRHs, along with academic departments of general practice, were funded as part of the Research Capacity Building Initiative from 2000 to 2011 to provide training and support in primary health care research for early-career and novice researchers		
2001	Australian Rural Health Education Network established as peak body for university Departments of Rural Health to provide leadership and strategic direction in rural health education and research, strengthen the UDRH network through coordination and communication and represent UDRH interests through a national voice and conduit for members	Medical Rural Bonded Scheme —Additional 100 places per annum	More Allied Health Services program established to help rural communities better access to allied health services
2002			The Puggy Hunter Memorial Scholarship Scheme introduced to build Aboriginal and Torres Strait Islander workforce capacity

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
2003	Federation of Rural Australian Medical Educators (FRAME) conceived to promote rural medical education as part of Australia's rural medical workforce, higher education and regional development strategies and to facilitate the development and maintenance of RCS		National Review of Nursing Education–Additional CSP places for nursing as a priority
	Lapsing UDRH program review. Program objectives revised with emphasis on increasing and improving rural experiences for undergraduate health students, innovation in education, research on rural and remote health issues and contributing to development of innovative service delivery models		
	Australian Rotary Health Indigenous Scholarship program introduced to build Aboriginal and Torres Strait Islander workforce capacity		
2004	Rural Health Strategy (2004-2005 Budget) – workforce measures included The <i>Bonded Medical Places (BMP) Scheme; Prevocational General Practice Placement Program (PGPPP)</i>		
2005			

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
2006	Monash University Department of Rural and Indigenous Health established	COAG Health workforce reforms—605 additional medical places and guaranteed internship places for CSP students.	
	James Cook University's Regional Medical Program joins RCS initiative		
2007	Dental Training Extended Rural Placements (DTERP) is a component of the RHMT program providing funding for dental students studying at six universities throughout Australia. Capital funding to universities to establish training sites		
2008	Evaluation of the UDRH program and the RCS Program (URBIS Review). Recommended maintaining flexibility and innovation of both programs, increased collaboration between programs and consideration of further expansion of both programs		Rural Primary Health Services Program commenced incorporating the More Allied Health Services Program
			Strategy to build the Nurse Practitioner workforce in rural and remote areas - \$2.1m scholarships for Nurse Practitioners

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
2009	Bradley review of Higher Education recommended retaining cap on medical places but uncapping nursing and allied health.	<p>Rural Health Workforce Strategy announced as part of the 2009-10 Federal budget introduction of ASGC-RA classification and scaling or gearing incentives and return of service obligations to provide greatest benefit to most remote communities. Key strategies:</p> <ul style="list-style-type: none"> • General Practice Rural Incentives Program—Encourage move to and remain in a regional, rural or remote area (consolidating the Rural Retention Program and Registrars Rural Incentives Program) • Rural GP Locum Program • HECS Reimbursement Scheme—Scaling to fast-track repayment of medical school fees for doctors practising in outer regional, remote or very remote areas • Scaling Medical Rural Bonded Scholarship and Bonded Medical Places return of service obligation to encourage completion of obligations in more remote areas • Scaling incentives for Overseas Trained Doctors enabling reduction in ten year Medicare Moratorium for practising in regional, rural and remote locations 	
	<p>University of Notre Dame Sydney RCS was approved.</p> <p>Deakin University RCS was approved.</p> <p>Uni of Western Sydney RCS was approved.</p>		

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
2010	<i>Health Workforce Australia commenced operations as a Commonwealth statutory authority responsible for health workforce development for Australia.</i> Included a focus on innovation in clinical training reform, with funding for increased clinical training places, development of novel training sites and use of simulation learning environments	National Registration and Accreditation Scheme commences	
2011			Nursing and Allied Health Rural Locum Scheme (NAHRLS) provides placements for up to 14 days to enable rural nurses, midwives and allied health professionals to take leave. Also enables interested nurses, midwives and allied health experience rural work through locum placement

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
2011	<p>Northern Territory Medical Program established – fully accredited post-graduate medical program with students drawn from Charles Darwin University Bachelor of Clinical Sciences program, graduate entry applicants and Indigenous Transition Pathways</p>	<p>The Rural Health Outreach Fund consolidates the activities of five existing outreach programs, and provides a larger, flexible funding pool for initiatives aimed at supporting people living in regional, rural and remote locations to access a wide range of health care services.</p> <p>The five programs that form the Fund are:</p> <ul style="list-style-type: none"> • Medical Specialist Outreach Assistance Program (MSOAP); • MSOAP – Maternity Services; • MSOAP – Ophthalmology; • National Rural and Remote Health Program; and • Rural Women’s GP Service Program. <p>The Rural Health Outreach Fund supports the delivery of all medical specialties and a range of primary health care services in rural, regional and remote Australia. These include but are not limited to multi-disciplinary maternity services, eye health services and their coordination, and services by female GPs.</p>	
	<p>National Strategic Framework for Rural and Remote Health approved by Health Ministers and linked to the broader health reform agenda</p>		
	<p>RUSC and Rural Clinical Schools program merged to become Rural Clinical Training and Support (RCTS) Program</p>		
2012	<p>In response to the Bradley Review of Higher Education - Demand driven funding system commenced with the exception of medicine.</p>		

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
2013	Review of Australian Government health workforce programs (Mason Review) reported UDRHs and RCSs provided valuable infrastructure support for rural regions, that there was scope for increased investment in UDRH program to expand its contribution and a recommendation for the development of rural training pathways for the health professions, with an emphasis on generalist training		Voluntary Dental Graduate Year Program (VDGYP) established. 50 graduates per year with structured program for enhanced practice experience and professional development to increase dental workforce in public system and areas of need.
2014	Closure of Health Workforce Australia, with key functions transferred to the DoH		Expansion of the VDGYP from 50 to 100 per year Oral Health Therapist Graduate Year Program established
2015	Griffith University RCS launched		Nursing and Allied Health Scholarship and Support Scheme (NAHSS) for students and health professionals to facilitate entry of nurses and allied health professionals into the health workforce, encourage practice in rural areas and facilitate CPD. NHSS contracts transferred to Rural Workforce Agencies under the Rural Health Professionals Program (RHPP) and no longer provided funding to students. Focused on relocation grants, CPD, orientation support to communities for allied health and nurses in the private sector.

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
2016	Rural Health Multidisciplinary Training Program devised to integrate existing rural workforce strategies administered through universities	Medical Rural Bonded Scholarship Scheme closed end of 2015 with the 100 places transferred to the Bonded Medical Places Scheme.	NDIS commenced roll out nationally. Seeking to use a market approach to purchase services including allied health. Seeing growth of NDIS providers – private and non-government. Challenges for rural areas to operate under “market” model but also potential opportunities over time.
	Expansion of UDRHs within the new Rural Health Multidisciplinary Training Program GGT UDRH restructured: Deakin Rural Health in Victoria and Flinders Rural Health in South Australia	Rural Locum Assistance Program funded under the Health Workforce Program -administered by Aspen Medical since April 2016. \$35.6m to June 2019 to enhance ability of specialists (Obstetrics and anaesthetics), procedural GPs in rural Australia to undertake leave for CPD. Nurses, midwives and allied health also supported. Also supports eligible rural health professionals to access CPD or take leave, metro-based GPs to upskill in emergency medicine to better prepare for rural locum work, and urban based health professionals to experience rural practice by undertaking a locum.	

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
2017	Three additional UDRHs established: Kimberley Rural Health Alliance in Western Australia, Southern Queensland Rural Health and Three Rivers Department of Rural Health in New South Wales	<p>Rural General Practice Program (long standing program managed by the RWAs to support recruitment and retention of GPs) merged with the Rural Health Professional Program – resulting in Rural Workforce Support Activity (RWSA). Focus areas:</p> <ul style="list-style-type: none"> • <i>Access</i>: improve access and continuity of access to essential primary health care, particularly in priority areas, through a jurisdictional workforce assessment process involving health workforce stakeholders. Activities include locum support, relocation grants • <i>Quality</i>: build local health workforce capability with a view to ensuring communities can access the right health professional at the right time, reducing the reliance on non-vocationally recognised medical professionals in rural communities. Upskilling and additional training • <i>Sustainability</i>: grow the sustainability and supply of the health workforce with a view to strengthening the long-term access to appropriately qualified health professionals. Activities include: RWAs engaging with Rural Health Clubs to promote careers to rural secondary school students; university student rural immersion activities; Supporting clinical placements for nursing and allied health students; linking students with mentors to guide rural journey <p>This Rural Workforce Activity program consolidates and rationalises the following activities formerly provided by Rural Health Workforce Australia (RHWA) and RWAs:</p> <ul style="list-style-type: none"> • Rural and Remote General Practice Program Funding to the RWAs to support the rural workforce. • General Practice Rural Incentive Program – Flexible Payment System: Funding to the RWAs to implement. • International Recruitment Scheme: Previously funded through RHWA. • Rural Locum Relief Program: Funding to the RWAs to implement. • Additional Assistance Scheme (AAS) and Five Year Overseas Trained Doctor Scheme: Funding to the RWAs to implement. • Go Rural: Previously funded through RHWA. 	

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
2017		<p>Health Workforce Scholarship Program established and replaced a number of scholarship programs including Nursing and Allied Health Scholarship Support Scheme and Rural Australian Medical Undergraduate Scheme. Established to increase access to health services in rural and remote areas where skill shortage by providing bursaries and scholarships to existing health professionals committed to rural service. RWA administer program (\$33m over 3 years to June 2020) to deliver HWSP in MMM 3-7. Informed by Health Workforce Needs Assessment.</p>	
2018	<p>National Rural Generalist Pathway – principles and framework to build the rural (medical) generalist workforce “in place” to address rural community needs through integrated, collaborative regional training networks spanning rural Australia (MMM2-7).</p>		

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
2018	<p>Stronger Rural Health Strategy: Train in the regions, stay in the regions program announced with investment of \$95.4m over four years. Includes:</p> <ul style="list-style-type: none"> • Murray-Darling Medical Schools Network to enable medical students and graduates to undertake majority of study and training in the Murray-Darling region. The University's network include: University of NSW (Wagga Wagga), University of Sydney (Dubbo), Charles Sturt university in partnership with Western Sydney (Orange), Monash (Bendigo, Mildura) and University of Melbourne (Shepparton) with pathway for undergraduate students from La Trobe University (Bendigo and Wodonga). There are no new medical CSP – reallocate small number of existing CSPs in managed process with first student intakes in 2021. Funding predominantly for infrastructure (teaching facilities and extra student accommodation) • Curtin University funded for RCS activities to undertake short- and long-term clinical placements in rural WA • La Trobe university funded to establish a new UDRH to increase clinical training opportunities for nursing and allied health students in rural Victoria 	<p>Stronger Rural Health Strategy:</p> <p><i>New Junior Doctor Training Program</i> consolidates and builds on current training programs to create two New streams to support training in rural primary care and private hospitals.</p> <p>Rural Primary Care Stream – existing Rural Junior Doctor Training Innovation Fund continues and allows rurally based interns to experience working in primary health care settings. Up to 240 PGY 1 and 2 junior doctors will rotate into general practice. Assists in funding training and supervision to support creation of new jobs.</p> <p>Private Hospital Stream provides salary support for junior doctors including up to 100 internships in 2019 and up to 115 places in 2020. Full fee-paying international graduates of domestic schools will continue to have preference. Will also support PGY 2 and 3 training placements.</p>	<p>Stronger Rural Health Strategy:</p> <p><i>Strengthening the role of the nursing workforce</i> has three components:</p> <p>Nursing in Primary Health Care (NiPHC program) – to provide training and mentoring for nurses to transition to primary health care and support nurses in regional and rural areas through training in clinical areas of need.</p> <p>Raising awareness of role of the Nurse Practitioner</p> <p>3,000 additional nurses in rural general practice (over 10 years) through incentives to employ practice nurses</p> <p>Independent review of nurse education.</p>

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
2018		<p>Bonded Medical Programs reformed as part of the Stronger Rural Health Strategy announced in 2018-2019 Budget. Aim of the reform is greater flexibility and more support for bonded doctors and better target return of service to underserved areas in most need.</p>	
		<p>Aboriginal and Torres Strait Islander Health Professional Organisations – continued and additional funding to develop and implement strategies to improve recruitment and retention of Aboriginal and Torres Strait Islander health professionals in clinical and non-clinical roles; assist with increasing number of students studying to attain a health qualification; improve completion/graduation and employment rates and contribute to building evidence base to improve workforce planning and inform policy. Organisations include Australian Indigenous Doctors Association; Congress of Aboriginal and Torres Strait Islander Nurses and Midwives; Indigenous Allied Health Australia; National Aboriginal and Torres Strait Islander Health Worker Association.</p>	
		<p>More Doctors for Rural Australia Program (MDRAP)</p> <p>The MDRAP is a new 3GA health program designed to bring more doctors to rural and remote communities. Non vocationally registered doctor participating in the program will be able to access a Medicare benefit while working toward entry to a fellowship program.</p>	

Year	Rural health workforce education and training initiative	Wider rural workforce initiatives	
		Medicine	Nursing and Allied Health
2019			National Rural Health Commissioner – Development of Options paper for Commonwealth: Rural Allied Health Quality, Access and Distribution.
			Commonwealth commissioned An independent review of nursing preparation in Australia – Educating the Nurse of the Future
2020		GP Rural Incentive Program and Practice Nurse Incentive Program transitioning to Workforce Incentive Program 1 January 2020. Doctor Stream—eligible practitioners in MMM 3-7 locations receive annual incentive payment of between \$4,500 and \$60,000.	
		From 1 January 2020, participants of Bonded Medical Program can complete Return of Service Obligation through working in eligible location in MMM 2-6, Distribution Priority Areas (DPA) for GPs areas, outer Metro and Districts of Workforce Shortages for the participants chosen specialty.	

Appendix 2a: Australian Government funded Medical Training Pathway

Medical Student

Rural Health Multidisciplinary Training (RHMT) Program – supports universities to deliver medical training

The aim of the RHMT Program is to improve the geographic distribution of health workforce through the delivery of rural training experience. It includes:

- Rural Clinical Schools (19)
- University Departments of Rural Health (16)
- Northern Territory Medical Program (through Flinders University)
- 26 Regional Training Hubs are based at existing RHMT training sites, tasked with better connecting the rural medical training pipeline from undergraduate through to prevocational and vocational training to allow rurally-inclined medical students/trainees to complete more of their training in rural communities.
- The RHMT Program also supports rural clinical training for disciplines other than medicine.
- The National Rural Health Student Network (NRHSN) is the peak body for rural health clubs and is managed by the NSW Rural Doctors Network. Individual rural health clubs are mostly managed by RHMT funded universities.

Murray Darling Medical Schools Network

- End to end rural medical school programs.
- Commencing from 2021 there will be 5 medical school programs based in rural and regional Victoria and New South Wales

John Flynn Placement Program (JFPP) delivered by jurisdictional Rural Workforce Agency Network led by Health Workforce Queensland (HWQ)

- Designed to enable medical students to form long-term relationships with rural communities and gain a better understanding of rural medical practice and non-metropolitan health services.
- 300 medical students are selected each year and normally undertake a placement in the same rural, regional and remote community for a minimum of two full weeks per year over a four-year period.
- 1,200 placements are supported annually at any one time.

Pre-vocational (Intern/Residency)

Junior Doctor Training Program – Rural Primary Care Stream

- Rural Junior Doctor Training Innovation Fund PGY1-PGY2 rotations into a rural primary care setting.
- 240 rotations per annum

Junior Doctor Training Program – Private Hospital Stream

- places for PGY 1-3 in the private hospital sector.
- 200 places per annum
- Commonwealth investment in Intern training is delivered through this stream

Registrar

Specialist Training Program (STP) is managed and administered by 13 non-general practice specialist medical colleges. The program has three funding streams:

- core STP posts (957 full time equivalent – FTE per year ,
- Integrated Rural Training Pipeline (IRTP) (100 FTE per year) and
- Tasmania Project (62.6 FTE per year).

Australian General Practice Training Program

- Fully funded postgraduate vocational training program for medical practitioners wishing to pursue a career in general practice
- Delivered primarily by RTOs. Associated activities delivered through RACGP, ACRRM, RFDS, GPRA, GPSA
- 1,500 places per year

Remote Vocational Training Scheme

- Fully funded postgraduate vocational training program for medical practitioners wishing to pursue a career in general practice
- Administered by RVTS Ltd
- 32 places per year

To be implemented in 2021

- Additional 100 training places for rural generalists

Non Vocationally Recognised Fellowship Support Program

- Provides a subsidy to assist medical practitioners to gain fellowship and vocational registration as a specialist general practitioner.
- Delivered through ACRRM's Independent Pathway and the RACGP's Practice Experience Program.

Post-fellowship/specialist

General Practice Procedural Training Support Program (GPPTSP)

- anaesthetics grants are managed by ACRRM and obstetrics grants are managed by RANZCOG (25 grants per year)

Procedural Training Programs

- Rural Procedural Grants Program (entitlement program); delivered by RACGP and ACRRM with payments to rural GPs to support CPD in procedural skills;
- General Practice Procedural Training Support Program; delivered by ACRRM and RANZCOG to attain procedural qualifications in obstetrics and anaesthetics.

Appendix 3: Jurisdiction Rural Workforce Policies

Jurisdiction Policy			
	Medicine	Nursing and Allied Health	Rural training pathway
<p>NSW Government <i>NSW Health Professionals Workforce Plan 2012-2022</i></p>	<ul style="list-style-type: none"> • NSW Rural Medical Office Cadetship program with a return of service of first two of three years of hospital training in NSW rural hospital • Supporting prevocational training networks for junior doctors to experience rural practice • Rural Preferential Recruitment Program supports rural career pathways enabling junior doctors to do the majority of their first two years in a rural hospital • Building capacity for Aboriginal Medical Workforce initiative helps Aboriginal medical graduates guarantees allocation to the training network of their first preference 	<ul style="list-style-type: none"> • Rural Grow Your Own initiative – undergraduate nursing or midwifery student linked to a rural facility for up to 12 weeks during training with offer of employment after graduation and registration • Metro-Rural Exchange Program for newly graduated nurses and midwives to work for six months in rural and six months in metro facility in their new graduate year • Rural Postgraduate Student Midwifery Scholarships • Rural Allied Health Scholarships to attend education events • Allied Health Assistant Framework 	<ul style="list-style-type: none"> • Vocational training networks for emergency medicine, psychiatry, medical administration, paediatrics and basic physician training linking large teaching hospitals with rural training positions • NSW Rural Generalist Training Program – structured pathway for doctors to become GPs with an advanced skill in rural NSW • Dual physician training Pathway is a structured program that supports doctors to obtain specialist qualifications in general medicine and another speciality – Dubbo, Orange, Wagga and Port Macquarie

Jurisdiction Policy

<p style="text-align: center;">Northern Territory Government</p> <p style="text-align: center;"><i>NT Health Workforce Strategy 2019-20220</i></p>	<ul style="list-style-type: none"> • Partner with educational stakeholders to improve health workforce supply • Provide clinical workforce development through an NT Clinical Education and Training Strategy • Partner with higher education and training providers to more closely align workforce development to NT skills needs • Deliver innovative learning and development packages through variety of methods 	<ul style="list-style-type: none"> • Further the development of rural generalist training pathways
<p style="text-align: center;">Government of Western Australia</p> <p style="text-align: center;">Sustainable Health Review, 2019.</p>	<p>Strategy 7: Culture and workforce to support new models of care</p> <p>Implement contemporary workforce roles and scope of practice where there is a proven record of supporting better health outcomes and sustainability. Priorities in implementation:</p> <ul style="list-style-type: none"> • Evaluation of workforce roles and scope based on community health needs and interdisciplinary models of care, rather than only profession-based approaches. • Progressive introduction, evaluation, or expansion of workforce models that support working to full scope of practice including Nurse Practitioners (including primary care and residential aged care), Enrolled Nurses (including sub-acute and community care sectors – aged care, rehabilitation and geriatric evaluation and management), and GP Proceduralists/ Rural Generalists (country). • Progressive introduction, evaluation, or expansion of workforce models that support advanced skills including Advanced Scope Physiotherapists (including outpatients and emergency departments/fast track); Advanced Scope Community Pharmacists (including community interdisciplinary team models and immunisations); Advanced Scope Registered Nurse Endoscopists; Aboriginal Health Workers/Practitioners (including advanced scope immunisations); and Peer Support Workforce (including community recovery; acute interventions; employment pathways). • Progressive expansion of Midwifery Group Practice models to provide a single point of care through a woman’s pregnancy. 	

Jurisdiction Policy

**Government of
Western Australia**

Sustainable Health
Review, 2019.

Build capability in workforce planning and formally partner with universities, vocational training institutes and professional colleges to shape the skills and curriculum to develop the health and social care workforce of the future.

Priorities in implementation:

- Investment in a systemwide integrated workforce information system to support workforce planning and support through linked information including payroll, Human Resources, learning management, rostering, training, credentialing and performance development.
- Investment in improved workforce analytics and modelling capability.
- A 10-year health and social care workforce strategy developed by July 2021 with key stakeholders including joint planning of training needs and placements; ensure an interdisciplinary approach to care with training exposure in both acute and community settings, and equitable and adequate placements across professional groups with a focus on regional areas.
- Encourage and advance health and social care educational curriculum to include a sound understanding of how health, mental health and social care systems are organised and operate, including training in the skills needed for a digitally literate workforce.

**Tasmanian
Government,
Department of Health
and Human Services**

*Strategic Framework for
Health Services 2012-
2018*

Attraction and Workforce Distribution

- Grow the workforce in line with health service need, including developing a planning structure for small but critical sections of the health workforce.
- Develop career and education pathways for rural health professionals in conjunction with education providers, including training pathways for regional and rural specialists with broad generalist capabilities.
- Increase the utilisation of contemporary teaching and learning technologies, including to regional and remote areas.
- Develop flexible career pathways that enable professionals to transition in and out of rural areas to maintain skill development.
- Explore attraction and retention strategies for hard-to-recruit areas including flexible employment models that enable professionals to move ‘in and out’ of these areas.

Jurisdiction Policy

**Tasmanian
Government,
Department of Health
and Human Services**

*Strategic Framework for
Health Services 2012-
2018*

Access Data and Systems

- Contribute to the national collection of workforce data and ensure Tasmania has workforce data for informed planning and decision making.
- Develop and implement systems that capture and monitor student placements across the total health system in Tasmania.
- Collaborate with key stakeholders to improve access to workforce data, including at the local level.
- Strengthen the use of information and communication technology by health professionals and consumers to improve service effectiveness and
- make efficiencies.
- Maximise the use of contemporary communication and social networking technologies to enhance engagement of the workforce.

Build Capability to Work in New Ways

- Progress initiatives that enable Tasmania to deliver enhanced workforce capabilities including the introduction of new workforce roles.
- Work with key stakeholders to ensure education and training pathways reflect the needs of the health system workforce and desired population health outcomes.
- Identify and develop opportunities for interprofessional learning and practice.
- Maximise the use of simulated learning environments for education, training and professional development across the Tasmanian healthcare system.

Jurisdiction Policy

Queensland Government

Advancing Rural and Remote Service Delivery through Workforce: A strategy for Queensland 2017-2020

Designing the Workforce: Innovative Models of Care

- Develop/expand and continue to progress rural generalist workforce models for medicine, nursing and allied health professions.
- Strengthen workforce capacity and capability to deliver priority services in rural and remote communities
- Further embed the Aboriginal and Torres Strait Islander health practitioner role in Queensland Health
- Increase integration of telehealth services into models of care
- Develop workforce models and job designs that can support a range of professional disciplines in the rural and remote sector

Preparing the Workforce: Responsive, Capable and Sustainable

- Improve on-boarding processes for clinical placement students and staff.
- Staff and students have improved access to social and professional mentors (internal and external) to improve the on-boarding experience

Implement succession planning

- Grow your own' programs are designed, marketed and integrated with school based and tertiary education programs to provide clear education and employment pathways for local communities.
- Identify opportunities to upskill high-potential community members to meet the entry requirements of vocational education and training (VET) and university programs through tailored education pathways.
- Critically analyse and compare the enduring resource implications of overseas recruitment and 'grow your own' programs

Jurisdiction Policy

The Government of South Australia committed \$20 million over four years to developing and implementing a Rural Health Workforce Strategy outlined in the Government's 'Rural Health Workforce Strategy' 2018 election commitment. The Rural Health Workforce Strategy includes a commitment to develop 'a plan to recruit, train and develop the health professionals...needed to deliver country health services'. Implementation of the Rural Health Workforce Strategy will include the development of a workforce plan for all health professions, commencing with Medicine.

Following the development of the Rural Medical Workforce Plan, corresponding plans will be prepared for the South Australian Ambulance Service, nursing and midwifery and allied health practitioner workforce, with a further focus expected on the Aboriginal Health workforce and on the volunteers supporting rural health care

SA Rural Health

Medical Workforce
Plan (DRAFT), July
2019

Building a Skilled Workforce

- Expand training pathways to meet the minimum required numbers for sustainable rural medical practice Increase the number of doctors entering rural medical training and practice

New and Sustainable Models for Rural Health Care

- Develop sustainable models of rural medical care
- Increase support to rural General Practitioners
- Increase integrated multidisciplinary clinical services

Developing a Collaborative and Coordinated Health System

- Share the responsibility for rural health across the state
- Work in partnership to support the rural health workforce

Jurisdiction Policy

Victorian Government

health.vic

Allied health policy frameworks

<https://www2.health.vic.gov.au/health-workforce/allied-health-workforce>

health.vic has a number of allied health policies including:

- Allied Health Careers Pathways blueprint to provide guidance to individuals, services, sector and government to strengthen career development and progression opportunities
- Allied health clinical supervision framework
- Credentialing, competency, and capability framework for the safe introduction of new allied health service models, therapies and procedures and roles
- Advanced practice in allied health
- Allied health postgraduate funding for first year graduates
- Aboriginal cadetship program for nursing, midwifery and allied health
- Allied health research and allied health workforce research

Nursing

- Nursing and midwifery workforce development fund
- Funding initiatives to develop midwifery workforce, graduate nurse program, interprofessional nurse paramedic graduate program

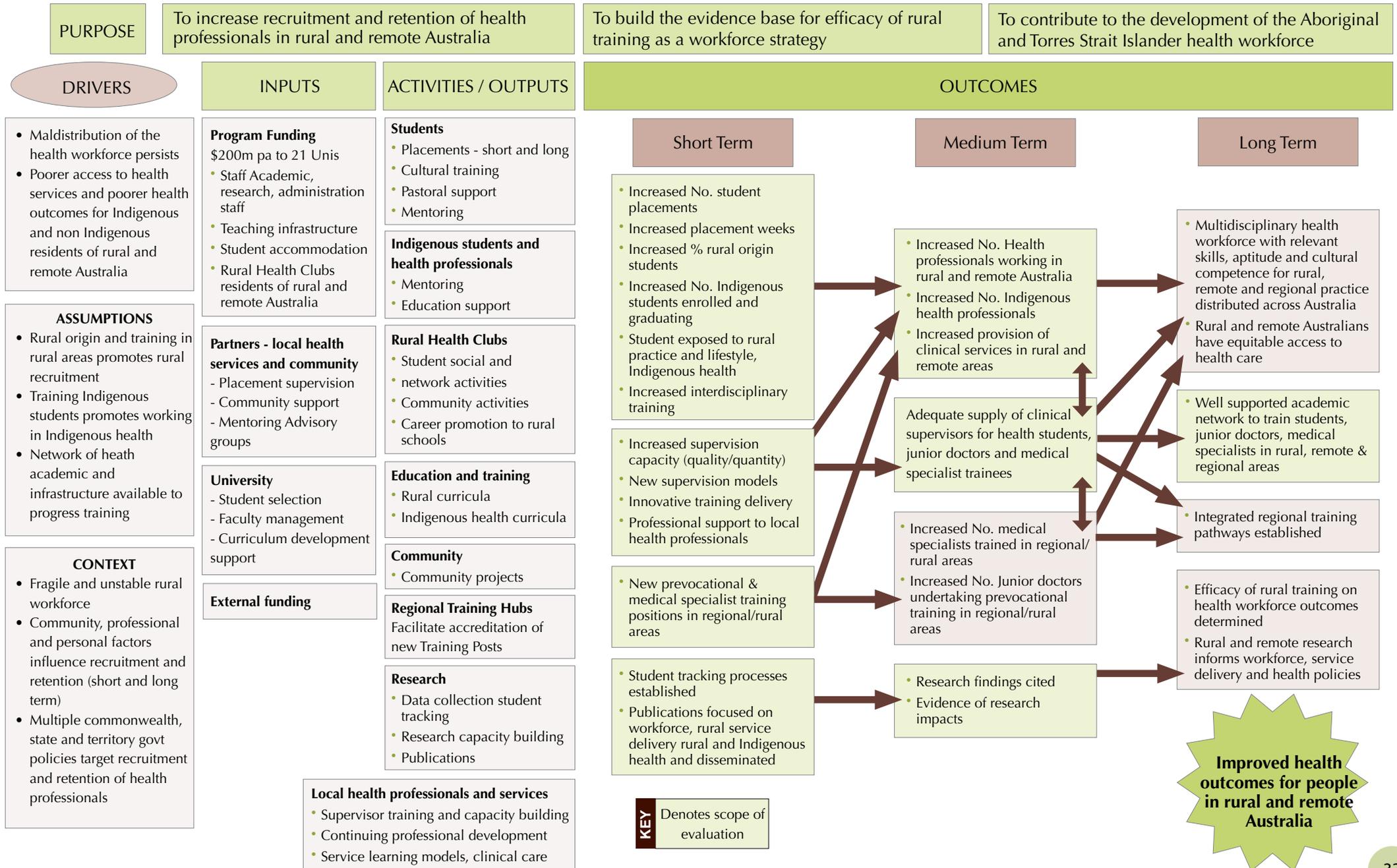
Rural medical workforce initiatives

- Victorian Rural Medical Scholarship Scheme
- Rural Community Intern Training – to support internships in small rural and regional hospitals
- Victorian GP - Rural Generalist Program
- Rural Extended and Advanced Procedural Skills Program
- Consolidated Skills Program for rural GPs, GP registrars and salaried Medical Officers working rurally

Many of the rural GP programs are administered by Rural Workforce Agency Victoria or in conjunction with GP Regional Training Organisations

Appendix 4: Program Logic - Rural Health Multidisciplinary Training Program

Rural Health Multidisciplinary Training Program



Appendix 5: Rural Health Multidisciplinary Workforce Survey

KBC Australia—RHMT Evaluation, Health Workforce Survey

Introduction

The *Australian Government Department of Health* has commissioned *KBC Australia* to undertake a national study of health workforce training outcomes. As part of this study, we invite you to participate in our Health Careers Pathways Survey. All nursing, midwifery, pharmacy, dentistry and allied health practitioners who graduated between 2005-2018 are invited to participate.

The survey only takes about 8 minutes to complete. All responses will be de-identified to protect participants' anonymity. Participation in this study is entirely voluntary and you are free to withdraw any time. Human research ethics approval has been provided by Bond University [HREA JS00505].

By undertaking this electronic survey, you are indicating your consent to participate.

If you have any questions about the study, please feel free to contact KBC Australia:

E | manager@kbconsult.com.au T | (02) 63 61 4000

This survey will be open until 31 October 2019. Thank you for your time and input.

1. What is your main profession? (dropdown select)
2. What roles do you undertake in your main profession? (select all that apply) (multiple select)
 - Clinician
 - Educator (including academic supervision)
 - Researcher
 - Administrator (including management)
 - Other: _____
3. Did you obtain your [Q1] degree in an Australian university? (Y/N)
4. What year did you complete your [Q1] degree?
5. Date of birth (Month, Year)
6. Gender
7. Do you identify as Aboriginal and/or Torres Strait Islander?
8. Please indicate how many YEARS you have lived in Australia outside of metropolitan city (i.e. in a regional, rural or remote area with a population of less than 200,000)? Please round to the nearest full year.

- Birth to 6 years of age
 - 7 to 12 years of age
 - 13 to 18 years of age
9. Do you consider yourself to come from a 'rural' background? (Y/N)
10. From what university did you gain your [Q1] degree? (dropdown select)
11. When did you commence university studies for your [Q1] degree? (Month, Year)
12. Please indicate your university enrolment type (at commencement)
- Commonwealth supported (HECS) Place
 - Industry supported Place
 - Australian Full Fee-paying Place
 - International Full Fee-paying Place
13. Was this a bonded place? (Y/N)
14. Did you receive a scholarship whilst at University? (Y/N)
15. When you commenced your university studies, were you enrolled as a full-time or part-time student?
16. Please indicate your level of agreement with the following statements:
Over the course of my [Q1] degree, my ability to undertake clinical placements was negatively affected by: (Likert-type item, strongly disagree ... strongly agree)
- Having family commitments
 - Preferences of my partner/spouse
 - The needs of my children or other dependents
 - My financial situation as a student
 - Work/employment commitments
17. During your university studies, did you undertake a RURAL clinical training placement (i.e., in a regional, rural or remote area with a population of less than 200,000)? (Y/N)
18. Please indicate the TOTAL number of weeks you spent on RURAL clinical training placements over the duration of your [Q1] degree. (Please round to the nearest WEEK)
19. To your knowledge were any of these placements supported by a University Department of Rural Health (e.g., a University Department of Rural Health provided you accommodation, academic resources, administrative support)? (Please select all that apply) (multiple select list)
20. How many hours did you work in total LAST WEEK in your main profession ([Q1])?
21. Please indicate the town or metropolitan area (e.g. Sydney, Gold Coast, Newcastle, Central Coast), in which you worked most LAST WEEK in your main profession. (autocomplete text entry)
22. What are the most important reasons you chose to work in [Q21]? (Please select your top

five (5) motivations from the list below) (randomised multiple select)

- Salary, benefits
- Postgraduate/specialist training
- New graduate position
- Opportunities for my own professional advancement
- Obligation related to a bonded university place
- My professional networks are strongest here
- Could not find employment in my preferred rural location
- Cost of living
- Preferred lifestyle
- Employment for my spouse/partner
- Education for my children/dependents
- Proximity to my partner, family and/or friends
- Commitment to the health of this particular community
- Commitment to enhancing Aboriginal and Torres Strait Islander health
- I had a positive training experience in a similar community whilst at university
- Could not find employment in my preferred metropolitan location
- Other (please state): _____

23. Thinking about the last 12 months, what percentage of your annual work time was spent providing health services in a regional, rural or remote area (i.e., with a population of less than 200,000)? (slider, 0 – 100)

24. Since graduating, approximately how many MONTHS have you been employed as a regional, rural or remote health service provider in your main profession?

25. We'd like to learn more about your unique career path. If you would be willing to do a brief follow-up interview, please provide your contact details below.

Appendix 6: Statistical Analysis framework

Estimating the effectiveness of rural clinical placements

This analysis aimed to better understand the impact of undertaking a rural clinical placement on health graduates' subsequent work in rural areas. The outcome of interest was defined as 'hours (per week) of professional practice in a regional or remote setting (RA2-5).' By distinguishing the impact attributable to rural placements, we may better articulate the costs and benefits associated with providing such placements through the RHMT. However, the relationship between training and subsequent workplace location is complicated. Graduates take a number of factors into account, including their personal preferences and those of their partners, opportunities for their families and the professional and vocational requirements of their discipline. Propensity score matching (PSM) is a statistical method that can take such factors into account.

PSM controls for differences between groups to isolate the impact of an intervention on an outcome of interest (Gemici et al., 2012). In some ways, PSM mimics the effect of randomisation in a randomised-controlled trial.

Using observational data, students likely to participate in a rural training placement were paired with students who did not participate in rural training placements, based upon their shared background characteristics. This pairing, or 'matching,' was based on their individual 'propensity scores': the *conditional probability of selecting into a long-duration rural clinical placement*, given a defined set of observed characteristics (Rosenbaum & Rubin, 1983). Each survey respondent who had undertaken a long-duration rural clinical placement (i.e., around 20 weeks) was matched with a respondent who did not undertake any clinical placements in a rural area. Each matched pair shares in common all potentially mitigating factors that could otherwise explain the relationship between participating in rural clinical training and subsequent work in a rural area. As such, the emergent differences between them can then be ascribed to rural clinical placement experience.

Model specification—The propensity score is first estimated through a generalised linear model, with likelihood of participation in a long-duration rural clinical placement as the outcome of interest (the dependant variable). The independent covariates—identified in the literature to affect selection into the RHMT—were age at commencement, gender, rural background, (part/full-time) enrolment status, family or financial barriers to participation and university of enrolment. This model produced the *conditional probability of selecting into a long-duration rural clinical placement*, that is, each respondent's 'propensity score.' Respondents who participated in rural clinical training were then matched with individuals who did not based upon the similarity of their propensity scores. One-to-one, 'nearest-neighbour' matching with replacement (within specified maximum bounds) was used.

Results of the propensity score estimation are presented in Table 1.

Table 1 Propensity score estimates (logit)—Likelihood of being in highest quintile of clinical placement duration (ASGS-RA 2-5) by discipline

Determinants of exposure	Highest quintile—clinical placement duration
Allied Health	
Age at commencement	0.01 (0.01)
Female	0.11 (0.26)
Rural background†	0.75 (0.10) ***
Fulltime student at enrolment	0.87 (0.33) ***
Barriers—Family obligations	0.06 (0.10)
Barriers—Financial stress	0.13 (0.08)
University	n/a ***
Number of observations	664
Pseudo R2	0.18
Log pseudolikelihood	342.77
Nursing and Midwifery	
Age at commencement	0.01 (0.01)
Female	0.56 (0.29) *
Rural background†	0.95 (0.11) ***
Fulltime student at enrolment	0.03 (0.28)
Barriers—Family obligations	0.12 (0.09)
Barriers—Financial stress	0.18 (0.09) **
University	n/a ***
Number of observations	590
Pseudo R2	0.26
Log pseudolikelihood	273.67

Note: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.10$. Standard error in parentheses; regression before imposition of calipers.

† Standardised index value (mean, 0; standard deviation, 1)

Post-estimation balance diagnostics

A number of post-estimation balance diagnostics were employed to ensure that respondents were appropriately matched, including appraisal of common support, between-group standardised differences of covariate means and prevalence's (Austin, 2009), and variance ratios before and after matching (Imai et al., 2008).

Common support—there must be sufficient overlap between the propensity scores of observations in the treated and control groups to ensure that matched observations are sufficiently alike with regards to their observed characteristics. Figure 1a and Figure 1b provide graphical illustration that in both models, matching on the propensity score has been conducted with common support.

Figure 1a Density plot: common support before and after matching, Allied Health

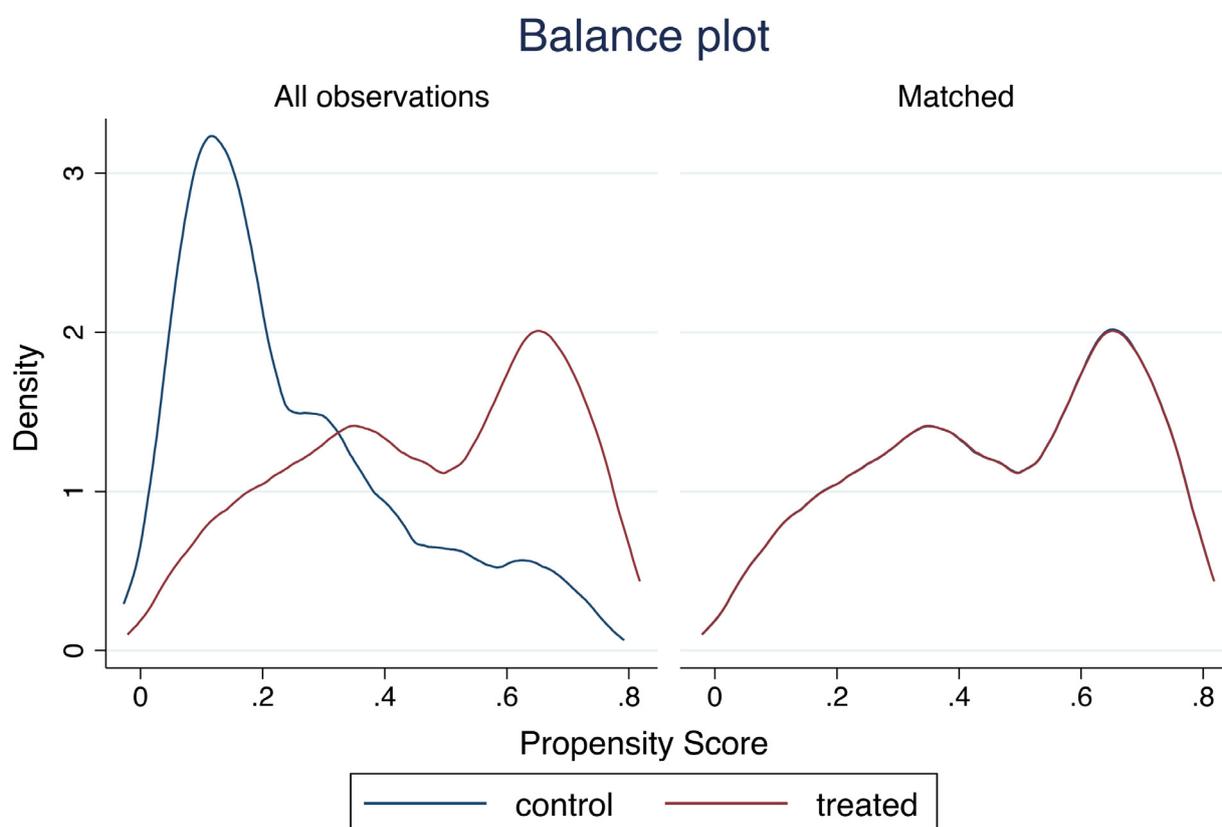
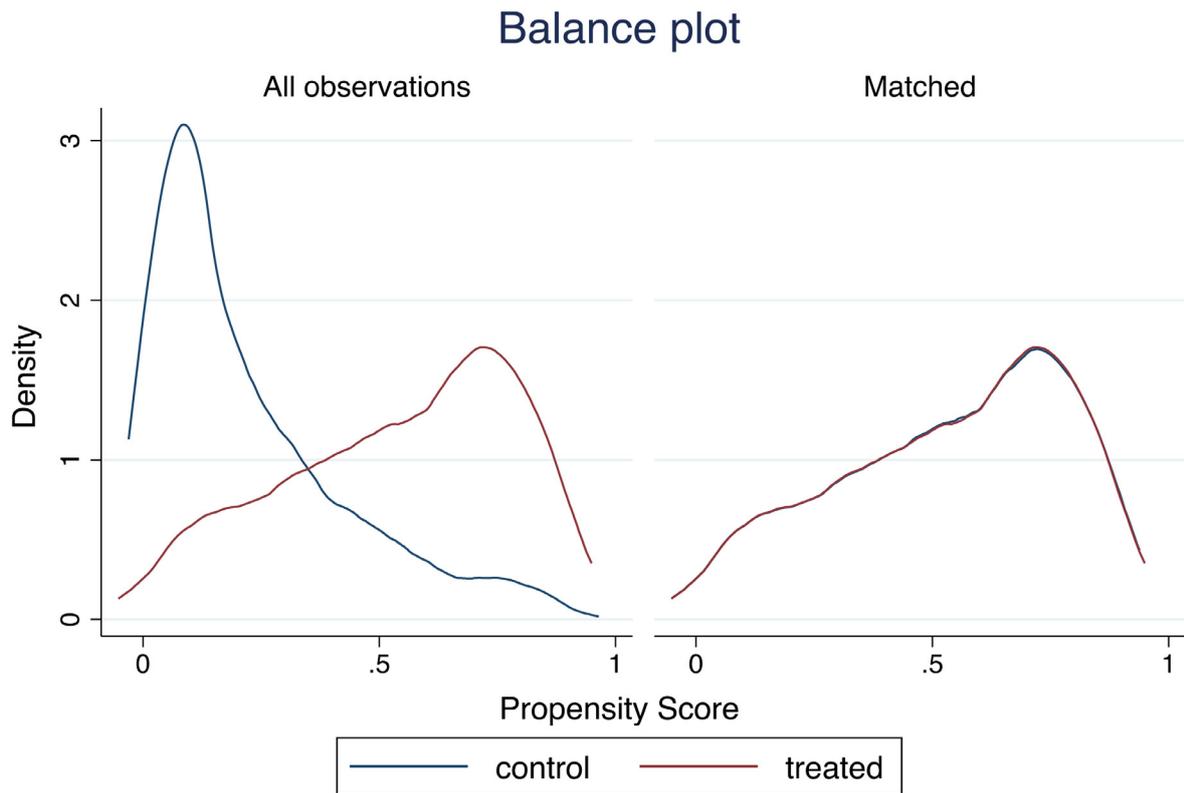


Figure 1b Density plot: common support before and after matching, Nursing and Midwifery



Distributions of covariate means and prevalences — Matching on the propensity score should balance the means and prevalences of covariates between the matched groups.

Figure 2a Standardised bias of covariates before and after matching, Allied Health

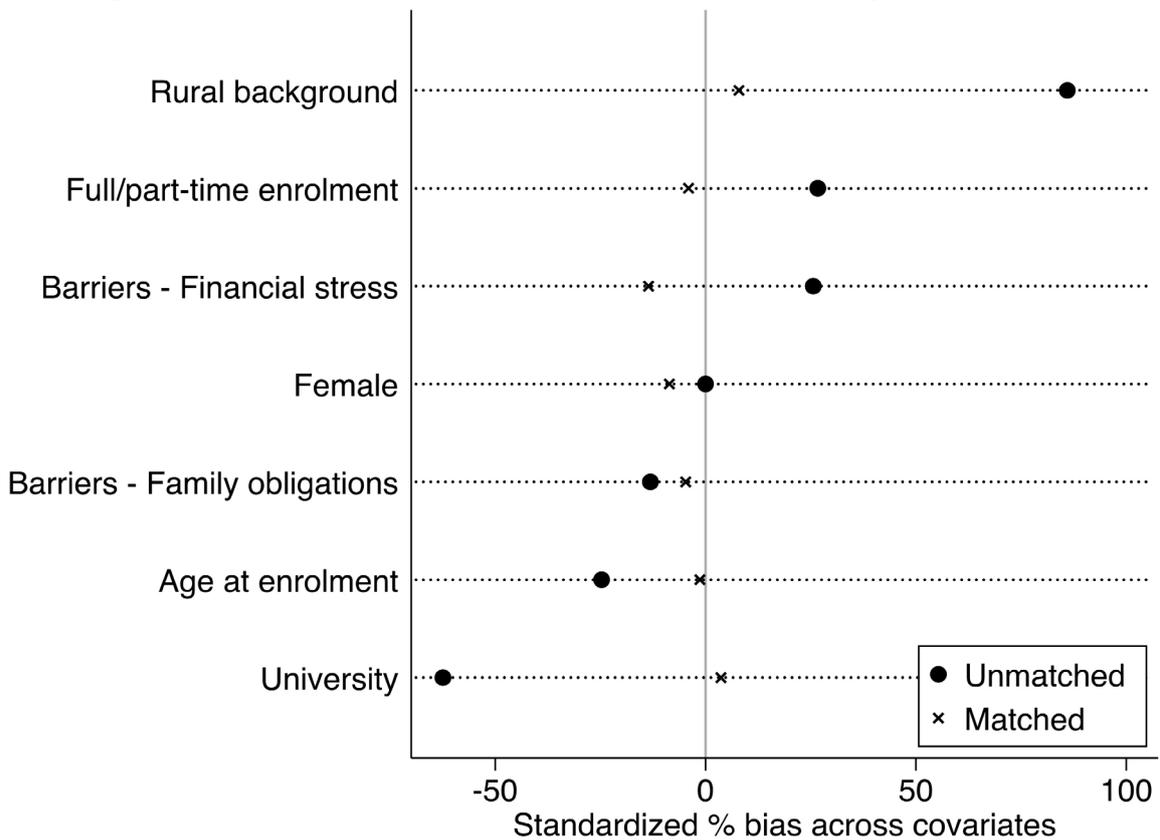
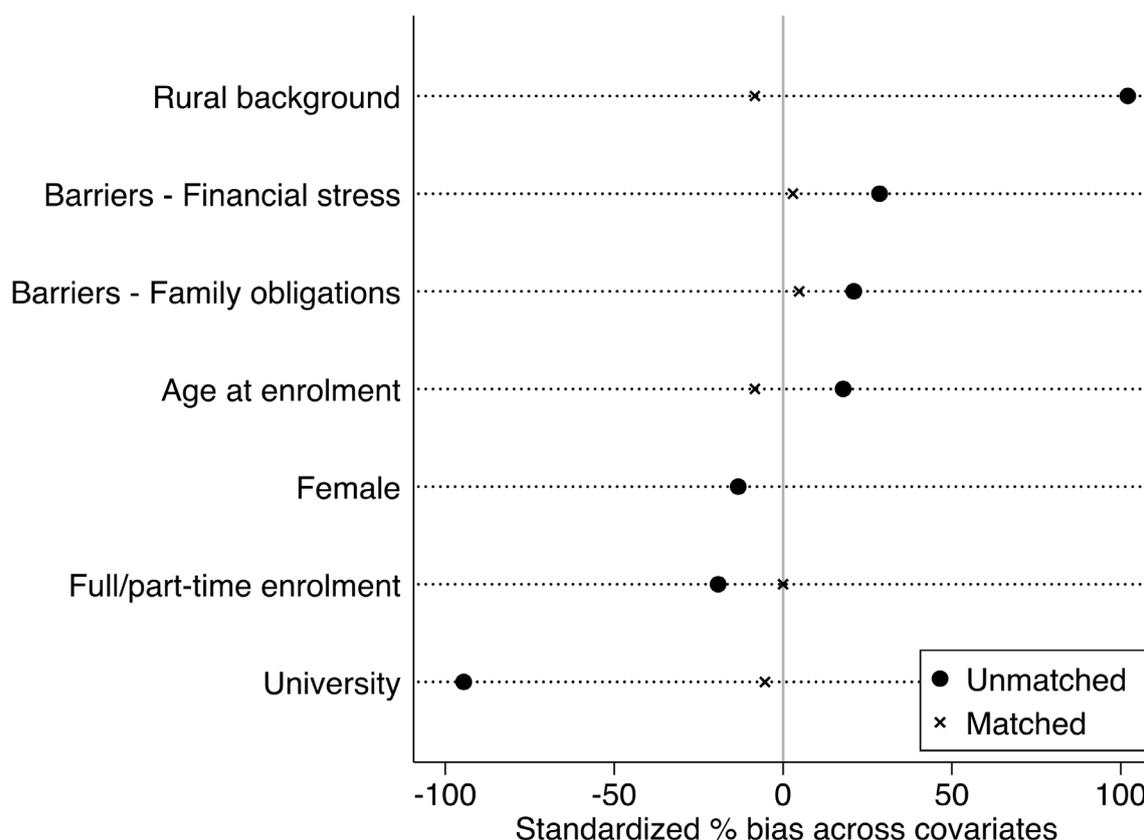


Figure 2b Standardised bias of covariates before and after matching, Nursing and Midwifery



Note: All values of percent standardised bias (after matching) fall within the respective 95% confidence intervals of the empirical sampling distributions of the standardised differences, indicating no significant evidence of propensity score model misspecification.

Figure 2a and Figure 2b demonstrate that matching on the propensity score has reduced most of the mean and prevalence differences in baseline covariates between the two groups. In both models, all values of percent standardised bias after matching fall within the respective 95% confidence intervals of the empirical sampling distributions of the standardised differences, indicating no significant evidence of model misspecification.

Variance ratios—Variance ratios of approximately one suggests similar distributions of the underlying baseline covariates in the matched groups. Table 2 presents comparison of the variance ratios of continuous covariates in the matched and unmatched groups by discipline.

Table 2 Variance ratios of continuous covariates by discipline

Allied Health	V(T)/V(C)[†] Unmatched	V(T)/V(C)[†] Matched
Age at enrolment	0.76*	1.20
Rural background	0.92	0.95
Barriers—Family obligations	0.84	0.87
Barriers—Financial stress	0.99	1.03
Nursing and Midwifery		
Age at enrolment	1.17	1.03
Rural background	1.08	1.03
Barriers—Family obligations	1.22	1.12
Barriers—Financial stress	0.83	1.05
Age at enrolment	1.17	1.03

[†] $V(T)$ and $V(C)$ are covariate variance in the exposure and control groups, respectively.

* if variance ratio outside [0.76; 1.31]

As shown in Table 2, all of the variance ratios of the matched sample fall within the 95% confidence interval of the F-distribution with $n-1$ and $n-1$ degrees of freedom, which may be used to benchmark the paired variances under the assumption of equality (Rosner, 1995). Results imply that balance has been achieved within properly specified models.

Cost-effectiveness analysis

The estimated effect of rural clinical training on hours worked in a rural area was utilised in conjunction with single-year (2018) aggregated cost data to estimate a (pseudo) Cost-effectiveness Ratio (CER). The CER is interpreted not as a whole-of-intervention cost (for example, as would be done with a clinical trial), but as an ongoing operational cost, with previous expenditures for the establishment of program infrastructure treated as sunk costs. Estimation of the CER utilises a stylised disaggregation of RHMT program expenditures to distinguish nursing/allied health training from other RHMT expenditures, with discretionary proportional allocations of shared expenditures based on each program's implicit budget rationale.

Appendix 7: Staff Survey

The Australian Government Department of Health has commissioned KBC Australia to undertake an evaluation of the *Rural Health Multidisciplinary Training (RHMT)* Program.

The aim of this evaluation is to assess the extent to which the current design and delivery of the RHMT Program is achieving its aim of improving the recruitment and retention of medical, dental, nursing and allied health professionals in rural and remote Australia. The evaluation will also consider the benefits to local health delivery from engagement in teaching and training through the RHMT program.

This survey offers the opportunity for professional/administrative and academic staff employed under the RHMT program, as well as people holding conjoint appointments, to participate in the evaluation.

Participation in this evaluation is completely voluntary and you may withdraw at any time without any consequences. Any information you had provided will be destroyed. All information collected in this evaluation will be treated as confidential and deidentified prior to being analysed into a final report to the Commonwealth. Human research ethics approval has been provided by Bond University [HREA JS00505]. By undertaking this electronic survey, you are indicating your consent to participate.

Your participation in this study will assist the Department in the future design and delivery of the RHMT program. We thank you for your time in contributing to this evaluation.

Question	Answer Choices
Q1. Please indicate the University where you are employed or hold a conjoint appointment.	Drop down list of participating universities
Q2. Which RHMT stream do you work with?	Rural Clinical School University Department of Rural Health Other (University faculty; NTMP, Dental Program) Across multiple streams
Q3. Do you identify as Aboriginal and/or Torres Strait Islander?	No, Yes- Aboriginal, Yes- Torres Strait Islander, Yes- Both Aboriginal and Torres Strait Islander
Q4. In what capacity are you employed?	Professional/operational/administrative Student support Academic Clinical Academic

Question	Answer Choices
<p>Q5. What are the key strengths of your RCS/UDRH? (please choose up to 5)</p>	<p>Students/placements</p> <ul style="list-style-type: none"> Variety of placement settings available to students Opportunities for service learning placements Opportunities for hands on clinical experiences Quality of pre-placement preparation and orientation for students Strong focus on student well being Students return for multiple placements Opportunities for inter-professional learning Quality of academic and mentoring support provided to Aboriginal and Torres Strait Islander students <p>Community and Partnerships</p> <ul style="list-style-type: none"> Strong community engagement Strong links with the Aboriginal and Torres Strait Islander community and Aboriginal Community Controlled Health Services Opportunities for students to engage in rural/remote community experiences Quality of clinical supervision training and support Partnerships with local health service providers to support placements Provision of professional development for local health professionals <p>Research</p> <ul style="list-style-type: none"> Quality research program Building local research capacity Capacity to attract research funding <p>OTHER.....</p>

Question	Answer Choices
<p>Q6. What are the key challenges in delivering the RHMT at your RCS/UDRH? (please choose up to 5)</p>	<p>Students/placements Logistics of managing short term placements Managing placements for multiple universities Ensuring placement learning outcomes are met for individual students Managing accommodation for students on placement Selecting students for placement who have genuine interest in rural/remote practice Managing multiple placement sites Providing academic and mentoring support to Aboriginal and Torres Strait Islander students</p> <p>Community and Partnerships Placement capacity has been met (i.e. no capacity in local health services for more or expanded placements) Fragility of supervision capacity Difficulty in engaging health service providers to supervise students Competition for placements between universities Cost of placements Recognition of the university within the local community Establishing strong links with the Aboriginal and Torres Strait Islander community and Aboriginal Community Controlled Health Services</p> <p>Research Limited scope of research under RHMT Accessing funding for rural health research</p> <p>Workforce Recruiting and retaining UDRH/RCS staff Limited local pathways to employment for students after graduation: Medicine Nursing Allied Health Dental</p> <p>Administration Alignment of reporting with program activity Capacity to meet and report on KPIs outside sphere of influence of funded RHMT program participants</p> <p>OTHER.....</p>

Question	Answer Choices
<p>Q7. Please provide up to three (3) suggestions to improve the learning experience for students</p>	
<p>Q8. Please provide up to three (3) suggestions to improve the capacity of the RHMT program to deliver improved rural and remote workforce outcomes (at a local, state/territory or national level)</p>	

Appendix 8: Organisational Stakeholders

SITE VISITS		
New South Wales		
Wagga		
Universities	3 Rivers	<ul style="list-style-type: none"> • Director, research, clinical educators, placement support • Student focus groups – Wagga & Dubbo • Orange based staff – indigenous success, student support, educator
	CSU	<ul style="list-style-type: none"> • Executive Dean, Faculty of Science • Schools of: <ul style="list-style-type: none"> • Community Health • Nursing Midwifery & Indigenous Health • Dentistry & Health Sciences
	UNDA	<ul style="list-style-type: none"> • Assoc Dean, research, clinical educators, placement support • Student focus group – students, interns, registrars • Community Advisory Board Chairman • RTH
	UNSW	<ul style="list-style-type: none"> • Head of School, Manager, Director of Medical Education, research, medical educators, education support • Student focus group • RTH
Other Stakeholders	Murrumbidgee LHD	<ul style="list-style-type: none"> • Director Clinical Governance, Allied Health, Nursing, Medical Services, JMO Manager & Recruitment
	Murrumbidgee PHN	<ul style="list-style-type: none"> • Senior Manager, Commissioning
	Private GPs	<ul style="list-style-type: none"> • Riverina Family Medicine • Koorungal Health • Glenrock Country Practice
	Private Hospital	<ul style="list-style-type: none"> • Calvary
	Community Groups	<ul style="list-style-type: none"> • Wagga Multicultural Centre
	Local Government	<ul style="list-style-type: none"> • Mayor

SITE VISITS		
Broken Hill		
University	USYD – Main Campus	<ul style="list-style-type: none"> • Dean, Medicine & Health, Exec Officer Sydney Medical School, Academic Lead Dental & Dental School Manager
	Broken Hill - USYD	<ul style="list-style-type: none"> • Head of School, Executive team, research, medical educators, clinical educators, placement management & support, cross cultural program • Student focus groups – nurses, medical, pharmacy, social work, new graduates • RTH education support staff
Other Stakeholders	Far West LHD	<ul style="list-style-type: none"> • Chief Executive, Director of Medical Services, Allied Health & Nursing supervisors
	ACCHOS	<ul style="list-style-type: none"> • Maari Ma Aboriginal Health • Coomealla Health Aboriginal Corp
	Local Government	<ul style="list-style-type: none"> • Wentworth Shire- Mayor, Councillor, General Manager
	RFDS	<ul style="list-style-type: none"> • CEO and medical supervisors
	Community	<ul style="list-style-type: none"> • Railway Town School - Health Hub
	Collaborations	<ul style="list-style-type: none"> • Monash collaboration
Central West		
Universities	USYD RCS – Orange & Dubbo	<ul style="list-style-type: none"> • School Manager, Deputy Head of School, education support, research • RTH
	3 Rivers UDRH	<ul style="list-style-type: none"> • Student support, educator, Indigenous health • Student focus group - Dubbo
	WSU RCS - Bathurst	<ul style="list-style-type: none"> • Director, rural program coordinator, research
Other Stakeholders	LHD	<ul style="list-style-type: none"> • Director Medical Services, Director Allied Health
	ACCHO	<ul style="list-style-type: none"> • CEO Orange Aboriginal Medical Service

SITE VISITS		
Wollongong		
Universities	UoW – Main Campus	<ul style="list-style-type: none"> • Dean, RCS Director, RCS Manager, research, graduate outcomes
	UoW RCS - Nowra	<ul style="list-style-type: none"> • Medical educators & supervisors, private GP educators & supervisors, student recruitment, research, indigenous health, operations • Student focus group • RTH
	UoW - Murwillumbah	<ul style="list-style-type: none"> • Academic lead
Other Stakeholders	LHD	<ul style="list-style-type: none"> • Shoalhaven Hospital GM, Director of Nursing, Director of Medical Services
	Community	<ul style="list-style-type: none"> • Advisory Group
	Community/ACCHO	<ul style="list-style-type: none"> • Aboriginal Community Partners group • Woolyungah Indigenous Centre
	Local Government	<ul style="list-style-type: none"> • Shoalhaven City Council Councillor
Lismore		
University	UCRH	<ul style="list-style-type: none"> • UCRH Director, centre manager, operations, educators, indigenous health, clinical & medical educators & supervisors, researchers • Student focus groups – Exercise Physiology & Medical • NNSW RTH
Other Stakeholders	LHD	<ul style="list-style-type: none"> • Chief Executive NNSWLHD, Director Integrated Care, Director Oral Health, Senior Medical Officer, Junior Medical Officers Ballina & Lismore Hospital (ex-students)
	Site Visits - ACCHO	<ul style="list-style-type: none"> • Bullinah Aboriginal Medical Service • Casino Aboriginal Medical Service
	Site Visit	<ul style="list-style-type: none"> • Richmond Lodge Aged Care – Casino (students on placement)
	Community	<ul style="list-style-type: none"> • Kyogle Public School

SITE VISITS		
Newcastle & Tamworth		
University	UoN – Main Campus	<ul style="list-style-type: none"> • Pro Vice Chancellor Health and Medicine, Ass. Director Faculty Services, Academic Lead Research, Executive Officer Dept of Rural Health
	UoN - Tamworth	<ul style="list-style-type: none"> • Director, clinical & medical educators and supervisors, research, placement supervisor, operations, student support • Student focus group
Other Stakeholders	LHD	<ul style="list-style-type: none"> • General Manager Tamworth Hospital
	Private GP	<ul style="list-style-type: none"> • Smith Street Practice
	Community	<ul style="list-style-type: none"> • Community advisory group
	Community/ACCHO	<ul style="list-style-type: none"> • Gomeroi gaaynggal Centre (UON) visit
	Local government	<ul style="list-style-type: none"> • Economic & destination development, Tamworth Regional Council
Australian Capital Territory		
University	ANU RCS	<ul style="list-style-type: none"> • Head of School & Manager of School, medical educator

SITE VISITS		
South Australia		
Universities	Adelaide Uni – Main Campus	<ul style="list-style-type: none"> • Exec Dean, Health & Medical Sciences; Dean, Dentistry; Dean, Medicine; Director, Medical Programs; Student Support
	Adelaide Uni - Whyalla RCS	<ul style="list-style-type: none"> • Director, Manager, medical educators, research, clinical educators, placement support, placement supervisors • Operations staff • Student focus group • RTH
	Uni SA - Main Campus	<ul style="list-style-type: none"> • Dean, Academic & Clinical Education; Heads of: Health Science, Nursing, Pharmacy & Medical Sciences; clinical educators; clinical placements
	Uni SA - Whyalla UDRH	<ul style="list-style-type: none"> • Director, Manager, clinical educators, research, operational staff, • Student focus groups – current and graduates
Other Stakeholders	Public Hospital	<ul style="list-style-type: none"> • Whyalla Hospital & Health Service Visit
	Country Health SA	<ul style="list-style-type: none"> • Allied Health, Clinical Facilitator, Mental Health, Nursing & Midwifery
	Community Groups	<ul style="list-style-type: none"> • Rotary, Solid Start, South Whyalla Football Club
	Local Government	<ul style="list-style-type: none"> • Mayor & Council CEO
	ACCHOs	<ul style="list-style-type: none"> • Ceduna Koonibba Aboriginal Health Service • Port Lincoln Aboriginal Health Service • Nunyara Aboriginal Health Service • Pika Wiya Health Service Aboriginal Corporation
University	Flinders SA - Main Campus	<ul style="list-style-type: none"> • Head of Rural & Remote Health, Manager, clinical educators, operational staff, clinical placements, research • RTH • Student focus group – Parallel Rural Community Curriculum
Other	Community Group	<ul style="list-style-type: none"> • Berri Barmera Health Advisory Council

SITE VISITS		
Tasmania		
University	UTAS - Main Campus	Director MBBS, Indigenous Student Support, Education GP Training, Student Pathways
	UTAS – CRH Launceston	Director, Head of School Health Sciences, placement support, clinical educators, research, operational staff
	UTAS – RCS Burnie	Director, operational staff, medical educators, skills team, student support, community engagement team Student focus groups – Years 4 & 5, graduates RTH
	North West THS	Director of Medical Services
	Private GP	Saunders Street Clinic
	Other Stakeholders	Training visits
	ACCHO	Tasmania Aboriginal Corporation
	Government	Labor Member for Braddon (ex Mayor of Burnie)
Queensland		
University	JCU - Townsville	Deputy Vice Chancellor, Tropical Health & Medicine; Dean, Medicine; Manager, College of Medicine & Dentistry Aboriginal and Torres Strait Islander Health educators & researchers Student focus group – RHINO medicine, pharmacy, dentistry Clinical placements – Allied Health RTH
	JCU - Mt Isa - CRRH	Director, Manager, research, clinical educators & supervisors, operations and placement staff Aboriginal and Torres Strait Islander Health educators & researchers

SITE VISITS		
Other Stakeholders	HHS	Chief Executive, Executive Director Aboriginal and Torres Strait Islander Health, Executive Director Nursing & Midwifery
	PHN	CEO & Exec Manager, Western Qld
	Partnerships	North West Community Rehab
	NGO	Gidgee Healing
	Government	Local: Mayor, Mt Isa; Mayor, Cloncurry State: MP, Traeger
	ACCHOs	IAHA CATSINAM
	Community	Gulf Christian College
South East Queensland – Toowoomba/Dalby		
University of Queensland	UQ – Main Campus	Deputy Exec. Dean & Medical Dean; Exec Dean, Faculty of Medicine; Director, Medical Education; Exec Dean, Health & Behavioural Sciences; Head of School, Dentistry
	UQ – RCS, SQRH	Head of School, Director RCS, Director SQRH, Board Members SQRH, Ops Manager Clinical & medical educators & supervisors, research, operations, student placement & support medical and allied health, skills coordinator RTH Student Focus Group - RCS
	Dalby Dental Clinic	CEO, School Manager, placements, dental educator and supervisor, operations

SITE VISITS		
Other Stakeholders	HHS	<ul style="list-style-type: none"> • Chief Executive, Darling Downs HHS • Exec Director Medical Services, Darling Downs HHS • Chief Executive, South West HHS
	Private Hospital	<ul style="list-style-type: none"> • CEO, St Vincents Private
	Community Advisory Committee (CAC)	<ul style="list-style-type: none"> • members of UQRCS CAC
	Community	<ul style="list-style-type: none"> • Toowoomba Surat Basin Enterprise
Griffith University	Griffith – RCS, Dental	<ul style="list-style-type: none"> • Sub Dean Rural, School of Medicine • CEO, QRME • Head of School Medicine, Head of School Dentistry & Oral Health, medical & clinical educators & supervisors, research • Student Focus Group – RCS
Other Stakeholders	Community Advisory Group	<ul style="list-style-type: none"> • Members of QRME Advisory Group
	HHS	<ul style="list-style-type: none"> • Exec Director, Medical Services Darling Downs HHS, GP & Clinical supervisor
	ACCHO	<ul style="list-style-type: none"> • Goolburri Aboriginal Health Advancement Co. Ltd
Western Australia		
University	UWA – Main Campus	<ul style="list-style-type: none"> • Head, Faculty Service Delivery, UWA Health & Medical Science & Academic Services Manager, Dentistry
	WACRH - Geraldton	<ul style="list-style-type: none"> • Director – WACRH, Centre Manager – WACRH • UWA - Head of Medical School, RCS Team Leader • Private GPs employed as clinical educators medical operations, medical & clinical educators & supervisors, research, student support, RPLO (Karratha & Geraldton), cultural educators • Student Focus Group – RCS, Allied Health

SITE VISITS		
Other Stakeholders	WACHS	<ul style="list-style-type: none"> Regional Director, Regional Medical Director, Population Health, Director Medical Services Geraldton Hospital
	Private Hospital	<ul style="list-style-type: none"> CEO & DON St John of God Hospital
	Private Allied Health	<ul style="list-style-type: none"> Central West Rehabilitation
	ACCHO	<ul style="list-style-type: none"> GRAMS CEO & Clinical Manager
	NGO	<ul style="list-style-type: none"> Desert Blue Connect
	Community	<ul style="list-style-type: none"> Mitchell Street Community Centre Geraldton Sporting Aboriginal Corp Bluff Point Public School Mt Magnet District High School
	Local Government	<ul style="list-style-type: none"> City of Greater Geraldton, Mayor City of Greater Geraldton, Director of Development
	Other	<ul style="list-style-type: none"> AHREN Meeting AHREN - Aboriginal Staff Association Research symposium
Broome		
Universities	UNDA – Main Campus	<ul style="list-style-type: none"> Dean of Medicine
	UNDA – Broome	<ul style="list-style-type: none"> Director of Kimberley Rural Health Alliance Manager, Majarlin Kimberley Centre for Remote Health Student breakfast
	UWA – Broome	<ul style="list-style-type: none"> RCS Head, medical educators & supervisors, operations, research Ex-student focus group

SITE VISITS		
Other Stakeholders	WACHS	<ul style="list-style-type: none"> Regional Director, Regional Medical Director, Senior Medical Officer
	ACCHO	<ul style="list-style-type: none"> CEO, Kimberley Aboriginal Medical Service CEO, BRAMS & Senior Medical Officer, Brams
	Community	<ul style="list-style-type: none"> Broome High School, Clontarf Academy
	Local government	<ul style="list-style-type: none"> Shire representative
Derby		
University	UWA – Derby	<ul style="list-style-type: none"> Deputy Director, medical coordinators, operations, medical supervisors
Other Stakeholders	Community	<ul style="list-style-type: none"> Captain, Derby Volunteer Fire & Rescue Service Director of Derby Clontarf Academy
	Local Government	<ul style="list-style-type: none"> Shire President & Deputy Shire President

SITE VISITS		
Victoria		
University	Deakin – Geelong RCS, UDRH	<ul style="list-style-type: none"> • Former Exec Dean & Head of Medical School, Exec Dean Faculty of Health • Director RCS, Director UDRH • Operations, student placements medical & allied health, allied health educators & supervisors, research, Aboriginal & Torres Strait Islanders health • Student Focus Group – Medicine
Other Stakeholders	Community	<ul style="list-style-type: none"> • Collaboration with Brauer College
	Local Government	<ul style="list-style-type: none"> • Senior Economic Development Officer, Warrnambool City Council
University	Monash - Clayton	<ul style="list-style-type: none"> • Deputy Dean, MBBS, Faculty of Medicine, Nursing & Health Sciences • Head of School, Monash Rural Health • Acting School Manager, Manager Rural Education, Faculty General Manager, Aboriginal & Torres Strait Islander Health – Gukwonderuk, Nursing & Allied Health program • Database management • Student representatives from Rural Health Club
	Monash – Mildura RCS UDRH	<ul style="list-style-type: none"> • Head of School, Director • Operations, clinical & medical educators & supervisors, research, placement coordinators • Student representatives from Rural Health Club • RTH
Other Stakeholders	Mildura Base Hospital (managed by Ramsay Health Care)	<ul style="list-style-type: none"> • CEO, Director of Emergency, Supervisor of Intern Training
	Private Hospital	<ul style="list-style-type: none"> • Mildura Health Private Hospital
	ACCHOs	<ul style="list-style-type: none"> • Director, Mallee District Aboriginal Service

SITE VISITS		
University	UoM – Main Campus	<p>Head of School & School Manager, Melbourne Medical</p> <p>School Manager, Dental</p> <p>Rural dental program educator & oral health</p>
	UoM – Shepparton RCS	<p>RCS - Head & Deputy Head Rural Health</p> <p>Manager and operations, medical student education, clinical skills, medical educators & supervisors, private GPs employed as educators</p> <p>research</p> <p>Student focus group - RCS</p>
	UDRH	<p>UDRH Director, Aboriginal Health, Nursing & Allied Health, Culture & Rural health, student placements, private specialists employed as clinical educators, operations</p> <p>Student focus group – former UDRH students working in region</p>
Other Stakeholders	Private GPs	<ul style="list-style-type: none"> • Lister House Medical Centre • Shepparton Medical Centre • Goulburn Valley Health • Ballarat Health Services
	Private Allied Health	<ul style="list-style-type: none"> • Maryborough District Health Service, Physiotherapist • Healing the Spirit Pty Ltd
	LHS	<ul style="list-style-type: none"> • Moira Health Care • Echuca Regional Health
	Community	<ul style="list-style-type: none"> • The Smith Family • Student Ombudsman

SITE VISITS		
Northern Territory		
University	Flinders NT - Darwin	<ul style="list-style-type: none"> • Exec Dean Medicine and Public Health, Director Medical Education & Training NTMP • Medical & allied health educators & supervisors, research, operations, student placement & support, Aboriginal health educators & researchers (POCHE) • Student focus groups – medicine • Indigenous student focus group - medicine • Alumni focus group - medicine • RTH
Other Stakeholders	Top End HS	• Exec Director Medical Services, Exec Director Allied Health
	Private GP	• Palmerston Super Clinic
	GP Training	• NTGPE
	University	• Charles Darwin University
University	Flinders NT – Katherine	<ul style="list-style-type: none"> • Director, indigenous health educator, supervisor • Student focus group – nursing & allied health
Other Stakeholders	Top End HS	• Senior Emergency Specialist, Katherine Hospital
	Community	• St Joseph’s Catholic College
	Aboriginal Elders Group	• Banatjarl Wumin

SITE VISITS		
University	Flinders NT – Alice Springs CRH	<ul style="list-style-type: none"> • Clinical educators & supervisors, NTMP medical educators & supervisors, operations, student placement, Aboriginal health educator, research, RPLO • Rural Interprofessional Placement Learning NT (RIPPL) • Student focus groups – NTMP, RIPPL Nursing & Alumni • Student representative CARAH
Other Stakeholders	CAHS	<ul style="list-style-type: none"> • Chief Operating Officer, Executive Director of Medical Services, Remote Nursing, Pharmacy, Nursing, Dental, Director of Medicine
	Private Allied Health	<ul style="list-style-type: none"> • Alice Springs Physiotherapy • Eyecare Plus
	ACCHO	<ul style="list-style-type: none"> • Central Australian Aboriginal Congress - site visit • Aboriginal Medical Services Alliance NT
	Research	<ul style="list-style-type: none"> • Menzies Research • NT Government Research • Central Australia Research Centre
	Community	<ul style="list-style-type: none"> • Acacia Hill School

JURISDICTIONS	
NSW	Workforce Planning & Development, Medical Workforce
QLD	Allied Health, Dental, Medical, Nursing, Rural Generalist
VIC	Allied Health, Medical Workforce, Health Workforce Strategy
WA	Allied Health, Allied Health Workforce, Medical Workforce
SA	Trainee Medical Unit, Regional Training Manager
NT	Chief Health Medical Officer, CEO, Allied Health, Pharmacy

OTHER CONSULTATIONS	
Rural Health Commissioner Universities Australia Editor, Australian Journal Rural Health Rural Doctors Association Department of Health – Workforce, Nursing, Allied Health, Medical Specialists, Medical Advisory & Prevocational Accreditation, Aboriginal & Torres Strait Islander Department of Education Medical Deans Australian Council of Deans of Health Sciences	
Meetings Attended	FRAME Meetings –Tamworth & Canberra
	AHREN Meetings – Canberra & Geraldton
Conferences Attended	Allied Health Conference
	RMA19

ROUND TABLES	REPRESENTATIVES
Workforce Agencies	Rural Health West Health Workforce Queensland NSW Rural Doctors Network Rural Workforce Agency Victoria Rural Doctors Workforce Agency SA HR Plus TAS Rural Workforce Agency NT Rural Workforce Agency Network
Aboriginal & Torres Strait Islander	AIDA IAHA LIME NACCHO

WRITTEN SUBMISSIONS

Responses received from:

ACCRM
AHHA
AHREN
AMA
ANZCA
40
APS
Aust College of Dermatology
Aust College of Nursing
CATSINAM
CRANAPlus
ESSA
EVGP Training
IAHA
JCU GP Training
LIME
Murray City Country Coast GP
NRHA
NRHSN
NTGPE
Occupational Therapy Australia
RACGP
RACS
RANZCOG
RANZCP
SARRAH
Universities Australia
Uni of Syd School of Medicine
WAGPET

Appendix 9: Evaluation Interview Schedules

University – Deans

Questions

- What role does your faculty have in training medical/nursing/allied health/ dentists to meet rural workforce needs?
- Under the RHMT program, enrolment targets were established for rural origin medical students and for nursing, allied health and dental students since 2016. What have been the challenges and enablers to meeting targets?
- Under the RHMT program, enrolment and graduation targets have been set for Aboriginal and Torres Strait Islander students. How does activity under the RHMT program align with and complement broader efforts by the University to support enrolment and graduation of Aboriginal and Torres Strait Islander students?
- What has been the value/benefit of having the RCS/UDRH?
 - To your university
 - To the Faculty
 - To community engagement
 - To research impact
- What investment (financial and in-kind) does the faculty make in rural training in addition to the RHMT contract?
- For your university, do the benefits of the having the RHMT program outweigh the costs?
- What has been the impact of restriction of research to workforce and rural service delivery since 2016?
- What is needed to dovetail the RHMT program into a broader rural health workforce response?
- When was the last time the university undertook an internal evaluation of the RHMT program?

University – Faculty Manager/ Course Coordinator

Quality rural training experiences

- What role does your RCS/UDRH play in ensuring quality rural placements for students?
- For students being placed with the RCS/UDRH, to what extent has the university been able to provide training and training placements for students with educational standards comparable with metro-based placements?
- To what extent do rural placements provide:
 - Exposure to unique rural practice contexts

- High quality supervision
- Interdisciplinary learning opportunities
- Cultural safety training
- Student support
- What are the strengths and weaknesses of current approaches to prepare/promote a student for rural practice or rural health career? Do you think many of your students intend to work rurally after graduation?
- How has the university incorporated an understanding of rural health and Aboriginal and Torres Strait Islander Health into the course curricula?
- To what extent has the RHMT program contributed to changes to curricula over time?

Consolidation of the RHMT Program

- To what extent has consolidation of the RHMT program changed the delivery of your medical, nursing and allied health courses/programs?
 - New training and supervision approaches
 - Broader placement opportunities
- What are the advantages and disadvantages of a single contract for RCS, UDRH (and DERTP, NTMP where relevant)?
 - Efficiencies? Costs?

Rural origin and rural streams

- What strategies has the university adopted to increase the number of rural origin students into:
 - Medicine
 - Nursing
 - Allied Health
 - Dental
- Are the targets for rural origin students appropriate/achievable for this university?
- Selection occurs at the point of entry to university, are rural origin students/ rural interest students streamed into rural training placements? How?
- What's working well? Challenges?
- What criteria do you use to choose students for a rural placement with the UDRH/RCS?
 - Differences between medicine, nursing, allied health, dental?

Management and Administration

- For your university, do the benefits of having an RHMT program outweigh the costs? In what way?

- How is the program managed from a financial perspective? (Who manages the budget? Who determines where the \$ are spent?)
- When was the last time the university undertook an internal evaluation of the RHMT program?

Directors RCS/UDRH and Senior Staff

Quality Rural Training

- What role does your faculty have in training medical/nursing/allied health/ dentists to meet rural workforce needs?
 - What investment (financial and in-kind) does the faculty make in rural training in addition to the RHMT contract?
- How does the RCS/UDRH ensure that students have rural training opportunities comparable with or better than metro placements?
- To what extent has the RCS/UDRH met training targets?
 - Barriers and enablers
- UDRHs – what are the challenges and benefits of providing placements to multiple universities?
- How has the university incorporated Indigenous health and rural health into the course curricula?
 - How is this contextualised at a site level?

Rural origin/ rural stream

- To what extent does the RCS/UDRH have input into the selection of students for rural placements?
 - Are there opportunities to better align selection processes for students with interest in rural health?

Health of Aboriginal and Torres Strait Islander people improved by having and RHMT in the region

- Do you know of any strategies the RCS/UDRH have in place to support students (Indigenous and non-Indigenous):
 - To engage with local Aboriginal health services
 - To engage with local Aboriginal culture
- What's working well? What's not?

- Do you know of any strategies the UDRH/RCS have in place to promote development of the Aboriginal and Torres Strait Islander health workforce?
 - Factors facilitating/ hindering development?
 - Exemplars/ case studies/ Innovative approaches
- In your opinion is there value/benefit that the RCS/UDRH provides to local Aboriginal health services and the local Aboriginal communities?

Academic Networks available in RHMT areas

- How has the RCS/UDRH developed and maintained supervision capacity?
- How has the RCS/UDRH developed research capacity and capability in the local workforce and in students?
- Do the UDRH/RCS Researchers have equal access to Faculty grants, research support and collaboration opportunities to that of the main campus?
- What has been the impact of restriction of research to workforce and rural service delivery since 2016?
- To what extent has research generated through the RHMT program at this university, been applied in the education and training, health service development or workforce policy environment? Examples

Benefits to the Community

- To what extent has the community/region benefitted by having the RCS/UDRH in the area?

Appropriateness as a workforce response

- To what extent has the RHMT and its precursors contributed to health workforce outcomes?
 - Policies or programs that help or hinder (Local Health Network, jurisdiction or national level)
 - What are the key factors/ strategies that facilitate the transition from training in rural areas to rural practice?
 - What is needed to dovetail the RHMT program into a broader rural workforce response?

Management and Administration

- How is the program managed from a financial perspective? (Who manages the budget? Who determines where the \$ are spent?)
- When was the last time the university undertook an internal evaluation of the RHMT program

- If you could suggest anything to improve the program at your university or the program overall what would it be?

Local health service providers

Quality rural training placements

- To what extent have you/ your service been involved in or supported the provision of rural clinical training placements for students?
 - What has worked well? Challenges?
 - Benefits/costs to you/your organisation? (financial/in-kind e.g. conjoint appointments, fee for service, block payments)
- What would be needed to increase the number of placements you host, or extend the duration of placements?
- What do you see as the benefits for students in undertaking the rural placement?
- How does the RCS/UDRH ensure students have rural training opportunities comparable to or better than metro?
 - Academic outcomes
 - Student support
 - Clinical supervision
 - Cultural safety training
- How has the university incorporated Indigenous health and rural health into the course curricula? How is this contextualised at your local site?

Rural Origin

- To what extent do the students you have on rural placement have a genuine interest in rural health and a rural career?
 - Are there opportunities to better align selection processes for students with interest in rural health?
- What are the key factors/ strategies that facilitate the transition from training in rural areas to rural practice? In your opinion, what percentage of the students who go on rural placement go on to work rurally?
-

For Aboriginal Health Services/ Organisations

- Do you know of any strategies the RCS/UDRH have in place to support students (Indigenous and non-Indigenous):
 - To engage with local Aboriginal health services
 - To engage with local Aboriginal culture

- How well are these working?
- Do you know of any strategies the UDRH/RCS have in place to promote development of the Aboriginal and Torres Strait Islander health workforce?
 - Factors facilitating/hindering development?
- In your opinion what value/benefit does the RCS/UDRH provide to local Aboriginal health services and the local Aboriginal communities?

Academic Networks

- To what extent have you/ your service benefited from the work of the RCS/UDRHs to develop academic networks?
 - Supervision capacity and capability
 - Recruitment and retention of new staff
 - Research capacity building
 - Application of local research and evaluation findings

Local health service delivery

- Are you aware of any additional clinical services or health related programs that are in place in your community/region through the work of the RCS/UDRH?
- Do you know if any of your doctors, nurses or allied health staff had a rural placement in their university training years?
- Who provides cultural competency training for your new staff?
 - Does the RCS/UDRH partner in this?
- What are the benefits/costs to you/your organisation to work with the RCS/UDRH (financial/in-kind)?
- How visible is the RHMT program/UDRH/RCS in your community?
- For your service do the benefits of having the RHMT program outweigh the costs? In what way?
- To what extent has the community/region benefitted by having the RCS/UDRH in the area?

Appropriateness as a workforce response

- To what extent has the RHMT and its precursors contributed to health workforce outcomes?
 - Policies or programs that help or hinder (Local Health Network, jurisdiction or national level)
- What is needed to dovetail the RHMT program into a broader rural workforce response?

Community Stakeholders

Quality rural training placements

- To what extent have you/ your community group supported the provision of rural clinical training placements for students?
 - What has worked well? Challenges?
- Benefits/costs to you/your group? (financial/in-kind)
- What do you see as the benefits for students in undertaking the rural placement?

Rural Origin

- With the students that you have engaged with, to what extent do you think they have a genuine interest in rural health and a rural career?
- Are there opportunities to better align selection processes for students with interest in rural health?

For Aboriginal Health Services/ Organisations/ Community groups

- Do you know of any strategies the RCS/UDRH have in place to support students (Indigenous and non-Indigenous):
 - To engage with local Aboriginal health services
 - To engage with local Aboriginal culture
- How well are these working?
- Do you know of any strategies the UDRH/RCS have in place to promote development of the Aboriginal and Torres Strait Islander health workforce?
 - Factors facilitating/hindering development?
- In your opinion what value/benefit does the RCS/UDRH provide to local Aboriginal health services and the local Aboriginal communities?

Benefits to the Community

- How visible is the RHMT program/UDRH/RCS in your community?
- To what extent has your community/region benefited from having the RCS/UDRHs in your area?
 - Community projects/ capacity building
 - Local education and training for health professionals and others
 - Economic and social impacts
 - Infrastructure
 - Research capacity building

- Application of local research and evaluation findings
- Are you aware of any additional clinical services or health related programs that are in place in your community/region through the work of the RCS/UDRH?

Appropriateness as a workforce response

- To what extent has the RCS/UDRH contributed to the health workforce in your area?
 - Do you know if any of the local doctors, nurses or allied health staff had a rural placement in their university training years?

What do you see as the key factors/ strategies that facilitate the transition from training in rural areas to working in rural practice?

What is needed to dovetail the RHMT program (UDRH/RCS) into a broader rural workforce response?

Northern Territory Medical Program - Additional Questions

Flinders University NT – Faculty Lead; UDRH and RCS sites; Charles Darwin University; ACCHOs; NT Government stakeholders;

- How has the University progressed pathways for Aboriginal and Torres Strait Islander Northern Territorians and non-Aboriginal and Torres Strait Islander Territorians into the NTMP?
- Are you aware of new approaches that have been adopted in recent years?
 - Partnerships/strategies to support Aboriginal and Torres Strait Islander secondary school students in the NT aspire to and enrol in the NTMP
 - Partnership/strategies developed with Charles Darwin University to promote pathway from CDU Bachelor Clinical Sciences to NTMP
 - Strategies to promote enrolment of Aboriginal and Torres Strait Islander students into Preparation for Medicine Program (PMP) and Flinders University Extended Learning in Science Program
- Challenges and enablers to current approaches?
- Opportunities for improvement?
- How does the University support Aboriginal and Torres Strait Islander student progress through and complete their course?
 - Partnerships in place to progress support strategies
 - Academic, financial, mentoring – uptake by students
 - Barriers and enablers to accessing supports
 - Areas of unmet need?
- To what extent has the NTMP curriculum and training activities changed over recent year to promote understanding of Aboriginal and Torres Strait Islander health and cultural safety?

- What's working well? Areas for improvement?

Recently established University Departments of Rural Health

Directors UDRH, Managers, Senior Staff

- What support/ contribution has the University made to the establishment of the UDRH?
 - Financial, in-kind, academic
 - What activities have been progressed to establish the new UDRH in relation to:
 - Student and teaching infrastructure
 - Student placements and supervision capacity
 - Student support and wellbeing
 - Developing academic capacity and capability
 - Linkages with local health services and Aboriginal Community Controlled Health Organisations
 - Linkage with community stakeholders
 - Linkages with other universities operating RHMT programs in the region?
- What is working well?
- What are the challenges? How are these being addressed?
- To what extent is the UDRH on track to meeting training targets?
- To what extent does the UDRH have input into the selection of students for rural placements

Regional Training Hub specific questions

Regional Training Hub personnel and RCS Directors; LHN – Directors of Medical Services; Jurisdiction and State/Territory Training Agency; Rural Workforce Agencies

- What activities have been progressed to facilitate the development of new training places and a regional training pathway?
 - Focus of new training posts and pathways (specialist/ generalist)?
- What is the role of the Regional Training Hub in developing the pathway?
- How has this role been negotiated with the Local Health Networks and medical colleges?
- To what extent is the hub integrated within the RCS/UDRH?
- What strategies are in place to identify and support medical students and junior doctors onto a regional pathway and guide them on the pathway?
- What's working well?
- Areas for improvement?
- What policies at a Local Health Network, jurisdiction or national level, help or hinder the

development of an integrated regional training pathway?

Jurisdictions

Chief Officers – Allied Health, Nursing, Medicine; Health Workforce Branch Managers

- Seeking to understand where the RHMT program fits in the context of state and territory health workforce development.
 - What are the key state/territory - level policies that are relevant to the education, training and early career development of the rural medical/ nursing/allied health and dental workforce?
 - What engagement does your office/dept have with the RHMT program (RCS, UDRH, Dental extended training placements, Regional Training Hubs)?
 - What value has the RCSs/UDRHs provided to the development of rural training and research capacity in your state/territory?
 - To what extent do you think the RCSs/UDRHs have contributed to developing the rural health workforce? Data or evidence to demonstrate your response?
 - What factors have helped or hindered their contribution?
 - What aspects of the RHMT program could be improved?
 - At a jurisdiction level, what are the key policies/ strategies that could strengthen the transition from training in rural areas to working rurally?
- Consider:
 - Training
 - Clinical Placements
 - Supervision capacity
 - Early career positions
 - Specific rural and remote recruitment and retention strategies.

Student Focus Group Questions

All Students

- What do you know about the UDRH/RCS and work they do to support students undertaking rural training?
- What was/is different about your rural placement compared with other placements?
Consider:
 - Quality of supervision and teaching experience
 - Opportunity to expand clinical learning and develop work readiness skills
 - Opportunity for interdisciplinary learning facilitated by the UDRH/RCS
 - Attitude of health service staff to student and organisational culture supportive of

teaching and learning

- Personal circumstances to be able to undertake the placement
- Engagement with the local rural community/ participation in local activities
- Engagement with Aboriginal and Torres Strait Islander community and services
- Financial and/or other support
- How well was your rural placement organised?
 - Are students and health services adequately supported by the learning institution/ parent uni.,
- Are you a member of the Rural Health Club?
 - What type of activities have been offered/ have you participated in?
 - What has been the value/benefits of engagement with the Rural Health Club?
- Did you choose to do a rural placement? Why/why not?
- What value or benefit has the rural placement provided to you?
- Did this placement influence your intention to work rurally and if not, why not?
- How could rural placements be improved?

Aboriginal and Torres Strait Islander Students

- What was the process/pathway you followed for selection into university?
- What supports are available to progress your education and training? (e.g. academic support, financial support, mentoring) Do you access these? If not, why not?
- What do you know about the UDRH/RCS and work they do to support students undertaking rural training?
- What was/is different about your rural placement compared with other placements?

Consider:

 - Quality of supervision and teaching experience
 - Opportunity to expand clinical learning and develop work readiness skills
 - Opportunity for interdisciplinary learning facilitated by the UDRH/RCS
 - Attitude of health service staff to student and organisational culture supportive of teaching and learning
 - Personal circumstances to be able to undertake the placement
 - How are connections to the local Aboriginal and Torres Strait Islander community facilitated?
 - Did you feel the UDRH/RCS is a culturally safe place to learn?
- Do you think the UDRH/RCS is having an impact on Aboriginal and Torres Strait Islander health in the community? How? If not, why not?
- Are you a member of the Rural Health Club?
 - What type of activities have been offered/ have you participated in?

- What have been the value/benefits of engagement with the Rural Health Club?
- What value or benefit has the rural placement provided to you?
- Did this placement influence your intention to work rurally and if not, why not?
- How could rural placements be improved?

Appendix 10: Evaluation Written Submissions

Evaluation of the Rural Health Multidisciplinary Training Program

Written Submission

Background to the Rural Health Multidisciplinary Training Program

It is well known that there are major inequities in health status for people residing in rural, remote and regional Australia when compared with metropolitan areas. Inequity in access to medical practitioners, allied health professionals, nurses, pharmacists and dentists for rural, remote and regional residents compromises Australia's ability to deliver comprehensive health care to all.

In the late 1990s and early 2000s, the Australian Government established a series of University Departments of Rural Health (UDRH) and Rural Clinical Schools (RCS) to provide an academic network and infrastructure to train rural medical and health professionals with the long term aim of addressing the maldistribution of the health workforce. In 2016 the Department of Health consolidated the UDRH Program, the Rural Clinical Training and Support Program, the Dental Training – Extended Rural Placements Program and the Northern Territory Medical Program into the Rural Health Multidisciplinary Training (RHMT) Program.

Overview of the RHMT Program

The RHMT program now funds a national network of 19 Rural Clinical Schools, 16 University Departments of Rural Health, six dental schools that support rural placements for students across the health disciplines – medicine, nursing, allied health, dentistry as well as 26 regional training hubs. There are 21 universities participating in the RHMT program with current funding of approximately \$200 million per annum supported by the Department of Health until 31st December 2020.

A list of the RCSs and UDRHs funded under the program is available on the Department of Health website:

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/rural-health-multidisciplinary-training>.

The **objectives** of the program are:

- To provide rural training experiences for health students;
- To develop an evidence base for the efficacy of rural training strategies in delivering rural health workforce outcomes;
- To provide support to rural health professionals to improve Aboriginal and Torres Strait Islander health;

- To increase the number of rural origin medical, nursing, allied health and dental students;
- To maintain well-supported academic networks to enhance the delivery of training to students, junior doctors and specialist trainees.

The RHMT Program Evaluation

KBC Australia has been commissioned by the Australian Government Department of Health to undertake an evaluation of the RHMT program. An earlier evaluation of the UDRH and RCS Programs occurred in 2008:

[https://www.health.gov.au/internet/main/publishing.nsf/Content/A3760E61F341B7F5CA257BF0001D73AB/\\$File/udrheval.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/A3760E61F341B7F5CA257BF0001D73AB/$File/udrheval.pdf)

The objective of this evaluation is to assess the extent to which the current design and delivery of the RHMT Program is achieving its aim of improving the recruitment and retention of medical, dental, nursing and allied health professionals in rural and remote Australia. The evaluation will also consider the benefits to local health delivery from engagement in teaching and training through the RHMT program.

Submission

As a component of the evaluation, we are seeking submissions from peak bodies, professional colleges and associations. Please consider the following questions.

Please limit your response to a total of 5 pages and return it to manager@kbconsult.com.au by Friday 6th September 2019.

Name of Organisation/Peak Body: _____

1. What has been your organisation's engagement and/or experience with the RHMT program to date? Please consider your experience with relevant streams of the program including RCS, UDRH, rural dental training programs and regional training hubs.
2. What is the value/benefit of the RHMT program to your profession or stakeholder group?
3. In relation to your engagement with the program, what aspects could be improved?
4. What opportunities are there to strengthen the transition from training in rural locations to working rurally for your profession/ stakeholder group?
5. In considering the appropriateness of the RHMT program as a continuing response to addressing rural health workforce shortages and improving workforce distribution:
 - a. To what extent is the development and maintenance of academic capacity and training infrastructure in rural and remote areas the right approach to improving workforce outcomes for your profession/ stakeholder group? What else is required?
 - b. To what extent is selection of health students on rural origin or interest, and training in rural locations, the right approach to contribute to rural service provision after graduation for your profession/ stakeholder group? What else is required?

Written Submission: Aboriginal and Torres Strait Islander Peak Bodies

Evaluation of the Rural Health Multidisciplinary Training Program

Written Submission

Background to the Rural Health Multidisciplinary Training Program

It is well known that there are major inequities in health status for people residing in rural, remote and regional Australia when compared with metropolitan areas. Inequity in access to medical practitioners, allied health professionals, nurses, pharmacists and dentists for rural, remote and regional residents compromises Australia's ability to deliver comprehensive health care to all.

In the late 1990s and early 2000s, the Australian Government established a series of University Departments of Rural Health (UDRH) and Rural Clinical Schools (RCS) to provide an academic network and infrastructure to train rural medical and health professionals with the long term aim of addressing the maldistribution of the health workforce. In 2016 the Department of Health consolidated the UDRH Program the Rural Clinical School Training and Support Program, the Dental Training - Extended Rural Placements Program and the Northern Territory Medical Program into the Rural Health Multidisciplinary Training (RHMT) Program.

Overview of the RHMT Program

The RHMT program now funds a national network of 19 Rural Clinical Schools, 16 University Departments of Rural Health, six dental schools that support rural placements for students across the health disciplines – medicine, nursing, allied health, dentistry as well as 26 regional training hubs. There are 21 universities participating in the RHMT program with current funding of approximately \$200 million per annum supported by the Department of Health until 31st December 2020.

A list of the RCSs and UDRHs funded under the program is available on the Department of Health website:

<https://www1.health.gov.au/internet/main/publishing.nsf/Content/rural-health-multidisciplinary-training>.

The objectives of the program are:

- To provide rural training experiences for health students;
- To develop an evidence base for the efficacy of rural training strategies in delivering rural health workforce outcomes;
- To provide support to rural health professionals to improve Aboriginal and Torres Strait Islander health;
- To increase the number of rural origin medical, nursing, allied health and dental students;

- To maintain well-supported academic networks to enhance the delivery of training to students, junior doctors and specialist trainees.

The RHMT Program Evaluation

KBC Australia has been commissioned by the Australian Government Department of Health to undertake an evaluation of the RHMT program. An earlier evaluation of the UDRH and RCS Programs occurred in 2008:

[https://www.health.gov.au/internet/main/publishing.nsf/Content/A3760E61F341B7F5CA257BF001D73AB/\\$File/udrheval.pdf](https://www.health.gov.au/internet/main/publishing.nsf/Content/A3760E61F341B7F5CA257BF001D73AB/$File/udrheval.pdf)

The objective of this evaluation is to assess the extent to which the current design and delivery of the RHMT Program is achieving its aim of improving the recruitment and retention of medical, dental, nursing and allied health professionals in rural and remote Australia. The evaluation will also consider the benefits to local health delivery from engagement in teaching and training through the RHMT program.

Submission

As a component of the evaluation, we are seeking submissions from peak bodies, professional colleges and associations. Please consider the following questions.

Please limit your response to a total of 5 pages and return it to manager@kbconsult.com.au by Friday 6th September 2019.

Name of Organisation/Peak Body: _____

1. What has been your organisation's engagement and/or experience with the RHMT program to date? Please consider your experience with the relevant streams of the program including the RCS, UDRH, regional dental training programs and regional training hubs.

Questions 2 - 5 focus on the elements of the RHMT program targeted to improving Aboriginal and Torres Strait Islander health and building the Aboriginal and Torres Strait Islander workforce.

2. What value/benefit has the RHMT program provided to develop the Aboriginal and Torres Strait Islander workforce?
3. What value/benefit has the RHMT program provided to improving Aboriginal and Torres Strait Islander health outcomes?
4. In relation to your engagement with the program, what aspects could be improved?
5. What opportunities are there to strengthen the transition from training to working for your profession/ stakeholder group?

Question 6 relates to the impact of the RHMT program on rural and remote health/workforce outcomes.

6. In considering the appropriateness of the RHMT program as a continuing response to addressing rural health workforce shortages and improving workforce distribution:
 - a. To what extent is the development and maintenance of academic capacity and training infrastructure in rural and remote areas the right approach to improving workforce outcomes for your profession/ stakeholder group? What else is required?
 - b. To what extent is selection of health students on rural origin or interest, and training in rural locations, the right approach to contribute to rural service provision after graduation for your profession/ stakeholder group? What else is required?

Appendix 11: Evaluation Rubrics

Quality Rural Training Experiences – Allied Health and Nursing

Excellent RURAL training experiences involve ALL of the aspects of Very Good training for the majority of students

Very Good RURAL training experiences involve most of the following for the majority of students:

- Placements of at least 6 weeks to allow for adequate rural experience
- Free or highly subsidised accommodation
- Written pre-placement information to students about local amenities and opportunities
- Regular access to educators and/or supervisors relevant to discipline
- Face-to-face orientation to clinical placement and location
- Clear learning outcomes of the clinical placement
- Face-to-face cultural safety training contextualised to the location
- Placement includes planned and structured engagement with Aboriginal health services and/or community organisations
- Access to library services
- Students have access to organised inter-disciplinary learning opportunities
- Students have opportunity to debrief with UDRH staff about clinical placement and personal issues
- Students have opportunity to meet people and undertake activities in the local community
- Evaluation processes for improvement

Good RURAL placements involve all conditions for Baseline placements plus two or more of components of Very Good placements for the majority of students

BASELINE RURAL placements involve the following for the majority of students:

- Placements of minimum 2 weeks
- Placements are in RA 2-5 locations
- Clinical experience specifically relevant to rural job opportunities
- Supervision provided by local clinicians
- Written orientation to placement and location
- Online or written cultural competence training provided
- Minimal accommodation support provided (e.g. scholarships, bursaries, minimal subsidies)

Poor RURAL placements involve the following for the majority of students:

- Placements of two weeks duration
- Minimum awareness of placement/student requirements by supervisor
- No orientation to location or placement
- No cultural competence training
- UDRH acts only as placement broker
- No accommodation support

Quality Rural Training Experiences – Medicine

Excellent RURAL training experiences involve ALL of the aspects of Very Good training for the majority of students

Very Good RURAL training experiences involve MOST of the following for the majority of students:

- Free or highly subsidised accommodation
- Written pre-placement information to students about local amenities and opportunities
- Regular access to medical educators and/or supervisors
- Students have access to organised inter-disciplinary learning opportunities
- Face-to-face orientation to clinical placement and location
- Face-to-face cultural safety training contextualised to the location
- Placement includes planned and structured engagement with Aboriginal health services and/or community organisations
- Opportunities for students to meet people and undertake activities in the local community
- Students have opportunity to debrief with RCS staff about clinical placement and personal issues
- Evaluation processes for improvement

Good RURAL placements involve all conditions for baseline placements plus two or more of components of excellent placements for the majority of students

Baseline RURAL placements involve the following for the majority of students:

- Placements are in RA 2-5 locations
- Clinical training experience specifically relevant to rural job opportunities
- Supervision provided by local clinicians
- Access to library services
- Written orientation to placement and location
- Online or written cultural competence training provided
- Minimal accommodation support provided (e.g. scholarships, bursaries, minimal subsidies)

Poor RURAL placements involve the following for the majority of students:

- No orientation to location or placement
- No cultural competence training
- RCS acts only as placement broker
- No accommodation support provided

Research

Excellent research capacity building involves (in addition to elements of good research capacity) most of the following:

- Opportunities for research collaboration (local, AHREN/FAME, NHMRC etc)
- Institutional recognition of applied research
- Research networks established (university or regional level)
- High level research skills and expertise available (ethics, statistical, IP/legal, methodological, grant writing)
- Mentoring for researchers
- Partnerships with Aboriginal and Torres Strait Islander services and organisations to inform and undertake local research activities
- Active development of research capacity and capability of local Aboriginal and Torres Strait Islander staff or community members
- Clear publication metrics for RHMT supported research
- Demonstrable institutional support for clinical practice-based research networks (e.g. funds provided; research skills training)
- Demonstration of research translation locally

Very Good research capacity involves (in addition to elements of good research capacity) most of the following:

- Opportunities for research collaboration (local, AHREN/FAME, NHMRC etc)
- Institutional recognition of applied research
- Research networks established (university or regional level)
- High level research skills and expertise available (ethics, statistical, IP/legal, methodological, grant writing)
- Engagement with Aboriginal and Torres Strait Islander services and organisations to inform local research priorities and activities
- Mentoring for researchers
- Clear publication metrics for RHMT supported research
- Demonstrable institutional support for clinical practice-based research networks (e.g. funds provided, research skills training)
- Demonstration of research translation locally

Good research capacity involves most of the following:

- Basic research skills available through university networks (e.g. statistics) to support local research (internal, students, local clinicians)
- Local research networks established
- Staff supported to complete higher degrees
- Dedicated research staff employed at local sites
- Demonstrable institutional support for clinical practice-based research networks (e.g. funds available)
- Research priorities reflect local priorities

Baseline research capacity involves the following:

- Research plan
- All academic positions include allocation for research
- Focus of research on Indigenous health, rural workforce and service delivery

Poor research capacity involves the following:

- No research plan
- No dedicated research positions
- Research limited to support for student projects

Building and Supporting Supervision Capacity

Excellent supervision capacity building involves (in addition to elements of good supervision capacity) most of the following:

- Support for supervisors to complete educational qualifications
- Support for supervisor-led research
- Documented governance processes to ensure supervisor safety and quality
- Building organisational capacity in local health services for supervision including administration, clinical education capability and workplace assessment capacity

Very Good supervision capacity building involves most of the following for the majority of supervisors:

- Opportunities to participate in research
- Face to face supervisor training
- Supervisor mentoring
- Conjoint appointments
- Formal process for dealing with issues/complaints from supervisors or students
- Supervisors familiar with curriculum and assessment requirements

- Supervisors provided with individualised information about students' learning objectives
- Supervisors provided with cultural safety training
- Regular feedback mechanisms
- Networking opportunities for supervisors

Good supervision capacity building includes all conditions for baseline capacity building plus two or more of components of Very Good capacity building for the majority of supervisors

Baseline supervision capacity building involves the following for the majority of supervisors:

- On-line supervisor training resources
- Basic supervisor orientation
- Ad hoc feedback to supervisors
- Informal processes for dealing with issues/complaints from supervisors or students
- Access to library services
- Supervisors provided with basic information about student learning objectives for placements
- On-line or written cultural safety training provided

Poor supervision capacity involves the following for the majority of supervisors:

- Placements organised by universities with no input from RHMT sites

Appendix 12: Framework for Integrated Rural Medical Training Strategy

1. **Joint Planning. Regional Training Collaborative** develops and maintains a single integrated medical workforce plan inclusive of public, private, acute and primary care for the region, developed in open partnership and collaboration with stakeholders, identifying opportunities, capacity and need across all levels of the training pipeline.
2. **Integrated information communication technologies**—The Regional Training Collaborative maximises the ICT capacity and capability of the parties to progress innovative methods of education and training, supervision and health care delivery.
3. **Effective change management**—The Regional Training Collaborative has the leadership capacity to coordinate each parties' resources and efforts towards implementing the integrated regional medical training strategy, and shared vision evidenced by willing (voluntary) collaboration at all levels, continued integration and sharing of resources, increased access to training and employment opportunities leading to improved access to medical services for patients and consumers.
4. **Shared Workforce Priorities**—The Regional Training Collaborative has established clinical networks that contribute to the formulation of clinical training practice and policies, design of training and employment models with shared key performance indicators, supporting and enabling the development of the region's medical workforce, and the continued improvement of patient care and experience.
5. **Aligned Incentives**—All stakeholders are engaged in a transparent allocation of investment so that the majority of financial and human resources are prioritised to increase regional medical workforce training aligned to regional need.
6. **Training provided to a geographically dispersed medical workforce**—The Regional Training Collaborative develops and delivers rural, regional (and remote) education and training opportunities for medical students, junior doctors, GP registrars and specialists in training to support the development of a medical workforce with knowledge and capability for rural, remote and regional practice.
7. **Use of data as a workforce and education planning tool**—The Regional Training Collaborative has a culture of accurate and timely decision making, enabled by sharing data and informed by the collection and analysis of data that supports evidenced based education and training.
8. **Professional development**—The Regional Training Collaborative has a joint and integrated workforce and professional training and development agenda, ensuring: supervisors deliver consistently to agreed education accreditation standards; junior doctors, GP registrars and specialists in training have access to courses and professional development relevant to their training requirements.
9. **Community, consumer and patient engagement**—The Regional Training Collaborative has an engaged community of patients, consumers and health care providers actively

participating to inform policy, strategic thinking, implementation and management of workforce and health care improvement initiatives.

10. **Resourcing to support innovation**—The Regional Training Collaborative has an ingrained culture of sustained innovation, to lead the development of a fit-for-purpose capable medical workforce for the delivery of health services in rural and remote communities.