REPORT

Appraisal of the WAGPET Regionalisation Program in Western Australia 2011

WAGPET
Education and Training for General Practitioners

CONDUCTED BY:

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FOREWORD

I am pleased to present the following report on WAGPET's model of regionalisation. The report is supported by the WAGPET Board as part of the quality improvement cycle and conducted by an independent consultancy firm, PDT Consultancy, under the leadership of Director Ms Faye Harris.

As a state-wide organisation, WAGPET has been particularly focused on ensuring access to quality training across all our regions. In 2005, we commenced delivering aspects of the GP training program using a model that combined centralised and region-based components. Since then, Regional Advisory Committees (RACs) have been responsible for the delivery of a regional education program. Respect for, and responsiveness to, local autonomy and regional diversity lie at the heart of the model.

In order to assess the effectiveness of the model we needed to know, from those involved with the model, what is working well, what is not, and how WAGPET could move forward in very practical ways. To this end, we gathered the perspectives of both internal operational staff from WAGPET and all of the RACs. In addition, interviews were carried out with some key external stakeholders who also operate in a regionalised context. This appraisal was carried out in 2011, and included an academic research component.

There are forty-five recommendations contained in this report. They are underpinned by evidence of the effectiveness of the model and include pragmatic advice on improvements and opportunities for the future. The recommendations include strengthening regional partnerships, building connections across the regions, supporting regional diversity, raising the profile of WAGPET's work within the regions, enhancing the RAC structure and streamlining the regional education program processes.

We would like to thank members of the RACs and our stakeholders who provided their feedback on the model.

In 2012, we have committed to following up the report recommendations, developing an action plan to ensure the continued success of the model going forward.

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Chief Executive Officer, WAGPET

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EXECUTIVE SUMMARY

INTRODUCTION

This report contains findings from an external consultative process undertaken during 2011 by Faye Harris, a Director of PDT Consultancy. This work was commissioned by Western Australian General Practice Education and Training (WAGPET) as part of the organisations quality improvement cycle. The brief was to undertake a "health check" of WAGPET's model of regionalisation by gathering the perspectives of both internal operational staff from WAGPET and the ten Regional Advisory Committees (RAC). Another aspect of this work involved interviewing a range of key external stakeholders to gauge their views on regionalisation and how they themselves worked within a regionalised context. A search for any relevant literature was also undertaken. The Project Brief is provided as **Appendix A**.

It needs to be noted that this report is based on the gathering of qualitative data from a range of stakeholders and it essentially captures their perspectives at a particular point in time, rather than providing a detailed analysis of the regional model in relation to finances and budgetary implications and a comparison with other models that may be operating elsewhere. There are, therefore, some limitations on drawing more significant or longer-term conclusions from the data obtained.

THE QUESTIONS

The qualitative data was gathered in a snapshot of time, from July to December 2011, and focussed on the following key questions:

- Is the current model of regionalisation working?
- What are the key strengths of the model?
- What could be improved?

THE ANSWERS/KEY FINDINGS

1. Endorsement of the Current Model

The current WAGPET regionalised education model and support structure gained strong endorsement from respondents across all participant groups. The model was identified as working well and, although there were some suggestions for improvement, these tended to be concerned with refinements rather than whole scale changes. It was also held up as a very positive model by several external stakeholders who were interviewed. Many saw this as a model that worked very well for the doctors in training, the training practices and the regions. WAGPET was acknowledged by several respondents for the progress it had made in relation to regionalised education and training through the model it had established.

The model has accommodated and supported significant growth in a relatively short span of time. There was a reported increase in both the amount and quality of education and training that takes place in the regions, as well as an increase in the number of training practices wanting to be involved. This ability to accommodate growth within regional contexts was identified as critical to WAGPET'S future as the numbers of doctors in training increase as well as the increased percentage of them interested in training rurally.

2. The Key Strengths of the Model

There were several key aspects consistently identified throughout the consultation process as strengths of the model. These were:

- **The Dedicated and Committed Members of the Regional Advisory Committees**
  The dedication and commitment of the RAC members to their region and its needs and to the profession was highlighted by many respondents. This commitment allowed for direct feedback and input to be provided from those "on the ground" in order to deliver a responsive and relevant regional program, and also to assist in building networks and relationships within the local context.

  The various roles on the RACs (such as Registrar Liaison Officer and Supervisor Liaison Officer) were seen as critical conduits for communication, allowing representation of the interests and concerns of the supervisors and doctors in training, as well as providing a mechanism for strategic advice.

- **The Regional Education Programs**
  The Regional Education Programs were described as being responsive to the needs of supervisors and doctors in training. The use of local expertise to plan and deliver the program was identified consistently as a major factor in the success of the model. The programs were also described as ensuring greater relevance to the local context and building the networks across the region. Some RACs indicated that this helped to build longer-term connections with the region, with the possibility of attracting doctors in training to return to the area as workforce. The planning and delivery of Cultural Awareness Training in the region was highlighted by many (particularly doctors in training, but also several RACs) as being more relevant than the previously centrally coordinated program and was also seen as an opportunity to build links across the community.

- **The Commitment and Involvement of Training Practices and Supervisors**
  There was consistent acknowledgement that the commitment and involvement of training practices and supervisors was a critical factor in WAGPET's regionalised model. Their goodwill and ongoing commitment is central to offering a range of quality, relevant education and training experiences. The reputation of the program is dependent, to a very large extent, upon the doctors in training having a quality experience at the practice.

- **The Mix of Central and Regional Training**
  The provision of both regional and central training was identified by several as an appropriate mix in terms of economies of scale and the need for local input. The central workshops provided to doctors in training, supervisors, educators, training advisors and external central teaching (ECT) visitors are being increasingly regionalised wherever practicable. There was a good deal of satisfaction expressed about the combination of regional and metropolitan supervisor education that was provided, as it supported both regional and state-wide networking for supervisors.

- **The Commitment to Regionalisation by the WAGPET Board and Staff**
  The commitment by WAGPET to a regionalised model has continued to be reflected in its structures and processes since 2005. Regional engagement was identified by WAGPET in its 2010 – 2012 Strategic Plan as a key direction. A Regional Engagement Framework 2011 – 2012 was developed to integrate all of the major activities being undertaken to continuously improve the high quality regional training and education provided and to work through ten regional committees to regionalise what can be regionalised. This Appraisal is one of its key strategies to ensure improvements can be made based on feedback received. Another major commitment to a regionalised model by WAGPET has been the allocation of a key responsibility to a senior member of staff related specifically to regionalisation. There have also been some

internal processes put in place such as regular meetings amongst Regional Program Managers to share information related to regional needs and to look for opportunities for improvements and refinements and ways of strengthening the outer rim in the current hub and spoke model.

The involvement of WAGPET staff in the RAC was highlighted by several RACs as a very positive aspect. Since the beginning of this Appraisal, an increased understanding of the importance of regionalisation amongst WAGPET staff has been reported, no doubt due to the implementation of several of the above strategies.

The annual RAC workshop when all RAC members from across WA come together was identified by many as a positive and worthwhile activity as it supported networking across the regions and developed a sense of connection to WAGPET.

The Regional Development funding, made available for RACs annually, was seen as opening up opportunities to explore a range of initiative. Its greater flexibility, as a result of some recent changes, was also appreciated by most of the RACs.

- **The Involvement of the Networks and Divisions of General Practice**
  The involvement of the Networks and the Divisions of General Practice was highlighted as a positive feature by several of the RACs and WAGPET staff. The support provided was valued, as was the fact that it helped to showcase the work of the Division/Network to the doctors in training.

  The recent changes made to the Administrative Officer (AO) role and conditions of employment were widely supported. The development of a formal job description, the change of name to Regional Executive Officer (REO), and the contractual agreement that the role is to be allocated 0.3 FTE with increased remuneration, were all seen as positive actions.

- **Strengthening Partnerships Between WAGPET and Other Organisations**
  There was an acknowledgement that there had been an increase in the amount of trust between organisations within regions and WAGPET. The RAC structure had resulted in a more collaborative working relationship. The fact that some members of the RAC were also engaged with those stakeholders was seen as an important element of those relations.

3. What could be improved?

Most of the recommendations made by the respondents did not involve whole-scale change, but were more about maintaining and strengthening aspects that were working well. The key areas identified included:

- **Refining the RAC Model and Structure**
  There were some concerns expressed regarding confusion over specific roles and responsibilities on the RAC, although this was not universally reported. The lack of adequate succession planning for the various roles was also highlighted by several of the RACs, including the need for induction of new members. It is important to note, however, that in the eight years the model has been operational, no RAC has fallen overdue to lack of members.

  The issue of ensuring that RAC members were truly “representative of” supervisors and doctors in training, rather than representing them, was also raised.

- **Supporting the Regional Education Program**
  Most of the issues in this area were related to the administrative requirements associated with the regional programs. Even though some RACs acknowledged that there had been improvements, most still felt that more were required and several suggestions were made by various respondents. There were some concerns expressed about the work involved in regional CAT requirements and in the development of Indigenous Health Training Plans and a sense that the timing and consultation processes could have been better. There was also some concern about the funding arrangements for the education programs.

- **Refining WAGPET Internal Structures and Processes**
  There were some suggestions for improvements to the annual RAC workshop, as well as the application process for annual Regional Development funding.

  The need to ensure all WAGPET staff had a strong connection to the concept of regionalisation was also identified.

- **Raising the Profile of WAGPET's work within Regions**
  There is some further work to be done to raise the profile of WAGPET work within the regions. As in several regions, its role is not always known to others who are working outside the RAC or not directly involved with supervision and training.

- **Strengthening Regional Partnerships**
  Whilst there was an acknowledgement that partnerships between WAGPET and other organisations have been strengthening, largely through joint projects. This area was identified as requiring some additional actions to both maintain existing partnerships and build new connections.

- **Building Connections Across Regions**
  There was consistent feedback related to the value of collaboration and sharing across the regions through such activities as the annual RAC workshop and joint projects of interest through annual Regional Development funding. There were some suggestions for how the "rim" of the current hub and spoke model could be developed further with some opportunities for inter-regional and cross-regional activities.

- **Supporting Regional Diversity**
  A range of different issues that were regionally-specific were identified by the RACs. Some were related to funding disparities dependent upon the number undertaking training. Others related to the greater transience of supervisors and the resulting difficulty in getting a steady, reliable supply of presenters. Other regions had needs related to a variable supply of doctors in training as they had difficulty in attracting them to their region.

REGIONAL ADVISORY COMMITTEE STRUCTURE

1.1 The current Region Advisory Committee (RAC) structure should be maintained for all rural regions, but some consideration needs to be given as to its suitability in the three metropolitan regions, as there may be some economies of scale and opportunities for cooperative effort to be gained in an alternative model.

1.2 A manual for all RACs should be developed that outlines all key roles and responsibilities, WAGPET structures, processes and requirements. It should also outline the relationships between the RAC and the Supervisor Advisory Group (SAG) and Registrar Advisory Group (RAG).

1.3 Processes for induction and succession planning of RAC members' roles should be developed and implemented to ensure adequate handover for new role holders and efficient and effective running of the RAC.

1.4 Face-to-face RAC meetings should be maintained wherever/whenever possible.

1.5 RACs should consider opportunities and strategies for increasing relevant representative membership from within their region.

1.6 The involvement of a locally-relevant regional organisation providing administrative support to the RAC (such as regional Networks and Divisions of General Practice).

1.7 Promotion of the RACs, RAG and SAG and their roles to be built into the Orientation Program for new doctors in training.

1.8 RACs need to ensure that they have a regional view in their planning, based on seeking feedback and input through formal consultative processes with doctors in training, their supervisors and others, to ensure that there is true representation of regional interests.

REGIONAL EDUCATION PROGRAM

2.1 Further simplification of the administrative requirements related to the regional education programs should be made, wherever possible, whilst maintaining a focus on quality education.

2.2 Some strategies should be jointly developed by WAGPET and those RACs experiencing difficulty with obtaining a reliable supply of quality presenters. This may include such strategies as the use of videoconferencing with another region's program, bringing presenters from Perth who know the region, virtual education classrooms etc.

2.3 Consideration should be given to the development of a process to ensure that doctors in training, at the start of each semester, indicate what regional education has previously been undertaken and their current learning needs. This would assist in the provision of a highly relevant education program.

2.4 Further exploration of the impact on regions of the current differential funding model and an examination of the current funding that is provided for catering, be undertaken to support doctors in training in the region.

2.5 A review of the regional education evaluation form should be undertaken to ensure that it provides quality information to inform future planning.

2.6 Session plans and resources should be actively promoted on the WAGPET Learning Management System to encourage sharing amongst presenters and access by doctors in training.

WAGPET INTERNAL STRUCTURES AND PROCESSES

3.1 Maintain the role of the Senior Development Manager in coordinating aspects of regionalisation, including communication strategies.

3.2 Implement and monitor the Regional Engagement Framework 2011 – 2012 to support the regions to regionalise what can be regionalised.

3.3 Provide induction and training for WAGPET staff to ensure shared understanding of how their role relates to WAGPET's regionalised model and the importance of regionalisation. The rationale for a regionalised approach to be consistently made to all of the WAGPET staff, with a commitment to investigating what can legitimately be done within the regions.

3.4 Succession planning for roles within WAGPET, particularly for those with direct links to doctors in training, be undertaken to minimise disruption to service for those in the regions. The provision of a manual, as well as some mentoring of people as they adjust into those roles, would also be helpful. Communication processes and policies to be documented in this manual.

3.5 Maintain the involvement of WAGPET staff in the RACs and explore the possibility of ensuring that everyone at a particular level takes on a regional/RAC responsibility, with mentoring and support to be provided to support the roles.

3.6 The annual RAC workshop should be maintained as a key process for networking, with some consideration given to possible improvements based on feedback obtained. This could include providing greater clarity about its purpose, allowing RAC members time to discuss issues and identifying opportunities for cross-regional collaboration and sharing of ideas/resources.

3.7 Any new requirements/responsibilities for the RACs need to be introduced with consultation, clarification and support.

THE PROFILE OF WAGPET'S WORK WITHIN REGIONS

4.1 Clarification with the RACs as to their role in representing WAGPET within their region needs to occur.

4.2 RACs need to develop a strategy to raise the profile and visibility of WAGPET work within their region.

4.3 A general overview of what WAGPET is, and what it has achieved during a twelve month period within the region, to be developed and disseminated to all relevant parties.

4.4 The face-to-face contact by WAGPET staff with the regions should be continued and encouraged, and new opportunities to build WAGPET's profile in the region should be explored.

4.5 Monitoring of the impact of Medicare Locals at the regional level should occur and relationships should be established.

REGIONAL PARTNERSHIPS

5.1 Ensure there is a cohesive strategy in place to strengthen regional partnerships.
5.2 Consider inviting other regional key stakeholder organisations to participate in a more formal capacity on the WAGPET RAC in their region.
5.3 WAGPET needs to explore opportunities to work more closely with relevant organisations to meet common needs and identify strategies to assist this work.
5.4 Consider setting up regular forums to map regional needs in relation to workforce and education with organisations such as WA Country Health Services (WACHS), Australian College of Rural and Remote Medicine (ACRRM), Rural Clinical School (RCS) and Rural Health West.
5.5 Consideration of the impact and opportunities of Primary Health Care reforms on the work of WAGPET within regions should occur at the strategic planning level.
5.6 WAGPET should explore opportunities for greater connections to the mining industry in order to lobby for additional funding to assist with critical housing shortages some regional centres.
5.7 WAGPET to continue to work with relevant organisations to recruit high calibre doctors, supervisors and general practices.

CONNECTIONS ACROSS REGIONS

6.1 RACs need to investigate further opportunities for sharing and collaboration across regions in areas of common interest and where economies of scale can be made.
6.2 Consideration should be given by WAGPET to offer funding for more joint projects across regions.
6.3 The format of the RAC Day should be altered to accommodate regions having sufficient opportunity to discuss how to achieve improved coordination across regions to reduce duplication, whilst still maintaining local relevance and independence.
6.4 Consideration should be given to providing increased networking opportunities for Administration Officers (now Regional Education Officers).
6.5 Sharing of alternative models of regional operation should be coordinated by WAGPET.
6.6 Increased opportunities for inter-regional collaboration with cross-regional activities should be identified and implemented.

REGIONAL DIVERSITY

7.1 Consideration to be given to identifying each region and its specific needs, interests and capacity for taking on additional tasks, and the cost implications investigated so that what can be regionalised is regionalised.
7.2 Consideration needs to be given to WAGPET's staff involvement that is required for each RAC relevant to the needs of the region.
7.3 Investigate the possibility of setting up outcomes-based contracts with the regions, to increase the sense of ownership at the regional level.
7.4 Sharing of alternative models of regional operation should be coordinated by WAGPET.
7.5 Provision of relevant financial data to the RACs as to funding expended and deadlines for spending funding, to aid in their decision-making at the regional level.

THE BRIEF

This report is based on the findings from a consultative process that was commissioned by the Western Australian General Practice and Education and Training (WAGPET) Board. The brief was to undertake an appraisal of the WAGPET regional model as part of WAGPET's quality improvement cycle and to effectively conduct a "health check" of it.

It was intended primarily to gather perspectives on the effectiveness of the model, identify any areas for improvement and to involve both internal and external stakeholders. The Project Brief is included in **Appendix A**.

The external appraisal was conducted during 2011 by Faye Harris, a Director of PDT Consultancy.

It needs to be noted that this report is based on the gathering of qualitative data from a range of stakeholders and it essentially captures their perspectives at a particular point in time, rather than providing a detailed analysis of the regional model in relation to finances and budgetary implications and a comparison with other models that may be operating elsewhere. There are therefore some limitations on drawing more significant or longer-term conclusions from the data obtained.

THE CONTEXT

In 2002, WAGPET commenced operations in WA with the brief to regionalise the RACGP Training Program. In 2005, it commenced delivering all aspects of its GP training model across eight (now ten) regions in WA using a model that combined centralised and region-based components.

The commitment to regionalisation by WAGPET has remained constant and has even strengthened since 2005. This commitment was outlined in a Briefing Note to the Board in 2004:*"The main priority for WAGPET is the enhancement and long term stability of innovative and sustainable regionalisation*."[1]

In 2006, WAGPET commissioned an independent report *Review of Regionalised General Practice Training in Western Australia*[2]. The results of the Review indicated that participant groups were highly supportive of regionalisation in terms of what had been achieved to that point. Some areas of concern were highlighted as needing further refinement.

WAGPET's commitments to regionalisation included ensuring that:

- Those components of GP training that can be done regionally are done regionally wherever feasible
- All regional areas of WA are served through local and central activities.
- Economies of scale will be achieved through central organisation where appropriate.

There have also been several structural commitments to regionalisation such as:

- Requiring a rural majority on the Board to reflect rural interests.
- Setting up Regional Advisory Committees (RACs) in each region to provide support for doctors in training, developing the education program, support the supervisors and training posts and identifying new training opportunities in the region and working with WAGPET staff to develop these opportunities. "*The key function of the RACs is to provide a voice within the region and to represent the region."*[3]

The commitment by WAGPET to a regionalised model has continued to grow. Regional engagement was identified by WAGPET in its 2010 – 2012 Strategic Plan as a key direction. A Regional Engagement Framework 2011 – 2012 has been developed to integrate all of the major activities being undertaken to continuously improve the high quality regional training and education provided and to work through ten regional committees to regionalise what can be

[1] Briefing Note: WAGPET Board (9 June 2004)
[2] R & E Lockwood, 2006 *Review of Regionalised General Practice Training in Western Australia*
[3] Summary of WAGPET response to *Lockwood Review of Regionalisation,* (January 2007).

regionalised. Respect for and responsiveness to, local autonomy and regional diversity lie at the heart of this Framework. This Appraisal is one of its key strategies, in ensuring that improvements can be made based on feedback received.

Another major commitment to a regionalised model by WAGPET has been the allocation of a key responsibility to a Senior Program Manager related specifically to regionalisation. This occurred in 2011. This position coordinates and leads WAGPET's Regionalisation Program, part of which is reflected in the Regional Engagement Framework, but also in some internal processes that have been put in place such as regular meetings amongst Regional Program Managers to share information related to regional needs and to look for opportunities for improvements and refinements.

WAGPET is now the single provider of both PGPPP and AGPT in Western Australia, due to a recent decision by GPET. This brings with it some significant opportunities for strategic streamlining. There is substantial interest in models of training that are vertical and horizontal and making regional education work to the benefit of all.

There have been some significant reforms introduced at both state and federal levels in relation to primary health care in recent times[4] [5] that are likely to impact on the education and training of the general practice workforce. For example, the introduction of Medicare Locals across Australia from July 2012 as contracting organisations may have an impact on whether there will be a presence in regions to support regionalisation, which have up to now been provided by the GP Networks and Divisions of General Practice.

At the same time there is a strong imperative from GPET, the federal government and the state government to work with regions to deliver education that is of high quality and that support the ongoing provision of health services to Australians in regions. Coupled with a significant increase in the number of medical graduates, the challenges of providing high quality general practice training are significant.

It is hoped that this appraisal provides some insights that will be helpful in dealing with both the opportunities and the challenges.

PROCESSES FOR DATA COLLECTION

Internal Operational Appraisal (Interviews with WAGPET Staff)

One-on-one interviews with all WAGPET staff were conducted to examine WAGPET internal structures, communication mechanisms and processes and to identify achievements, strengths and areas of potential improvement in relation to WAGPET's model of regionalisation. A list of interviewees is included in **Appendix B.** Draft questions were identified by the Consultant and then refined with the input of the Project Manager in late May 2011. Initial interviews were then conducted with three key WAGPET staff with a view to gaining their input and to further refine the questions to be asked of other staff.

Given that several of the WAGPET team were either relatively new to the organisation and/or had roles that did not necessarily have a direct connection to the work of the regions, it was decided that a *Preamble Document* that summarised key aspects and intended outcomes of WAGPET's regionalised approach to general practice education and training would be beneficial. This was developed by the Consultant and checked for accuracy with the Project Manager and the initial interviewees. A copy of this is attached as part of **Appendix C.**

The Project Manager then met with all of the WAGPET staff to outline the purpose of the Appraisal, and provided them with the questions that would be covered and the Preamble document.

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[4] Commonwealth of Australia, 2009 *Primary Health Care Reform in Australia: Report to Support Australia's First National Primary Health Care Strategy*

[5] Government of Western Australia, 2011 *WA Primary Health Care Strategy*

Interviews were conducted during July 2011. The interviews were conducted on-site with individuals and ranged in duration from between 30 minutes and 90 minutes. The interviews were intended to be semi-structured in approach, to allow a free range of opinions and directions. The interviewees were assured that their comments would not be individually identifiable. The consultant kept notes of responses made during the interviews.

A summary of key themes identified during the interviews was then created, as well as any individual comments that were not necessarily made consistently but proved to be interesting perspectives that may be worth pursuing further with other stakeholders. In consultation with the Project Manager the areas that would be most pertinent to be explored for Stage 2 (gaining the perspectives of the RACs) were identified. A summary of the feedback from this stage of the process is included in **Appendix C.**

RAC Consultation

The Regional Program Managers then consulted with each of their RACs to gain their perspectives based on the areas identified as working well and areas requiring improvement by Internal WAGPET staff. Each RAC was also provided with a Preamble that summarised key aspects and intended outcomes of WAGPET's regionalised approach to general practice education and training.

This consultation took place from late September to late November, depending upon previously scheduled meeting times and/or additional teleconferences. The responses were then provided to the consultant for analysis. A summary of each individual RAC response is attached as **Appendix D.**

Consultation with Key External Stakeholders

A list of relevant key people from organisations with a vested interest in GP training was identified by the Project Manager. This was to ensure that the appraisal of the WAGPET model of regionalisation avoided insularity and to recognise the importance of the areas of interface between WAGPET and the relevant organisations.

An email was sent to them in November outlining the purpose and scope of the Appraisal and indicating that the consultant would be contacting them to invite them to be interviewed to gain their perspectives. The list of those interviewed is included in **Appendix B.** Of those invited, only one person was unavailable for interview due to work demands. The interviews took place from November to late December.

A different set of questions was developed for these interviews, which were semi-structured in their approach. Where possible, the interviews took place on a face-to-face basis; otherwise they occurred over the phone. The interviews took approximately 45 minutes on average. The interviewees were assured that their comments would not be individually identifiable. The consultant kept notes of responses made during the interviews. A summary of the key themes identified from this consultation is included in **Appendix E.**

Literature Review

A search was carried out of relevant literature during November and December. The parameters for the search were as follows:

- Time frame (2001 – 2011)
- Countries of interest - Australia; NZ; Canada
- Areas/industries of interest
  - Business
  - Government
  - Health
  - Education and training

- Topics within the above parameters
  - Effective models of regionalisation
  - Challenges of regionalisation
  - Benefits of regionalisation
  - Strategies to support effective regionalisation

A summary of the information gained from this search is included in **Appendix F.** A bibliography can be found in **Appendix G**.

KEY THEMES

Although there were some individual differences that are reported on in greater detail in **Appendices C, D** and **E**, the feedback tended to cluster around the following themes:

1. RAC Model and Structure
2. Regional Education Programs
3. WAGPET Internal Structures and Processes
4. The Profile of WAGPET within Regions
5. Regional Partnerships
6. Connections Across Regions
7. Regional Diversity

1. RAC Model and Structure

What's Working

There was consistent support for the RAC model being used to support the delivery of quality education relevant to the local context. The involvement of WAGPET staff was identified as a critical factor in building relationships and connections between WAGPET and the regions, and possible inter-connections across regions. The opportunities to meet face-to-face through the RACs was widely supported, as it helped WAGPET to gain knowledge of regional needs and interests. The use of local resources to plan and provide the training and to build the doctors in training knowledge of people and organisations within the region was seen as a positive aspect of the model.

The involvement of the Divisions of General Practice and Networks was also highlighted as an important factor in the success of the RAC model, not only for their role in providing support services for the Regional Education Program, but also for assisting doctors in training in making longer-term connections to the local context and reducing a potential sense of isolation. Another reported advantage was that it increased their understanding of what the Division could offer them in the future if they returned to the region.

Opportunities

An area of concern included the need for role clarification for members of the RAC as well as the various inter-relationships between the Supervisors Advisory Group (SAG), the Registrars Advisory Group (RAG) and the RAC. There was also a commonly identified need for clearer processes and guidelines as to responsibilities for each role, and appropriate induction for all new members in roles within the RAC.

The lack of succession planning for the various roles was also identified as an issue that needed to be addressed. A related issue was the concern expressed related to some lack of continuity of WAGPET staff in RAC roles due to staff changes.

Another area for further exploration that was identified is how to ensure that the members of the RAC are truly "representing" the various groups, rather than simply acting as someone who is "representative of" their peers. This was also signalled as a potential challenge for WAGPET by some of the external stakeholder group.

The need to re-visit the role and remuneration of the Administration Officer was another aspect that was highlighted in both consultation phases. It was acknowledged that the workload had increased and the role had expanded over time. It needs to be noted that these actions have already been put in place during the conduct of this appraisal, with new contracts having been negotiated to provide quarantined time of 0.3 FTE, a new formal job description with clear KPIs and an increase in remuneration. There has also been a name change (now Regional Executive Officer) to more accurately reflect the relevant responsibilities.

There was some discussion amongst several RACs that the current stipends that are paid may need to be reviewed, although other RACs indicated that it was more important to get the right people involved than to increase the stipends.

Recommendations:

1.1 The current Region Advisory Committee (RAC) structure should be maintained for all rural regions, but some consideration needs to be given as to its suitability in the three metropolitan regions, as there may be some economies of scale and opportunities for cooperative effort to be gained in an alternative model.

1.2 A manual for all RACs should be developed that outlines all key roles and responsibilities, WAGPET structures, processes and requirements. It should also outline the relationships between the RAC and the Supervisor Advisory Group (SAG) and Registrar Advisory Group (RAG).

1.3 Processes for induction and succession planning of RAC members' roles should be developed and implemented to ensure adequate handover for new role holders and efficient and effective running of the RAC.

1.4 Face-to-face RAC meetings should be maintained wherever/whenever possible.

1.5 RACs should consider opportunities and strategies for increasing relevant representative membership from within their region.

1.6 The involvement of a locally-relevant regional organisation providing administrative support to the RAC (such as regional Networks and Divisions of General Practice).

1.7 Promotion of the RACs, RAG and SAG and their roles to be built into the Orientation Program for new doctors in training.

1.8 RACs need to ensure that they have a regional view in their planning, based on seeking feedback and input through formal consultative processes with doctors in training, their supervisors and others, to ensure that there is true representation of regional interests.

2. Regional Education Program

What's Working

The regional education programs were reported as working well and being responsive to the needs of doctors in training, as well as to supervisors. This was reported by internal WAGPET staff, based on evaluations collected from doctors in training, as well as from informal feedback. It was also reported by all of the RACs.

Tapping into local expertise and knowledge to plan and deliver a program relevant to the local context was identified as a key strength. This was described as making really good use of resources and achieving better outcomes than could be achieved through a program organised by a central body.

The regional programs were also highlighted as important networking opportunities for doctors in training. One RAC indicated that the Cultural Awareness Training that had taken place in their region provided an opportunity to work with people in the community and to provide relevant information re: local Aboriginal culture.

The use of local presenters to deliver the programs was reported as encouraging attendance by doctors in training. It was also suggested that the doctors in training enjoyed the teaching being conducted in a smaller group and being asked to have input into the program. There was an acknowledgement by some of the internal operational staff that the regional people who put the programs together seemed to enjoy making a contribution to the profession.

There was some satisfaction expressed regarding the combination of regional and metropolitan supervisor education that was provided, as it supported both regional and state-wide networking for supervisors.

Opportunities

In some regions, it was reported that it was sometimes difficult to obtain an adequate and reliable supply of presenters. This was sometimes due to a lack of GPs wanting to put themselves forward as presenters, but also because in some regions there was a high turnover. The RACs who were experiencing these difficulties indicated the need for a strategy to be developed to support those regions.

There was an indication from some that sometimes the program was a little more "ad hoc" than it should be and there were improvements to be made in the planning carried out by some RACs in order to ensure that the program truly reflected the needs of Doctors in training. It was also felt by some that doctors in training may be given the same training that they have received in another region.

The Cultural Awareness Training being conducted at a regional level received mixed reviews. It was reported that feedback from the registrars had been very positive. However, while some RACs including both metropolitan and rural regions, found it to be a worthwhile and positive activity, for others it was a demanding task that lacked some relevance for the doctors in training in the region. There was a sense for many that it had been imposed with too little consultation or direction.

Another issue that caused some frustration for the RACs was the requirement to develop an Indigenous Health Training Plan. The major sources of the frustration appear to have been the extra burden it placed on RAC members, the lack of direction and guidance and the time-frame requirements. There was considerable financial support provided by WAGPET in the development phase, but most RACs reported that they had not implemented it as successfully as they believe it could have been.

The current administrative requirements for the regional education program were also identified by both WAGPET staff and the RACs as an area that needed further refinement. There have been some welcomed changes made within WAGPET's internal processes; such as the use of online processes, but the regions identified that more refinements would be welcomed.

There was quite a wide range of responses to the issue of the current model of differential funding to regions based on the number of Doctors in training. Some regions indicated that there were significant benefits in being able to run an education program regardless of the number, such as the creation of a network and a sense of belonging. Others felt that it was unrealistic and inappropriate to provide the same funding regardless of numbers. It is an area that needs further exploration.

There were also several RACs who raised the issue of the funds currently allocated for catering as insufficient. This was particularly relevant to those regions with larger numbers of Doctors in training.

Another concern that was raised related to the evaluation forms currently being used to gather data regarding the regional education programs from Doctors in training. It was felt that there could be more useful data collected and used to enhance the program.

There was some concern over the variable quality of session plans and their usefulness in improving education. Some groups viewed it as a bureaucratic process that didn't achieve the intended outcome of sharing a resource with others and keeping the focus on quality teaching and learning outcomes.

Recommendations:

2.1 Further simplification of the administrative requirements related to the regional education programs should be made, wherever possible, whilst maintaining a focus on quality education.

2.2 Some strategies should be jointly developed by WAGPET and those RACs experiencing difficulty with obtaining a reliable supply of quality presenters. This may include such strategies as the use of videoconferencing with another region's program, bringing presenters from Perth who know the region, virtual education classrooms etc.

2.3 Consideration should be given to the development of a process to ensure that doctors in training, at the start of each semester, indicate what regional education has previously been undertaken and their current learning needs. This would assist in the provision of a highly relevant education program.

2.4 Further exploration of the impact on regions of the current differential funding model and an examination of the current funding that is provided for catering, be undertaken to support doctors in training in the region.

2.5 A review of the regional education evaluation form should be undertaken to ensure that it provides quality information to inform future planning.

2.6 Session plans and resources should be actively promoted on the WAGPET Learning Management System to encourage sharing amongst presenters and access by doctors in training.

3. WAGPET Internal Structures and Processes

What's Working

WAGPET has fairly recently put in place some internal structures and processes to further support the regionalised model. A Senior Manager has a coordinating role in relation to Regionalisation. This involves supporting the building and maintenance of communication links between the regions and WAGPET, as well as across the regions.

The communication links being built across the regions are seen to support the strengthening of the outer rim in the current hub and spoke model. It was reported as allowing the sharing of good ideas and strategies, as well as a way of regions gaining an overall perspective of the whole state and its needs.

There are now regular Regional Program Managers (RPM) meetings where updates are provided after RAC meetings to ensure that all RPMs are kept informed and so they can also then act as a conduit for their own RAC in providing information regarding activities, issues and trends in other regions.

The relationships between WAGPET and the RACs were generally reported to be very positive, particularly in relation to the WAGPET personnel who were involved directly with the operation of the RAC in the roles of Regional Program Manager and the Regional Education Consultant. Particularly valued were the face-to-face contacts.

The annual RAC workshop that is held was generally viewed as a positive process that has been put in place. It was described as an important networking opportunity for sharing strategies and experiences across all regions. The relatively recent inclusion of AOs was also endorsed by several groups.

The Regional Development funding that is made available for RACs was seen as opening up opportunities to explore a range of topics. Its greater flexibility as a result of some recent changes was also appreciated by most of the RACs.

Opportunities

There were some concerns expressed about ensuring that the maximum value was gained from the annual RAC workshop and these were mostly around issues such as the timing of the event, the need for increased opportunities for sharing and collaboration across regions and being able to raise any relevant issues.

The Regional Development funding application process for some RACs was considered to be too bureaucratic, particularly when the programs being funded were likely to be repeated over several years, and new applications were still required. Some RACs reported a sense of pressure to apply for the additional funds in order to be "doing the right thing".

Another identified issue was the fact that several of the WAGPET staff had little connection to the concept of regionalisation that was core to WAGPET's functioning. This may have been due to several factors, such as being new to the organisation or in a new role (the number of staff changes was reported as fairly significant), not having work that directly related to the work of the RAC, and the lack of formal induction. This is an area that requires some attention.

There were reported difficulties for some regional people in their communication with WAGPET staff. Some commented that there were not consistent people to contact (due to staff changes and the number of part-time staff) and that sometimes their queries were not provided with a response for some time or that relevant processes were not clearly articulated.

As mentioned earlier, some of the RACs indicated that there had been a lack of clarity regarding what was required in the IHT planning process and in the Cultural Awareness Training. It was perhaps unfortunate that the two tasks were within a relatively short time-frame. Some RACs indicated that even if the end result had been positive, there was a strong sense of the tasks having been imposed with too little direction and consultation.

Recommendations:

3.1 Maintain the role of the Senior Development Manager in coordinating aspects of regionalisation, including communication strategies.

3.2 Implement and monitor the Regional Engagement Framework 2011 – 2012 to support the regions to regionalise what can be regionalised.

3.3 Provide induction and training for WAGPET staff to ensure shared understanding of how their role relates to WAGPET's regionalised model and the importance of regionalisation. The rationale for a regionalised approach to be consistently made to all of the WAGPET staff, with a commitment to investigating what can legitimately be done within the regions.

3.4 Succession planning for roles within WAGPET, particularly for those with direct links to doctors in training, be undertaken to minimise disruption to service for those in the regions. The provision of a manual, as well as some mentoring of people as they adjust into those roles, would also be helpful. Communication processes and policies to be documented in this manual.

3.5 Maintain the involvement of WAGPET staff in the RACs and explore the possibility of ensuring that everyone at a particular level takes on a regional/RAC responsibility, with mentoring and support to be provided to support the roles.

3.6 The annual RAC workshop should be maintained as a key process for networking, with some consideration given to possible improvements based on feedback obtained. This could include providing greater clarity about its purpose, allowing RAC members time to discuss issues and identify opportunities for cross-regional collaboration and sharing of ideas/resources.

3.7 Any new requirements/responsibilities for the RACs need to be introduced with consultation, clarification and support.

4. The Profile of WAGPET's work within Regions

What's Working

There was strong support for the regular contact provided by WAGPET to each training practice in the region and WAGPET was generally described as having a positive relationship with the practices, the supervisors and the Doctors in training, but lacking any real profile within the region.

Although it was not necessarily reported as an issue of WAGPET having a bad or poor relationship, it was seen as more an issue of not being known or being "invisible" within the region, with not many in the region knowing of its existence or understanding its role. It needs to be noted that this view was not universally supported, as some RACs reported that WAGPET was well known in their region. The fact that there are many other organisations in the regions competing for the attention of relevant parties was reported by one of the RACs as a contributing factor to its lack of profile.

It was interesting to note that many of the RACs who commented on this aspect did not seem to identify this as pertinent to them. Rather, it was seen as WAGPET's problem, as the members of the RACs did not necessarily identify themselves as part of WAGPET. Perhaps this is not surprising, given that many of the RAC members wear several hats within the region.

Opportunities

In addition to working with the RACs to clarify their role in representing WAGPET in the regions, WAGPET may need to look at further strategies to raise its profile in the regions. This may need to go beyond their involvement with the RACs and their work with the PGPPP and AGPT to achieve this.

Given WAGPET's not insignificant role in regional workforce and its need to expand the quality training opportunities, this is an area that needs some attention. WAGPET risks missing out on areas of opportunity and understanding the larger picture of regional needs and interests.

The continued development of formal and informal networks within regions should be encouraged amongst WAGPET staff as well as WAGPET Board members. There should also be some work in the regions to encourage RACs to develop a more prominent profile for the work they undertake for WAGPET.

The arrival of Medicare Locals was signalled by several groups as something that may impact on WAGPET and its work, although precisely how appears to be currently unknown.

Recommendations:

4.1 Clarification with the RACs as to their role in representing WAGPET within their region needs to occur.
4.2 RACs need to develop a strategy to raise the profile and visibility of WAGPET work within their region.
4.3 A general overview of what WAGPET is, and what it has achieved during a twelve month period within the region, to be developed and disseminated to all relevant parties.
4.4 The face-to-face contact by WAGPET staff with the regions should be continued and encouraged, and new opportunities to build WAGPET's profile in the region should be explored.
4.5 Monitoring of the impact of Medicare Locals at the regional level should occur and relationships should be established.

5. Regional Partnerships

What's Working

The relationship between WAGPET and the Divisions of General Practice and Networks was reported as being generally very positive, no doubt due to the close connections in their work with the RACs. There were also reported good and improving relationships with several key agencies. This was partly attributed to joint projects and the development of increased understanding regarding shared goals and the fact that some members of the RAC were also engaged with those stakeholders.

Some examples of the work with other regional partners that were cited included the work with Western Australia Country Health Service (WACHS) in PGPPP placements and the work with Rural Health West in the Obstetrics Mentoring Program, with placements funded in outer metropolitan and rural areas.

Opportunities

However, it also surfaced that there are some relationships that need to be improved, as well as some new ones that need to be formed if WAGPET is going to further improve its effectiveness in the regions. Some RACs suggested that these relationships were at the regional, state and national level.

WAGPET needs to actively seek ways of improving poor relationships that may be hampering their effectiveness, as well as identifying possible new partners that may provide useful new synergies. The fact that WAGPET is now the sole provider of PGPPP and AGPT means that this is an opportunity to build new connections with other agencies in order to bring those relevant groups together to meet shared interests and goals.

The lack of sufficient funding for housing doctors in regions and the impact this had on their decisions as to where they chose to undertake training was highlighted by a number of those consulted. There was a fair degree of support for WAGPET undertaking some lobbying with groups such as mining companies to secure additional funding.

Recommendations:

5.1 Ensure there is a cohesive strategy in place to strengthen regional partnerships.

5.2 Consider inviting other regional key stakeholder organisations to participate in a more formal capacity on the WAGPET RAC in their region.

5.3 WAGPET needs to explore opportunities to work more closely with relevant organisations to meet common needs and identify strategies to assist this work.

5.4 Consider setting up regular forums to map regional needs in relation to workforce and education with organisations such as WA Country Health Services (WACHS), Australian College of Rural and Remote Medicine (ACRRM), Rural Clinical School (RCS) and Rural Health West.

5.5 Consideration of the impact and opportunities of Primary Health Care reforms on the work of WAGPET within regions should occur at the strategic planning level.

5.6 WAGPET should explore opportunities for greater connections to the mining industry in order to lobby for additional funding to assist with critical housing shortages some regional centres.

5.7 WAGPET to continue to work with relevant organisations to recruit high calibre doctors, supervisors and general practices.

6. Connections Across Regions

What's Working

One of the common themes that came from the consultation with the RACs was how they valued the opportunities to share ideas and resources and even different models of regional management, such as the model working in the Kimberley region.

The annual RAC workshop is another example of supporting the connections to be made across regions and the widespread support for it from the regions was an example of this willingness to share.

The Regional Development Funding was highlighted by some as providing opportunities for greater collaboration across regions.

The RACs also consistently highlighted the connections that were made possible through WAGPET staff having roles within the RAC.

WAGPET has identified sharing of resources as a useful strategy, with the requirement that teaching material from regional educational sessions should be uploaded onto the Learning Management System.

WAGPET has also recently brought together the AOs to share the new formal job description and to support them in their work through the provision of information and the sharing of ideas. This was reported as having been very well received. The officers who have fulfilled this role in the past have often indicated that they felt isolated from WAGPET.

Opportunities

The current template for the way WAGPET operates in a "hub and spoke" model has regions operating pretty much in isolation from each other for most of their work. The strategies listed above are useful starting points, but increased opportunities should be explored to develop the regional 'rim' of the 'hub and spoke' model, without impacting negatively on regional difference.

Some of the RACs indicated that they would appreciate some changes to the annual RAC workshop to allow for greater opportunities for sharing and collaboration in a more formal sense.

The growth in communication technologies also has significant potential to build links between regions.

Recommendations:

6.1 RACs need to investigate further opportunities for sharing and collaboration across regions in areas of common interest and where economies of scale can be made.

6.2 Consideration should be given by WAGPET to offer funding for more joint projects across regions.

6.3 The format of the annual RAC workshop should be altered to accommodate regions having sufficient opportunity to discuss how to achieve improved coordination across regions to reduce duplication, whilst still maintaining local relevance and independence.

6.4 Consideration should be given to providing increased networking opportunities for Administration Officers (now Regional Education Officers).

6.5 Sharing of alternative models of regional operation should be coordinated by WAGPET.

6.6 Increased opportunities for inter-regional collaboration with cross-regional activities should be identified and implemented.

7. Regional Diversity

What's Working

There was an acknowledgement that RACs were at different levels of readiness and interest in taking on additional tasks and responsibilities and also had varying needs to be accommodated. The varied responses to the IHT planning clearly indicated these differences. The need to understand and respond to local capacity was highlighted.

Most of the RACs who commented on this aspect indicated that they did not see regional difference as an issue and that it was to be expected that there would be differences, given their very different contexts.

Opportunities

A range of different issues that were regionally specific were identified by the RACs. Some were related to funding disparities dependent upon the number undertaking training. Others related to the greater transience of supervisors and the resulting difficulty in getting a steady, reliable supply of presenters. Other regions had needs related to a variable supply of doctors in training as they had difficulty in attracting them to their region.

There was some concern expressed at the current level of WAGPET staff support in all of the RACs regardless of their needs and degree of "readiness". It was indicated that the provision of both a Regional Program Manager and a Regional Education Consultant to all RACs may not be the most effective use of resources. Some RACs were reported as being able to run themselves without much support from WAGPET, whereas others had greater needs. The need for a WAGPET person as a communication conduit was not questioned as it is clearly a critical role for all RACs, but there may be different types of expertise required for different contexts.

Until 2008, WAGPET delivered all "regional" education programs for all metropolitan RACs. The regional process was completed with dividing the metropolitan area up into Perth Outer Metropolitan South, North and East. There was some questioning as to whether or not this was an artificial distinction as there were no clear geographical boundaries and if it achieved its intention of true regionalisation. There was a suggestion for some that perhaps another model needed to be considered for the metropolitan regions.

Most of the metropolitan regions reported that the larger numbers of doctors in training had implications for the funding amounts provided for such things as catering during the education program. The larger number of Divisions of General Practice and Networks present in each of the regions also added a degree of complexity.

When the RACs were asked to comment on cost efficiencies and cost effectiveness of the model, the majority of them indicated that they had little information on which to base their opinion. One RAC indicated that "*clearer guidelines and communication as to funding; how much is left, rollover of unspent monies, and deadlines for spending funding*" would be useful information.

Those regions that have the interest, capacity and an identified need should be supported by adequate resources to enable the region to manage it, as long as it is also cost effective. There would still need to be appropriate governance procedures in place and established outcomes and KPIs for the work being carried out.

This would have the potential additional benefit of allowing WAGPET staff to work more intensively with regions that require their support or to pursue alternative strategies of engaging with other key stakeholders. It may also involve considering whether additional or alternative structures are needed in certain regions.

One of the key challenges is how to support regional difference to have a truly regionalised model, whilst maintaining economies of scale.

Recommendations:

7.1 Consideration to be given to identifying each region and its specific needs, interests and capacity for taking on additional tasks, and the cost implications investigated so that what can be regionalised is regionalised.

7.2 Consideration needs to be given to WAGPET's staff involvement that is required for each RAC relevant to the needs of the region.

7.3 Investigate the possibility of setting up outcomes-based contracts with the regions, to increase the sense of ownership at the regional level.

7.4 Sharing of alternative models of regional operation should be coordinated by WAGPET.

7.5 Provision of relevant financial data to the RACs as to funding expended and deadlines for spending funding, to aid in their decision-making at the regional level.

APPENDICES

Appendix A: Project Brief

Appendix B: List of Interviewees

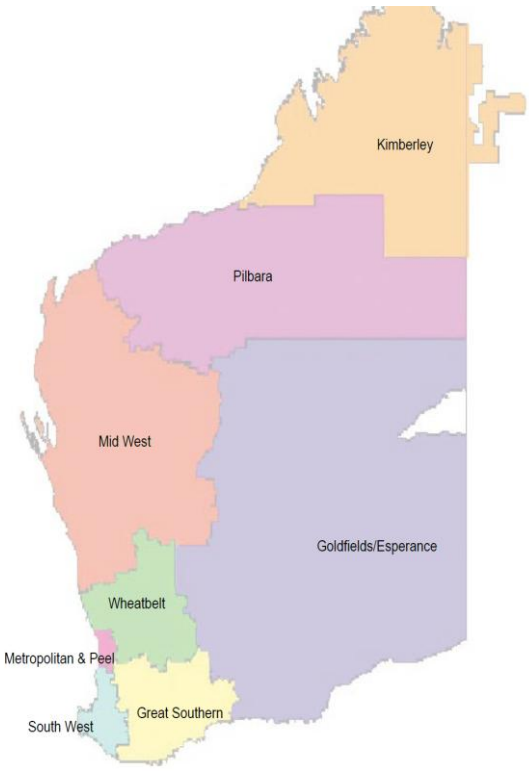
Appendix C: Feedback from Internal Consultation

Appendix D: Individual RAC Responses

Appendix E: External Stakeholder Responses

Appendix F: Literature Review

Appendix G: Bibliography



SCHEDULE 1 – SPECIFICIATION OF SERVICE

Background

In 2002, WA General Practice Education and Training (WAGPET) commenced operations in WA with the brief to regionalise the, then, RACGP Training Program for the state.

WAGPET is an independent Contract Authority funded by the commonwealth Department of Health and Ageing. WAGPET is the sole provider of the Australian General Practice Training Program for GP doctors in training in Western Australia and one of 17 Regional Training Providers (RTPs) in Australia appointed by the national training coordinator, General Practice Education and Training (GPET).

In 2005, the WAGPET CEO produced a paper on *Regionalising General Practice Training in Western Australia* to provide a rationale for, and description of, how WAGPET accomplished regionalisation of the national training program across WA.

In 2006, WAGPET commissioned an independent report *Review of Regionalised General Practice Training in Western Australia* undertaken by R&A Lockwood consultants and accepted by the WAGPET Board in 2007. The results of the Review indicated that participants groups were highly supportive of regionalisation in terms of what had been achieved to that point and approved of the model. Areas of concern were highlighted. As a result of the Report, a WAGPET Response Paper was developed to address recommendations.

In accordance with the growing maturity of WAGPET as an organisation, it is timely to ensure that an appraisal of the regional model is carried out as part of WAGPET's quality improvement cycle.

An "Appraisal", rather than a fully-fledged "Review", is being undertaken in 2011. The appraisal approach is reflective of anecdotal feedback from RACs that our supervisors and doctors in training would not be positive about another survey or broad spectrum review process in the near future. It also reflects the need for WAGPET to examine its internal workings rather than focussing simply on Regional Advisory Committees. An Appraisal will ensure that:

- WAGPET has a body of evidence about the ongoing effectiveness of a model
- any risks around complacency about the current model are addressed
- the potential of WAGPET as a whole-of-state model for RTPs is developed
- key focus areas of the WAGPET Strategic Plan are addressed, especially our work around WAGPET's Rural Preferential Pathway
- GPET Collaboration Planning requirements are met.

A staged process over two years, 2011-2012, is proposed to align with the current WAGPET Strategic Plan, as follows:

Stage 1: Internal Operational Appraisal

The purpose of this stage is to better serve the regions through an examination of our internal affairs. This stage aims to ensure our internal structures, communication mechanisms and processes are:

- reflective of: feedback already gained from WAGPET Advisory Groups and Committees (RAG, SAG and RAC); and further input from these groups collected informally during this stage about what works well and what needs to be improved
- developed, interpreted and implemented consistently
- aligned with work around WAGPET's Rural Preferential Pathway.

Stage 2: Internal & External Stakeholder Response

The purpose of this stage is to obtain feedback on the work achieved in Stage 1 from internal WAGPET stakeholders (RAG, SAG and RAC), assess their responses and gauge interest in changes to individual regional models.

The purpose of this stage is to examine the views of a broader range of GP Training stakeholders to obtain input on effective, sustained models of regional delivery of training and education.

Stage 3: Implementation

To be examined in light of feedback Stages 1-2.

The Regionalisation Appraisal will be the Management Responsibility of the WAGPET Senior Management Group with coordination provided by the Development team.

APPENDIX B– LIST OF INTERVIEWEES

Internal WAGPET Administration

1. Dr Janice Bell (CEO)
2. Dr Colleen Bradford (Director of Training)
3. Sarah Cleak (Program Officer – Training Post Support)
4. Maryanne Coombs (Senior Manager, Development)
5. Dr Denise Findlay (Director of Education)
6. Claire Fortune (PA to CEO and Communication Officer)
7. Samantha Korzec (Program Officer – PGPPP)
8. Gabriela Littlefair (Program Officer – Accreditation)
9. Janet McGrath (Training and Education Manager, Programs)
10. Dr Murray Nixon (Regional Education Consultant)
11. Norehan Razak **(**Finance and Office Manager)
12. Karen Russell (Project Officer – Development)
13. Bridgette Sara (Training and Education Administration Officer)
14. Dina Snyman (Education Coordinator)
15. Karen Tetlaw (Program Officer – doctors in Training)
16. Trina Turbett (Corporate Services Manager (Company Secretary)
17. Stephanie Walker (Training and Education Manager, Pathways)
18. Dr Janet Zint (Regional Education Consultant).

External Stakeholder Consultation

1. Ms Belinda Bailey (CEO, Rural Health West)
2. Dr Felicity Jefferies (Director, Western Australian Country Health Service)
3. Ms Noelle Jones (Director of Health & Community Services, AMA (WA))
4. Professor Geoff Riley (Head of the Rural Clinical School of WA)
5. Mr Chris Pickett (CEO, Pilbara Health Network)
6. Dr Simon Towler (Chief Medical Officer, Western Australian Department of Health).

APPENDIX C– FEEDBACK FROM INTERNAL CONSULTATION

It needs to be noted that during the time this appraisal has been occurring, some of the issues and concerns have already had some strategies put in place to deal with them. The most significant of these is the creation of a formal job description for the AO role (now known as the REO, Regional Executive Officer), as part of a new contractual arrangement with the organisation providing the support services for regional training. This is consistent with WAGPET's commitment to ongoing quality improvement processes.

The comments from the consultation stages that refer to any related issues have been included as a matter of integrity and transparency to those who raised them.

The Preamble and Interview Questions
I have been asked to conduct an appraisal of WAGPET's Regionalisation. This initially involves interviewing WAGPET staff to gain their perspectives on how regionalisation is going from their perspective.

I am aware that some of you are very new to the organisation and that you also may not be directly involved with the regions. This will still be useful information to collect as you will be able to provide a fresh or different perspective from those who are more directly involved. The following is a summary of WAGPET's current model of regionalisation.

Background:
"The main priority for WAGPET is the ***enhancement and long term stability of innovative and sustainable regionalisation****."* Briefing Note: WAGPET Board (9 June 2004)
WAGPET has made the following commitments to regionalisation:

- Those components of GP training that can be done regionally are done regionally wherever feasible
- All regional areas of WA are served through local and central activities
- Economies of scale will be achieved through central organisation where appropriate

WAGPET structures to support regionalisation include:
WAGPET Board and Members – There has to be a rural majority on the Board to reflect rural interests.
Regional Advisory Committees (RACs) in each region to provide support for GP Doctors in training, develop the education program, support GP supervisors and Training Posts and identify new training opportunities in the region, working with WAGPET staff to develop these opportunities. **The key function of the RACs is to provide a voice within the region and to represent the region.** *(Summary of WAGPET response to Lockwood Review of Regionalisation, January 2007.)*

- Each RAC is comprised of:
- A Regional GP Registrar Liaison Officer (RLO)
- A Regional GP Supervisor Liaison Officer (SLO)
- A Regional Training Advisor (TA)
- A WAGPET Education Consultant and Program Manager
- A Regional Administration Officer from the Division (AO)
- Other regional representatives (varies in each RAC)

- **The Education Program**
  - Core education has both regional and central components
  - On-line support and training
- **WAGPET Coordination and Infrastructure**
  - Streamlined administrative systems to support regional carriage of the program while retaining economies of scale
  - Ensuring quality control
  - Providing cross-regional coordination
- **Others**
  - Regional Development funding for ongoing regional activities - $15,000.00 per region.
  - RAC workshop held in Perth annually

Interview Questions

1. What is your current role in WAGPET?
2. What does regionalisation mean to you?
3. What parts of your job do you think relate to the work of the regions?
4. What's working well?
5. What isn't?
6. How could it be improved?
7. What other comments do you have in relation to this area?

The following were the key themes that were identified as a result of the interviews conducted with WAGPET staff. It also includes suggested strategies for improvement.

1. Interpretation and Commitment to Regionalisation

What does regionalisation mean to you?

The responses to this question tended to range from an acknowledgement that regionalisation was core to its very existence and survival and hence to the way that WAGPET operates, through to seeing it as a pragmatic way of dividing up the work. This range is perhaps not surprising, given that several of the interviewees were new to WAGPET and the fact that some of them had little or no direct connection with the regions in the duties they undertook, or at least, perceived little connection.

Those responses that saw regionalisation as core to WAGPET's very existence made comments such as these:

- *It's very simple – it is regionalisation or we die. It is the core of WAGPET; not a luxury or an add-on. We ask ourselves every day – what can be/should be regionalised? Our criteria for decision-making are (in this order):*
  - *Regional interest in doing it?*
  - *Regional capacity for doing it?*
  - *Regional effectiveness in doing it?*
  - *WAGPET cost in doing it? There are some economies of scale to be considered, but they are the last considerations.*
- *It is a hub and spoke model that was only set up to be a whole of state RTP, otherwise there is no reason for WAGPET to exist. We also need to have the outer rim for progress, which is an idea based on community development principles. While it is pragmatic to have a central hub (WAGPET), it needs two-way lines of communication, connected to 10 regions.*
- *WAGPET wouldn't exist without regionalisation. WAGPET provides education and training for all, specific to the regions, which are all different. It is a centralised place to make it work.*
- *Regionalisation is about getting the RACs fully functioning and mature, delivering local programs with local solutions supporting the ongoing training needs.*
- *Decentralisation of the role of WAGPET.*
- *Ensuring that there is no rural disadvantage.*

The vast majority of the responses indicated an understanding of the importance of regionalisation, based primarily on the good sense it made. There was consistent support for the idea that it is important to ensure

that local and regional needs are better identified and met through a regionalised model than a metro-centric one. Some of the comments that reflected this were:

- *You can't have a head office that tells everyone in Albany what training they are having. You have to be able to consult at the regional level.*
- *Regionalisation is about dividing the state into smaller portions to make it easier to manage and more direct rather than a blanket approach to the services we provide. For example, the issues in the Kimberley are very different to those in Albany. It is good to have it more directly related to their needs.*
- *What can be done regionally will be done regionally, so that it is more reflective of their context and what is going on.*
- *The ability for regions to take ownership of what happens in the region and ensure it is specific to their culture and demographics. Each region is different in its own right with different issues.*
- *I know the requirements of people in the regions, where not everything is like the metro area. There are different requirements. I have just come from a government job, where Canberra made decisions and this doesn't work as they don't know the realities from an office. Regional places need to have a say in what they need.*
- *It's about thinking about WAGPET across WA, not just here. Different places and regions have different needs. We need to predict those needs and give them a voice. We also use their voice (support in community for WAGPET). They have a lot of influence in the community. We rely heavily on what they hear or say out there. (RAC members, but also some people not on RACs, have a lot of sway or a big role in the training.) RAC is a more formalised way of communicating but everyone in the region is still part of WAGPET. We can't do what we do without their help. The AGPT process shows this.*
- *It gives the regions ownership and makes them an extension of us, but not "these are our rules".*
- *It is a way of dividing up the state into manageable –sized individual units with specific characteristics (e.g. remote or urban) that fits within a general practice community, that is the right size and in a community that already exists – ie all GPs in the region are likely to know each other. This impacts on how the training is delivered and it varies from region to region – e.g. technology and the assessment of suitability of doctors in training to work in specific regions.*

A slightly more pragmatic approach was reflected in the following types of comments:

- *The work has been split up into regions.*
- *I understand hub and spokes model. The people delivering education know what they want/need. We're also not doing it all. It eliminates other tasks such as invitations to training, bookings, venues etc.*
- *It means that because we are in Perth, we bring all the regions together and they can do the training in their own regions and don't have to fly down to Perth. They have the resources available within the region. It is more convenient and cost effective.*
- *It has always been a part of my job. We don't really see regions as sharp lines. It doesn't control how we work. It is more of a guide in the background. Regionalisation – we know it's there and it helps to make it easier; it is not a limiting factor. We can see what works in some regions and offer it to others.*

2. Aspects of Regionalisation that are Working Well

The RAC Model and Structure

There was a high degree of support for and commitment to, the Regional Advisory Committee (RAC) structure. It was noted by some that the fact that this structure had survived since it was established in a context of "fragile groups of interest" was very significant, given that this required a commitment to both the region and its needs, as well as to the profession.

The fact that none have fallen over, which was seen as a possibility at the beginning, was put forward to show the value of the model.

The governing bodies and structures within each region were seen as critical by most interviewees. It was highlighted that these processes enabled the identification of local issues and needs and the provision of support at both the regional and central levels.

Generally, the RACs were seen as working well and that their intent was honourable and positive, with a sense of belonging and little internal division. This was despite the acknowledged fact that those involved in the regions undertake work for a variety of regional organisations and are often in a competitive context.

Although there was acknowledgement that the RACs operate in different ways and are at differing levels of self-management, they were seen to be working well, particularly in relation to:

- Identifying how to sell their region to doctors in training
- Ensuring the delivery of high quality education and offering direct support to doctors in training if they are experiencing any problems as well as alerting WAGPET to these issues. This was seen as a major strength of the regionalised model in that any problems in this area were much easier to detect at the local level.
- Feeling themselves to be an entity
- Supporting their supervisors so they can bring issues directly to the RAC, to discuss with other supervisors in the region, as well as with WAGPET
- Building up a rapport with the Regional Program Manager (RPM) role. This was seen as supporting the RPM acting as a conduit of information from what's out in the region to WAGPET, as well as providing information to the region re: what is happening outside of the region.
- Virtually a full contingent of stipend RAC members on each RAC, and in most regions, many other unpaid members
- There was some recognition that regionalisation was embedded into the way WAGPET operates through the RAC structure being in place, in conjunction with the Registrar Advisory Group (RAG) and the Supervisor Advisory Group (SAG). These various structures were seen as always being factored into the communication processes used by WAGPET. This structure was identified by several WAGPET staff as being very helpful for them in gaining insights into the issues being faced across the regions as well as being a way of communicating to and across regions.

Internal Structures and Processes

WAGPET has fairly recently put in place some internal structures and processes to further support the regionalised model. A Senior Manager has a coordinating role in relation to Regionalisation. This involves supporting the building and maintenance of communication links between the regions and WAGPET, as well as across the regions. The communication links being built across the regions are seen to support the strengthening of the outer rim in the hub and spoke model. It allows the sharing of good ideas and strategies, as well as a way of regions gaining an overall perspective of the whole state and its needs.

As part of this coordinating role, there are Regional Program Managers (RPM) meetings where updates are provided after RAC meetings to ensure that all RPMs are kept informed and so they can also then act as a conduit for their own RAC in providing information re: activities, issues and trends in other regions.

An additional internal strategy that has recently been put in place and was highlighted by many as a positive step forward was the provision of updates to the CEO from RPMs after each RAC meeting. This is to provide information on what is going on in the region, through providing a "bulletin" on key aspects such as both the good and bad news, as well as what is happening regarding practices and the region itself. It was identified that this was an important strategy to ensure that the CEO was kept in touch with the regions and their needs in order to more effectively represent them.

The Regional Education Programs

The regional education and training programs that are being provided across the regions was highlighted as being generally of high quality and responsive to registrar and supervisor needs. This view was supported by registrar Feedback Surveys (obtained each 6 months) and by informal feedback that indicated that it was meeting their needs.

Overall, the regions were described as providing a variety of topics (although this varied in some regions, where there seemed to be a repetition of previous topics and less evidence of consultation with Doctors in training). Regionalisation was identified as providing the opportunity for regions to select those topics relevant to their context and to the identified needs.

Regions were described as being able to identify individual expertise of people within the region which would be harder for WAGPET to do from a central perspective, with a local education cohort and knowledge of how to access good resources. As one interviewee described it "It makes so much sense, creates a sense of community and involves local practitioners. The model is really positive."

One interviewee indicated that the various members of the RAC such as the Supervisor Liaison Officer (SLO), the Registrar Liaison Officer (RLO) and the Regional Training Advisor (RTA) seemed to enjoy putting the program together and making a contribution to registrar education. As one interviewer commented "Many of them stay on in their role due to a degree of altruism and "giving back" to the profession."

The delivery of the Cultural Awareness Training in the regional areas, has reportedly received positive feedback from Doctors in training, even though it was initially met with some opposition in some regions. One interviewee indicated that this had provided an opportunity to link in with others and a networking process that could be built upon into the future.

Involvement of Divisions of General Practice and Networks

The involvement of the Divisions of General Practice and Networks, through the Administration Officers and/or their representation in the RAC, was highlighted by several interviewees as a positive. The Regional Administration Officer provides administrative support in the development and implementation of the GP vocational training program and the associated processes, procedures and services. The work of these Administration Officers was particularly valued when there was some degree of continuity in the person undertaking the role, as they in turn, also provided some continuity to the processes used.

The Annual RAC Workshop

The annual RAC workshop that is held annually was identified as being a positive and worthwhile activity. This view was based on feedback that was received from participants, indicating that they enjoyed the opportunity for networking and hearing about other regions.

An improvement that was noted by several interviewees was the fact that last year was the first time that Education Consultants and RACs came together and they felt part of one region. All staff were also there for the full day when RAC Program Managers and Education Consultants were presenting. The opportunities this provided for the sharing of ideas and for linking up with each other for shared projects was highlighted.

This strategy has the potential to continue to build the "rim" of the hub and spoke model of regionalisation that was mentioned previously.

Regional Development Funding
The availability of funding to support development in specific areas identified from within the region was highlighted by several interviewees. This offers funding to each region of up to $15 000 per year to support an area of interest.

The grant is no longer labelled as an "Innovations Funding" but is a "Regional Developing Funding" which was applauded by some of the interviewees, as they felt that it had lead to increased interest from the RACs.

Growth and Development
There was general agreement that there had been significant growth since 2005. This growth was across several areas. They included:

- An increase in the number of doctors in training volunteering to go to the regions, which was described as a "fundamental shift" by one interviewee. This is consistent with an increased interest in general practice across the board.
- An increase in both the amount and quality of education and training that takes place in the regions was seen to be the result of an emphasis by WAGPET of its importance, WAGPET support for this to occur, and the increased numbers of doctors in training within the regions, as well as the commitment made by those within the regions.
- New practices coming on board. This was identified as being significantly supported by the input of local knowledge that comes from the RACs. Another interviewee highlighted the increased opportunities for Indigenous Health Training with the increased numbers of suitable training posts as a positive.

The Central Program
Specific aspects of this program that were singled out included the increasing use of the virtual classroom as a strategy and e-Learning as it provided greater ease of access to education and training and resources.

It was acknowledged that there is a need for balance of training provision that is both regional and central and that with WAGPET being a single Regional Training Provider (RTP) it was able to provide quality training for central issues that are difficult for regions to take on and that needed a core group of experts. As one interviewer commented, "The model is a successful one for WA. The RACs would struggle without the central component and the central would struggle without the regional training. It is a win/win model."

Relationships with Key Stakeholders
There were several comments made on the improving relationships with a range of key stakeholders. This range included the RACs, the training practices, the Administration Officers, and other key agency partners.

Strategies that have been identified as supporting this strengthening of relationships have included, but are not limited to:

- Visits by WAGPET staff to some specific regions in order to meet new staff within training practices, and to be there to assist with accounting issues etc. As one interviewer described it: "It helps the practices to know I am there to help, not just harass them!"
- The Regional Program Managers and Regional Education Consultants being involved with the RACs. This enables a response to local issues due to people from the regions contacting WAGPET staff to alert them to any issue, such as one involving a registrar. This was described as occurring due to the role of the WAGPET staff member on the RAC and therefore being known to the individual. It also allows any regional concerns to be aired and brought to the attention of WAGPET sooner rather than later.
- Responding as quickly as possible to any concerns or questions raised by the Administrative Assistant and an acknowledgement of the importance of this relationship as part of the Induction for new staff or existing staff in new roles.

- WAGPET staff having an understanding of the different regions and practices within the regions, as well as knowing the dynamics within each region.
- The tour of the regions that was undertaken by Janice Bell (CEO), Peter Wallace (then Chairperson of the Board) as part of the IHT follow-up with a specific purpose.
- The work with Western Australian Country Health Service (WACHS) in sorting out PGPPP placements has resulted in a strengthened relationship and some agreements re: travel and the recruitment by Albany Hospital of five doctors to do one rotation each and for next year and WAGPET will recruit another five doctors so that there will at all times be two doctors to complement each other between surgery and the practice.
- The work with Rural Health West in the Obstetrics Mentoring Program with placements funded in the outer metropolitan and rural areas and funding being obtained for a Pilot Mentoring Program to be put in place for GP Anaesthetists in 2012.

Cost Effectiveness and Efficiencies

Apart from the previously cited benefits of a regionalised education program, another identified benefit was the economies of scale that this provided. Some interviewees highlighted that if some regional education did not occur, then the impact on the budget for the coordination and delivery of central education would be massive, taking into account flights, payments and other associated costs. The resultant administrative requirements and the impact for increased workload and the potential need for increased staff, was also highlighted. It was also identified that the negative impact of the disruption of the training would also be a significant cost.

3. Aspects of Regionalisation That Could Be Improved ("Hotspots" for WAGPET Operations) and Suggested Strategies for Improvement

Commitment and Connection to Regionalisation for All WAGPET Staff

One of the challenges identified by several of the interviewees was the fact that some staff did not realise the importance of regionalisation to WAGPET's existence and saw it as somewhat of an administrative burden at times. One interviewer described this viewpoint as being "the equivalent of 'institutional racism'", where staff considered that processes would be much easier if there was a centralised approach adopted. The need to have all staff commit to regionalisation as a concept, regardless of the type of work that they carried out, was emphasised quite strongly by many interviewees.

Alongside this need for commitment to regionalisation was the need to recognise that WAGPET staff should be focussed on training up regional people to undertake key tasks within their region, rather than providing expertise when needed. It was acknowledged that this took more time and was at times, quite difficult, but nevertheless a worthwhile goal.

Many staff indicated that for them, regionalisation had very little direct impact on their role and this no doubt reinforced the view that some aspects (particularly administrative ones) were seen as "a bit of a nuisance and not part of my real job."

Some key factors that contributed to this viewpoint that were identified included the issue of time pressures, feeling overwhelmed by the complexity of the structures and processes (particularly for new staff) and not being sure how the programs and processes fitted together. Another factor that was raised was that sometimes there was an apparent possessiveness of WAGPET staff regarding "their regions", so some felt that it was hard to connect and get to know certain regions and their needs.

One interviewer raised the issue of a lot of the Board members not being involved in the regions, even though majority rural representation is required in the Board structure.

Strategies for Improvement:

- The Coordinator role for a Senior Manager related to regionalisation referred to previously, that involves fortnightly RPM meetings to assist with consistency of approach and enhanced communication.
- The post-RAC meeting briefings to the CEO from the RPMs referred to previously to be continued.
- The possibility of ensuring that everyone at a particular level takes on a regional/RAC responsibility.
- The rationale for a regionalised approach to be consistently made to all of the WAGPET staff, with a commitment to investigating what can legitimately be done within the regions.

Connection of People in the Regions/RACs to WAGPET

There was recognition by several of the interviewees that the people in the regions did not always feel as if they are "part of the WAGPET family". This was seen as partly due to the fact that they work for four or five different regional organisations, such as the GP Network, the RCS, RACGP, and they may also do ECT visits for Rural Health West as well as WAGPET. Another reality mentioned was the fact that they are also running their own private practices. There was an acknowledgement that they are beholden to no-one and can stop and start when they like, but in the main, they continue to work within the region. It was acknowledged that the answer was not to try to get these people to be WAGPET employees, as this top-down approach was unlikely to work and would be seen as arrogant and insulting to the regions.

Strategies for Improvement:

- Continuing to have face-to-face contact with the regional people to build the relationship and better understand their issues and needs.
- Conducting more regionally-based training for supervisors and conducting forums in the regions.
- Investigate the possibility of setting up outcomes-based contracts with the regions, to increase a sense of ownership at the regional level.
- Continuing with the annual RAC workshops to bring all members of RACs together and build relationships.
- Facilitating opportunities for the sharing of ideas across regions, such as with the Cultural Awareness work.

Current Education Administrative Requirements

There was fairly consistent acknowledgement that the current requirements for those providing education and consequently for the AOs in each region were somewhat burdensome and cumbersome and that there needed to be some changes made.

Since 2009, a copy of the session plan, attendance list, evaluations, power point slides etc need to be uploaded into WAGPET e-learning. One of the reasons that was highlighted for getting the materials is so that they can be shared on the system for others to access, such as doctors in training or other presenters, although some indicated that they felt very little use seemed to have been made of this.

Currently, the process requires that once it is uploaded, then the invoice is paid to the person who has provided the education, provided all sections are completed. This can sometimes take considerable time; with many WAGPET staff directly involved in dealing with these matters suggesting this sometimes resulted in many contacts needing to be made with the AOs and the providers and some frustration for all parties.

Some interviewees indicated that some of the presenters had indicated to them that the actual session planning requirements were too bureaucratic, but the interviewees felt that it was critical to ensure that there was a clear focus on education in terms of outcomes and strategies and that the requirements assisted this to remain the focus.

From a WAGPET staff perspective, the process to set up on-line regional education modules was also described as laborious and taking approximately one day per week for an officer to keep on track with it, with the setting up of 80 sessions on the Learning Management System (LMS).

With the relatively high turnover rate of those in AO positions, it was also identified that the bureaucratic processes required ongoing training and support to be carried out by WAGPET staff every time a new person took over the role. This required additional time that was seen as a distraction from other key tasks.

Strategies for Improvement:

- Workshopping in regions for half a day to explore this aspect with time devoted specifically to this area.
- Phone calls to AO to explain how it works and the need to work together, rather than emails.
- Putting in place a timeline such as a week in which to complete it after the session.
- Streamlining the process such as with the recently redesigned invoice, where the presenter now signs off that required paperwork has been provided to AO. This may alleviate time delays. It is still early days yet to see if it makes a difference.
- Asking for the bare minimum but the LMS/e-learning is only as good as what's put into it for others to access and use.
- Perhaps having more staff employed on a part-time or casual basis to help out the AO.
- Have the AO administer it all and trust that it will be done.

The AO Role (now the Regional Executive Officer Role)

The AO has many other roles and the WAGPET role is an additional one. The current payment goes to the Networks and Divisions of General Practice and not as additional payment to the AO for the additional work. The demands on the AO role have also increased. The current formal job description does not reflect the current expectations of the role.

The frequent changeover of staff was identified by several of the interviewees as a problem, particularly given the fact that they were trained for the role by WAGPET staff who then needed to repeat the process when the AOs were replaced.

Strategies for Improvement:

- The annual job description needs to be reviewed to more accurately reflect the requirements of the role.
- The relationship needs to be built to ensure that the responsibility is shared. It was identified by several respondents that it was important to have regular visits and to know people by face and name.
- Engage more with them in a group for inter-regional meetings.
- Invite the AOs to the annual RAC workshop every year and to have direct relationships with them.
- Pay them more. Take a proactive approach and say: "This is what we can offer. What does it actually cost for the AO role? Consider a sliding scale dependent upon the number of Doctors in training.

Conditions within Regions

There was a concern raised regarding the lack of sufficient funding for housing for doctors in regions. This was identified as something that impacted significantly on registrar choices regarding regions to carry out their training.

Strategies for Improvement:

- WAGPET staff to drive the push for increased housing through lobbying and seeking funding from e.g. mining companies.
- Local government may be potential new partners.

- Regional development activities to develop more things regionally to consolidate our RACs and provide a constant flow of Doctors in training.

Funding Disparities for Regions

The current policy of providing less money to provide education if there are less than three doctors in training was raised as a concern by one interviewee. The identified result was that the RAC doesn't put together a program for them. The potential consequence of this was that RACs meet less frequently and then are not in a good place to reinstate education for the following year.

Strategies for Improvement:

- The policy needs to be reviewed, in order to encourage RACs to invite others in the region to training. Each region should get the same funding, and be expected to invite others to attend.

Internal Processes for Induction of WAGPET Staff in Relation to Regional Roles

There was general agreement that there is currently insufficient induction for WAGPET staff in relation to their roles within the regions. This was identified as becoming more of an issue due to staff turnover, the increased size of the organisation and to the growing responsibilities and expectations of staff related to the work with regions, particularly in the RAC roles. Some staff reported that induction processes that had been planned for them when they joined WAGPET had not taken place due to "something always coming up".

Several staff highlighted inconsistencies regarding the processes used and some resultant confusion over whose role was responsible for them. This included such aspects as sign off responsibilities regarding payments and contract management for RAC stipends. Policies and procedures that had previously been in place were reported as no longer being up-to-date and this was seen as leading to lack of clarity internally, which was seen to impact externally. No handbook or manual and process for handover were seen as gaps that needed to be addressed.

The specific roles of Regional Program Managers lacked clarification and this tended to become more of an issue with new people taking up these roles. There was recognition of the need for WAGPET staff to understand their role and responsibilities in order to build their capacity to become functional members of a RAC. Although there was some acknowledgement that there has been some improvement in this area, it was seen as not working so well when new people take up the roles in the RACs. It was highlighted that in this situation, it is very easy for WAGPET staff to take on roles that are not theirs, such as chairing meetings, taking minutes etc.

There was a recognised need for induction and role clarification for WAGPET staff, as well as greater consistency across regions as to the roles being undertaken by WAGPET staff. It currently varies across the RACs in terms of use and roles and the form of support given. There was no formal induction or plan for change-over of WAGPET RAC members for Regional Education Consultants and Program Managers, and when people left WAGPET the need for clear direction as to what needed to be handed over such as how to set up regional consultation etc.

One interviewee suggested that regionalisation was critical to WAGPET, but that it "is really a side serve on our existing, everyday work and it shouldn't be. It is not reflected in the formal job descriptions."

Strategies for Improvement:

- Development of a RAC Manual that specifies roles and responsibilities of WAGPET staff within the RACs.
- Development of an induction process and handover plan for new staff taking on RAC responsibilities.

- Development of a spreadsheet that outlines such things as practice links with hospitals, a matrix of all relevant data and a visual map of how the various processes and programs interact in order to best support the doctors in training and the practices.
- Communication procedures and policies to be documented.
- Acknowledgement that the RAC role brings with it some significant responsibilities and time commitments and this needs to be built into and reflected in the job descriptions.
- Explore the possibility of rotating staff every few years in regions so that they get to know the state, although relationships with regions take time to develop so the potential benefits would need to be weighed against the costs.

Roles and Responsibilities within the RACs

The lack of clarity regarding roles and responsibilities within the RACs was raised as an issue by several interviewees, as well as some noted variable commitment within RACs.

There was some reported confusion over the RLO role when on the RAC compared to the RLO role when in the RAG. There was also a concern raised as to whether SLOs are always really representing the supervisors, although it was acknowledged that this was often not through lack of trying.

Some variable commitment from RAC members was noted by some interviewees and the point was made that the RLOs, SLOs/AOs get paid no matter whether they do the job or not. Some were described as regular participants compared to others, but they all get paid the same money.

Strategies for Improvement:

- New people being given greater clarity regarding their role through training and induction.
- RACs work best where there are clearly defined parameters.
- The development of a Manual for RACs.
- Greater clarity about roles etc. Is RAC best placed compared to WAGPET?

RACs / Regions at Different Levels of Readiness

It was identified that some RACs seemed to be keen for more responsibility, but that this varied according to the different levels of readiness within the RAC. Some growing pains were described, with some RACs retreating from taking on too much more.

An example of this was that the IHT funding going to regions to develop IHT Plans was described as working well in some regions and not in others. It required the RAC to be a lot more active than usual and sometimes they were reported as not always being sure of what the funding was intended to achieve. It was described as a real testing ground for RACs that showed the differing levels of readiness across the RACs.

Strategies for Improvement:

- Intra-regional collaboration with cross-regional activities.
- Greater clarity about roles etc. Is the RAC best placed compared to WAGPET to do certain tasks?
- Need to stop starting new things without finishing previous things. An example of this was not confusing RACs with two similar things such as Cultural Awareness Training and IHT Plans at the same time.
- Each RAC has to be looked at differently and have differentiated resourcing.
- Each RAC needs a WAGPET person as a communication conduit (Regional Program Manager), but it doesn't necessarily need a Regional Education Consultant.
- A decision should be made as to who is the best person to be placed on the RAC and how many are required. There are some RACs who only need one WAGPET person, as they run themselves. Different expertise is needed for different RACs.

- The RACs need to co-opt other people to strengthen the ties within the region. The RACS don't seem to understand that they can recruit/enlist /invite a person to be involved in the RAC.
- Intra-regional collaboration with cross-regional activities.
- Greater clarity about roles etc. Is RAC best placed compared to WAGPET?

Metro Regions and Rural Regions – Different needs

Until two years ago, WAGPET delivered all "regional" education programs for all metropolitan RACs. The regional process was completed with dividing the metropolitan area up into POM South, North and East, in order to differentiate it from WAGPET. There was some questioning as to whether or not this was an artificial distinction as there were no clear geographical boundaries and if it achieved its intention of true regionalisation. There was a suggestion for some that perhaps another model needed to be considered for the metropolitan regions.

There was recognition amongst some of the interviewees that Perth-based regions seemed to struggle more than other regions on how to spend innovation funds or IHT planning. It was thought that this was perhaps because of the fact that they can already do things across regions as they are not as isolated as rural regions.

APPENDIX D– INDIVIDUAL RAC RESPONSES

The information in the following section reflects the various RACs' responses to the areas identified by WAGPET internal operations during Stage One of the data-gathering. Where recommendations have been made, they are listed at the end of each report.

What's Working?
Generally, there was strong endorsement that the RAC model was working well, in that it enabled "direct feedback and input from those 'on the ground'." There was acknowledgement that the regional program was very responsive to the needs of doctors in training drawing on presenters with local knowledge. The program was described as working particularly well having a Training Advisor who is familiar with the region and /or involved in the RAC, especially for a basic term GP Registrar who is new to primary care.

The RAC members did not agree with any perceived lack of clarity regarding roles and responsibilities within the RACs, but thought they were clear and attributed any issues as being dependent upon personality rather than the lack of role clarity.

The RAC members identified strongly as part of WAGPET and therefore did not agree with the perceived lack of connection reported by the internal consultation process. They attributed this close connection to other or previous connections that members had with WAGPET as Doctors in training.

There was strong support for the involvement of the Divisions of General Practice and Networks, with an emphasis on the value of the Network CEO being an active part of the RAC.

The opportunity to access additional funds to support local development was valued by the RAC, as was the opportunity for networking with other RACs during the annual RAC workshop. It was identified that it provided reinforcement for work being undertaken by the RAC, as well as ideas for improvement and transfer of practices across regions.
The RAC identified that the local relationships with other key stakeholders such as the Rural Clinical School (RCS) and the Western Australian Country Health Service (WACHS) were working well, supported by the fact that some members of the RAC were also engaged with those stakeholders. The feedback and input from WAGPET operations was also seen as "critical to ensuring the best delivery on the ground."

What's Not Working?
There was an acknowledgement that the online process for regional administration had reduced the time commitment for paperwork, but also that any further efforts and changes to improve and streamline the processes would be welcome.

The AO role was described as challenging, especially when additional tasks are added to the role, such the IHT Plan and CA Training. A potential extra challenge for the future was the increasing number of GP Registrars needing placement, although it was not currently impacting on the Goldfields region.

Housing was not identified as an issue for the region at this point in time, but early notification of likely needs would assist in the future.

There was strong support for the benefit to be gained in being able to run an education program regardless of the number of GP Registrars and to include other GPs and trainees in the region, as it "creates a sense of belonging and a network." It was identified as being hard to keep being engaged when there are no GP Registrars in the region. One of the members of the RAC reported: *"I strongly agree that regional education should happen with a wider potential audience and so continues regardless of GPR numbers. RLO's have flagged previously that GPR's consider the teaching (quality/quantity) they will get regionally when deciding between areas – it's hard to say they will get good regional Ed if it's not already running. (This is not a personal gripe as planning my own education this year worked really well for me!)."*

The RAC agreed that greater clarification on projects such as the RIHT would have been helpful.

Additional Issues / Concerns

- There is a risk in larger regions where there are two or more large regional towns to ensure that there is feedback and engagement across both – may be useful to have more than one RLO, SLO in each region.
- Regional Training Advisors don't have the same structure to that of RLO, SLO (i.e. RAG, SAG groups) – may be useful to have some connection between RTAs.

Recommendations

- More face-to-face contact arranged at both a regional and central level to build on what already occurs, as this helps to build and maintain relationships and good processes.
- Further simplification of administrative systems requirements wherever possible.
- Earlier notification of GP Registrars and prevocational doctors coming to the region in order to secure required accommodation.
- A change to the policy to allow regions to run an education program regardless of the number of GP Registrars and to include others within the region.
- Greater clarification on expectations for any new projects to be provided by WAGPET.
- The structure needs to be maintained even in times of small numbers of GP Registrars as a longer term strategy for building the region.
- Consideration to be given to having more than one RLO and SLO in regions where there are two or more large regional towns.
- Consideration to be given to creating a structure for RTAs similar to RAG and SAG structures.
- Endeavouring to ensure that a Training Advisor (TA) is familiar with the region and involved in the RAC.

What's Working?

The current structure and model was endorsed by the RAC, as it "allows education to occur effectively within the region." The value of face-to-face meetings via the RAC model was identified as being "invaluable" to making connections and exploring issues and ideas. The connection with WAGPET through the RAC (via the Education Consultant and the Regional Program Manager) was described as "excellent".

The Regional Training Program was endorsed as working well for GPRs for the formal education aspect, but also as important networking opportunities. The devolution of Cultural Awareness Training was highlighted as a very positive move, as it opened up the opportunity to work with people in the community and to provide relevant information regarding local Aboriginal culture. The RAC reported that their involvement in its organisation and exploring local regional options was very enjoyable.

The involvement of the Network was viewed very positively. It was also seen as helping GP Registrars become familiar with the work of the Network.

The current flexibility of the Regional Development funding was described as working well for the region, in that it opened up opportunities to explore a range of topics and ideas within a better timeframe. There was some concern expressed however, in relation to a sense of pressure in applying for the funding, with extra demands on RAC members' time. There was also a concern as to whether or not some of the projects pursued offered value for money for WAGPET in terms of education and training.

The annual RAC workshop was identified as an important opportunity for sharing strategies and experiences across all regions, as well as catching up with the latest approaches and education tools. It was also seen as an important part of communication between RCS and WAGPET. The only concern was related to the timing of the event, with the suggestion that this should occur at the start of the year to introduce new RAC people to the RAC model and their role. Alternatively, if held at the end of the year, the next year's identified RAC members should be invited to the workshop.

WAGPET's relationship with GP Registrars and supervisors was identified as working well and its reputation within the region was "not bad". The concern was for the lack of visibility and knowledge of WAGPET across the region, including practices. Good communication processes were seen as critical to compensate for the lack of physical visibility within the region.

There was support from the RAC for the development of the formal job description for the AO role and its 0.3 FTE allocation. The development of KPIs was also supported, as well as having an expanded role for the AO to run programs developed by the RAC.

What's Not Working?

WAGPET's current communication processes with doctors in training in the region were identified as confusing and difficult, with no clear processes articulated which resulted in difficulty in getting responses from staff members, and the frequent changing of staff adding to this issue.

The lack of visibility of WAGPET across the region was identified as an issue that needed attention. Although the current stipend payments were described as satisfactory, there could be consideration given to broadening the number of stipends offered to ensure that the RAC represents all the training within the region, especially other supervisors. This was identified as potentially assisting to increase WAGPET's visibility.

The potential for GP Registrars experiencing a "double-up on education topics if they move regions" was considered to be an issue.

There were still some concerns regarding the current education administrative requirements and AOs needing more support from WAGPET to meet them.

The current funding arrangements for regional education whereby regions with more doctors in training receive the same as those with fewer doctors in training were not seen as appropriate. Catering costs varied and were not adequately covered via a flat amount being provided.

Lack of succession planning for RAC members and the resultant lack of handover was identified as an issue related to a lack of clarity regarding roles on the RAC. Although there was an acknowledgement that all RAC members take responsibility for the induction of new members in the region, it was seen as critical for the Regional Program Manager to ensure this happens, particularly in relation to WAGPET structures and requirements.

Developing the IHT Plan for the region created some difficulties and caused some concern. "The burden of responsibility for the IHT Plan fell on a few shoulders. The challenge with extra things for RAC work is not funding, but time, especially to communicate with the community. The IHT work was tricky to do as well as it could have been done and although the RAC knows it has fulfilled all the requirements, it knows it "*...could have done better with more time provision*."

Recommendations

- Face-to-face meetings for the RAC to continue.
- Consideration needs to be given to conducting the annual RAC workshop at the start of the year, in order to introduce new RAC people to the model and their role, or alternatively, if it is held at the end of the year, inviting new RAC members to attend.
- Communication processes between WAGPET and doctors in training need to be improved, with a clearer articulation of standard processes and prompter responses to queries. Greater stability in terms of staff who are the links to the GP Registrars would also support this.
- A standardised process as part of WAGPET central planning is instituted that – prior to the commencement of each semester – doctors in training coming into the region are contacted to list the regional education already received and provide feedback into their new region's program. This needs to be done centrally, rather than regionally by the RLO, as RLOs can also change each semester and it needs to be a standard practice that occurs.
- A better flow chart is needed from WAGPET that AOs can provide with education paperwork for presenters so they can meet the necessary requirements.
- Differentiation of costs provided for the regional education (eg catering costs) needs to be considered and perhaps done on a per head basis rather than a flat amount.
- A comprehensive induction for all new RAC members to be carried out by the Regional Program Manager, especially in relation to WAGPET structures and requirements.
- Succession planning to be built in to RAC processes, to ensure adequate handover when new members take on roles.
- Consideration to be given to expanding the membership of the RAC to include other supervisors. These should be supported by additional stipends.
- Ensuring that whenever there is a new requirement for the RAC (such as the IHT Plan) that there is a better handover provided with some straight delegation of what people need to do, especially if there are new people in the RAC.
- A presentation on how the Kimberley model works as a region should be provided for the annual RAC workshop.

It needs to be noted that the RAC indicated that they were unable to comment on several aspects of the key themes identified by the Stage One consultation process. This was identified as being partly due to the different relationship between KAMSC and WAGPET and the contract between the two parties. In other instances, it was because some of the RAC members were relatively new to their role or to the region.

What's Working?
The development of the Regional Training Program with a working group that included supervisors to help plan the program was identified as a positive aspect. The role of the RAC in monitoring how well the program was operating was also identified.

The involvement of the Division was identified as a potential action for the future. Curriculum mapping of the content, formalising the process and program matched to WAGPET central education allowing for variations in ability/knowledge was an area commented upon in relation to the training program. There is further sub-regionalisation of program delivery such as in Kununurra. Learning activities from each area / town is documented and shared.

Regional Development funding was seen as a positive contribution, even though up to this point, Kimberley RAC had not accessed these funds.

The visits by WAGPET staff to build and maintain relationships with key stakeholders was identified as being crucial, particularly given the high turnover of supervisors and staff within the region.

Although the RAC was not aware of the costs and value for money, there was a perception that the current structures and processes connected with regionalisation were efficient.

What's Not Working?
The lack of a good process for structure/governance, where it is not clearly defined what each party is responsible for, and communication mechanisms not being defined were identified as issues, but there was an acknowledgement that this could be due to limited activity from the individual RAC member who raised them.

There was agreement that improvements needed to be made regarding conditions within regions, with the housing situation in Kimberley being described as "dire". Subsidies have been increased for remote area more than for regional, with Derby now funded more than Broome.

The lack of obvious or existing links with the Clinical Training Network was identified as a potential issue. There was a question raised as to whether or not the RAC had a role in promoting education / workshops in the region.

The advent of Medicare Locals is likely to have an impact on the involvement of the Divisions of General Practice and Networks.

Recommendations
- An orientation to the RAC for new members through the provision of a training manual.
- People from other sites should be invited to attend events, eg across practices/hospitals etc via video conference for example.

What's Working?
The RAC model was seen as being functional for the delivery of education programs within the region. Doctors in training were reported as liking the small group teaching and learning and having a voice in their education. The Regional Education Program is viewed by doctors in training as good quality and is based on input from the Doctors in training. One of the difficulties experienced by the RAC is in getting GP speakers.

The Network has been very positive in providing the assistance of the Administration Officer and this has enabled the RAC to provide the necessary Regional Education Program. The impact of Medicare Locals was identified as an unknown factor at this stage that may have an impact in the future.

The Regional Development Funding model was identified as a good opportunity to explore other options however the roll out / timing and administration was an issue as a group.

The annual RAC workshop was identified as a good day for networking and sharing amongst other RACs. Its purpose is not always as clear as it could be and the timing is not always the best, as it clashes with exams and other local events. The issue of it being scheduled on a week day was also identified as not being GP friendly because of its impact on the practice.

Relationships with key stakeholders were considered to be positive within the region. This was attributed in part to the close knit nature of the region, but also to the good relationship with the Network. This in turn enables sourcing of good quality and a variety of education from within the local region.

The visits from WAGPET were viewed positively, providing an opportunity to discuss things face to face and the provision of guidance and discussion on points requiring clarification. "To continue to maintain a good relationship with WAGPET via the Regional Education Consultant and Program Manager is important for the RAC to 'stay on track'."

There appears to be sufficient housing for the number of doctors in training that come to the region and this is generally arranged at the practice level, so housing is not currently an issue.

Having each RAC being different in terms of their varying levels of readiness was not identified as an issue.

What's Not Working?
The RAC has had difficulty in trying to organise appropriate CAT training in the necessary time frames and last year did not meet the criteria.

The current administrative requirements are considered to be still too burdensome and time-consuming. A change suggested for the future could be that at the beginning of each semester the Network invoices WAGPET $1600 being the total for catering, room hire for the semester instead of having to raise invoices for 8 half day sessions, then would just need to follow up on the presenter's invoice. The process would still need the AO to monitor and remind.

The AO role is an issue with the Network and the RAC. It seems that the current position being undertaken by the Network person performing the AO is too big for the position/time provided. Clearer definition of roles is needed.

Although availability of housing is not an issue, not being able to attract GP Registrars to the region is one. This could be improved by WAGPET providing other incentives.

The RAC disagreed with the suggestion of providing the same funding to all regions, regardless of whether or not they had any GP Registrars undertaking training. The Midwest is in a unique position whereby the region is rather extensive and encompasses a number of practices in a large geographic area and so the region has not had a situation whereby it has had less than three GP Registrars.

The role and responsibility of the RAC Chair was not clearly defined or adequately acknowledged.

The rollout of IHT and CAT at the same time created uncertainty around what it was and it was not clearly defined and there seemed to be a lack of understanding of what was required from the onset. It was also difficult to get doctors in training to engage and be motivated with implementation.

There appears to be a disparity for RLOs and SLOs who have to attend RAG/SAG meetings in addition to RAC meetings. This could be taken into account when determining stipends, which are minimal after tax.

Recommendations

- Rural RACs need to look at more opportunities for cooperative effort, especially around funding and local expertise.
- Earlier feedback from doctors in training at the beginning of each semester would enable earlier identification of the registrar's educational needs.
- Clearer communication regarding the purpose of the annual RAC workshop to be provided in advance.
- Consider scheduling the annual RAC workshop at a different time of year (such as the new year) as this would better support induction of new members.
- Ongoing commitment from RAC members to have a clear appreciation of what their roles are, as well as an acknowledgement from WAGPET that they too lead very busy lives.
- The RAC taking ownership for the education program in their region.
- At the beginning of each semester the Network invoices WAGPET $1600 being the total for catering, room hire for the semester instead of having to raise invoices for 8 half day sessions, then would just need to follow up on the presenter's invoice. The process would still need the AO to monitor and remind.
- Transparency of funding by WAGPET and what is outstanding / available would be of benefit to the RAC and this could be done by regular updates to the RAC's.
- Clearer definition of the AO role is required.
- WAGPET negotiates with the Network and makes the Network accountable to support the AO.
- WAGPET consider the provision of additional incentives to attract greater numbers of GPRs to the region.
- The RAC Chair needs to be given an additional stipend to acknowledge their position with a clearly defined role statement.
- Consideration should be given to ensuring only one major project is required of a RAC before another is commenced.
- Consideration should be given to addressing the apparent disparity for stipends paid to RLOs and SLOs who are required to attend RAG/SAG meetings as well as RAC meetings.

The RAC indicated that all members were new to their role within the RAC and at this stage, were not really sure what should be happening. They anticipated having a clearer sense for assessment purposes in 12 months' time.

What's Working?
The RAC model and structure was endorsed as working well.

The Regional Education Programs were also identified as working well, given that the RAC was able to tap into the local intelligence on the best people in the region to present sessions.

The involvement of the Divisions of General Practice and Networks was identified as being crucial to the work of the RAC: *"The RAC could not function without this administrative support. The SLO and RTA are the clinical leads but do not have the time or expertise to implement the program."*

The Regional Development Funding changes were supported by the RAC.

The value of the RAC workshop was acknowledged.

Accommodation was not identified as a problem in this region, as there is plenty available and it is of good quality.

The RAC agreed with the issue raised regarding funding disparities for regions and the need to review the policy.

The value of communication via regular meetings to avoid confusion about roles was supported by the RAC.
The RAC indicated that they believed that the stipends currently being paid were irrelevant, as the members were not doing the role for the money but as professional people *"who pride ourselves on doing what we're supposed to be doing and doing things well."*

What's Not Working?
Although WAGPET "*is not given any bad press in the region*", it is relatively invisible ie most people don't know it exists or what WAGPET does.

WAGPET is competing with a lot of other organisations/things for RAC members' attention and this can lead to a lack of connection of people in the regions and the RACs to WAGPET. Direct contact on a person-to-person basis is often more effective especially when there are urgent/important messages to convey and using email for less important things.

The current administrative requirements such as uploading of paperwork on the website were identified as time-consuming and not user-friendly.

Staff changes at WAGPET have also made contact difficult, especially in the finance section, with some uncertainty over who to contact and oftentimes receiving no follow-up. Sometimes invoices have been paid twice over and at other times have not been paid at all.

The issues raised by WAGPET staff relating to the AO role were supported by the RAC. The AO estimated that the WAGPET work accounts for 0.5FTE of time in her position but the work has to be done over and above her core duties.

Although the RAC workshop was seen as a useful strategy, some improvements such as the provision of a list of acronyms used in training, induction for all positions on the RAC and increased understanding of the roles and terms of reference for the RAC were identified as possible strategies.

There is an issue in that most doctors in training choose to live in Perth and commute to the region. This was seen as having implications for education delivery in the region and detracting from involvement in the community where there is no commitment to the region by these doctors. The RAC is willing to provide orientation for doctors in training and social networking for doctors in training and their families in the region as a way to building community capacity and commitment to the region. This will form a central piece of the RAC's work in 2012 and the RAC may be looking for WAGPET support for this.

The issue of ensuring real representation within the RAC was also identified and the RAC indicated that there needs to be networking with other regions as a priority in order to form the 'rim' of the hub and spoke model currently in place.

Recommendations

- WAGPET should supply a list of acronyms used in training for members of the RAC.
- Induction should be provided for all positions on the RAC regarding the role and terms of reference for the RAC.
- A generic communiqué be provided to the region once a year to keep the WAGPET profile alive – this is who we are and what we've achieved in the region.
- The process for monitoring supervisor education requirements needs to be clearer. Suggest an email to supervisors every 6 months indicating what their tally is so they are kept abreast of where they're at and how much more they need to do. Note: could this be prompted automatically from the LMS?
- Person-to-person contact between WAGPET and RAC members/supervisors/practice /GP Registrars should be used when there are urgent/important messages to convey and email to be used for less important things.
- A review of the funding arrangements should be undertaken to remove the current disparities.
- Networking with other regions needs to be a priority to foster sharing and greater regional representation and ownership within and across regions.
- Maintain regular meetings in the region to avoid confusion and ensure the region is progressing in the right direction.

What's Working?
The RAC indicated that they were very pleased with people from WAGPET coming to the regions and the support that they provided to the work being done in the Pilbara.

Although there was agreement as to the value of the Regional Training Program, there were some comments as to the challenges the region faced. This included gaps that developed exist when putting together education sessions due to the high turnover of presenters in the region.

The RAC considers the involvement of the Network as vital to the successful functioning of the RAC, along with having members from other organisations on the RAC. This was seen to provide a connection to the community for WAGPET. Forward planning is therefore made more effective.

Regional Development Funding was identified to be a very positive RAC activity for the region. Combining with other organisations was also considered beneficial.

The RAC agreed that the annual RAC workshop was a useful opportunity for networking across the regions.

There was satisfaction expressed regarding the combination of regional and metro supervisor education that was provided. It was seen as facilitating regional and state-wide networking for supervisors.

The Pilbara Health Network identified that WAGPET had a key role in the development and success of the Pilbara Super Clinic.

What's Not Working?
The RAC indicated that although WAGPET is liked within the region, stakeholder relationships must be strengthened at a regional, state and national level, as positive relationships are essential and developing and strengthening them needs to be a priority.

Administrative requirements were identified as an issue, but there was an acknowledgement that staff changes at both PHN and WAGPET had made administration of RAC activities more difficult. There is now more stability at PHN and WAGPET. There was support for the changes to the invoicing process that had been put in place by WAGPET.

The RAC was supportive of the new Admin Officer formal job description to acknowledge the lack of clarity regarding the current expectations of the role. It was not supportive of a sliding scale of payment for AO depending on registrar numbers – RAC feels they are more active when there are fewer doctors in training in the region, with the AO role focused on other areas for the RAC.

Accommodation was identified as a significant problem in the region. The MSIP - Medical Services Incentives Program under review and there is concern about the continued commitment of the Shire and Mining companies.

As for funding disparities across regions, the RAC support full payment to the region for regional education, even with less than three doctors in training in the region. It was seen as important to get doctors in training together and interacting with each other, and other medical providers, in a rural region. It was identified as essential to develop community spirit as it will encourage doctors in training to stay in the region for extended periods.

Additional Issues / Concerns
- Medicare Locals will change the nature of each region - WAGPET invited to sit on Advisory Group for Kimberley Pilbara Medicare Local.

Recommendations

- Bringing presenters from Perth for education sessions would be beneficial when gaps in the program occur due to the high turnover of staff in the region. The presenters engaged would have to have had some experience working within the Pilbara region. This strategy was also suggested as a way to help keep past supervisors connected with the region although they no longer reside in the region.
- Consider the use of virtual classroom education sessions as a back-up for the regional program. Sessions would still need to be culturally appropriate and suitable for the region.
- Stakeholder relationships must be strengthened at a regional, state and national level, as positive relationships are essential and developing and strengthening them needs to be a priority.
- WAGPET should consider strategies to make greater connections with mining companies as this is a stakeholder with whom they are not currently connected and this could be a missed opportunity. This connection could lead to the possible provision of scholarships, the hosting of regional education sessions or regional development activities, or the development of an OHS Extended Skills post.
- RAC needs to focus on getting the WAGPET brand out into the region – promote and give due credit to WAGPET.
- Area for development: connection to community media to raise the profile of WAGPET and RAC activities within the region.
- More ongoing training is required for the Admin Officer – the position was largely learnt along the way.
- RAC to push for continuation of MSIP program.
- Consider Health Infrastructure Funding for accommodation. Joint effort would be stronger (PHN, WACHS, Rural Health West, WAGPET).
- The RAC supports full payment to the region for regional education, even with less than three doctors in training in the region.
- The RAC supports WAGPET meeting with mining companies to seek funding. PHN has already attempted this with no success.
- Plethora of health organisations in the region can be confusing – WAGPET is advised to simplify this and encourage communication between organisations, rather than add to the confusion.
- RAC manual necessary for clarity of positions and RAC responsibilities – include description as well as maps, timelines, pictures and other visuals.
- Face-to-face meetings are essential as they are very informative and enable feedback and clarification of queries more easily and more often.
- Central Regional Education Consultants available to present at regional education sessions when local presenters cannot be attained – possibly also via virtual classroom. Opportunity to connect those previously in a region with the region again should be considered.
- Focus on pastoral care support for PGPPPs and doctors in training in the region – such as thorough induction, ongoing social events, end of semester dinner etc.

What's Working?
The current RAC model and structure was seen to work well with appropriate support, funding and commitment. It was seen as enabling interaction and relationship building between doctors in training and divisional staff, through such activities as presentations on programs run by the Division, Aboriginal Health Worker mentoring etc. Its success was identified as being dependent upon the host organisation, the level of involvement of local supervisors and other GP Supervisor, continuity of RAC membership, the development of local resource people and networks, and the stability of support personnel to the RAC from WAGPET. The model was also seen to provide opportunities to support local GP's as educators with local, smaller groups being supported.

While there was agreement regarding the value of the Regional Training Program, there was a concern expressed regarding that at times , the programming was considered to be "ad hoc" and that it would benefit from guidance / structure to increase awareness of curriculum goals and educational objectives. The changes to the CAT model were identified as making it more relevant to doctors in training and the region.

The involvement of the Divisions of General Practice and Networks was also seen as a positive contribution, but the need to ensure a clear understanding of the job description and some negotiation of who is doing what in the RAC was highlighted. Being based at the Division was seen to increase registrar awareness of its role and its programs, services and resource people.

The Regional Development Funding was an area that the RAC agreed was a positive contribution, but it was felt that the RACs needed more support and guidance to make the most of it. There was also an acknowledgement that it requires extra commitment to implement in addition to the Education Program and that it should be planned in the early part of the year, with the involvement of doctors in training and supervisors.

The annual RAC workshop was also seen as a positive contribution, but further discussion on how to achieve improved coordination across regions to reduce duplication but maintain local relevance and independence would be a useful addition to the agenda. The inclusion of AOs at the annual RAC workshop was supported.

The Regional Program Managers and Education Consultants were identified as supporting and enhancing the RAC. They also were seen to have a key role in strengthening the link between regional and central programs and educational goals, as well as enabling early feedback of any problems in the region.

What's Not Working?
There was a concern expressed regarding the lack of consistency of WAGPET roles on the RAC. The continuous change of personnel was described as "disruptive" and having a negative impact on the potential support of the RAC.

The addition of some significant additional responsibilities for the RAC such as IHT, CAT and regional development has occurred. It was identified that these changes need to be introduced with consultation, clarification and appropriate remuneration and an acknowledgment that some RACs will be more prepared/willing/available than others.

There was agreement that the AO needed to be well supported in the role. At times there were difficulties for the AO in communicating with a wide range of WAGPET staff due to many part-time and casual staff being employed. This had sometimes resulted in missed and lost communication.

Changes to website content were not currently well signalled which sometimes resulted in relevant information being missed by the AO.

There was agreement that the AO role has increased significantly and the remuneration must reflect the time taken to undertake the increased responsibilities. There was also support for increasing the allowance for larger groups.
The RAC did not agree with the proposition related to funding disparities across regions, with each RAC getting the same funding regardless of the numbers of Doctors in training. They viewed this as not being realistic. Their recommendation was for Educator RAC /presenters and SLO/RLO and TA payments to be the same but for administrative payments to be varied according to the number of doctors in training in the region as larger regions require more work. An alternative model proposed could be to pay RAC members for work done as it was thought that this might encourage more participation. The issue was seen to require further clarification and discussion.

There was agreement that clear, updated role descriptions for various RAC roles were needed. These roles needed to reflect several years of experience of regional programs and roles.

There were some concerns expressed at the way the IHT Planning was rolled out. *"The IHT Plan was given to RACs with minimal consultation, preparation or training. It was left intentionally open but this made it difficult for a metro RAC with no prior experience of preparing such a plan or working with indigenous organisations. Our RAC has struggled with it and wasted a lot of time with poor results."*

When asked to comment on cost effectiveness and efficiency of the WAGPET model, there was agreement that there needs to be clearer guidelines and communication as to funding; how much is left, rollover of unspent monies, and deadlines for spending funding. There was an indication that there had been an under-spend for most semesters as some of the presenters did not require payment. There was also a concern regarding the current situation related to the catering budget as it did not currently reflect the number of doctors in training in a region.

Additional Issues / Concerns
The quality of session plans and evaluations were very variable due to the wide range of presenters from different backgrounds and at times it seemed like a bureaucratic formality and was not utilised very well to improve education. There was difficulty expressed in obtaining session plans from presenters within a reasonable timeframe to enable dissemination to the RAC before their presentation as is described in this statement:. *"..often, after numerous communications, the session planner will arrive together with a huge amount of photocopying the day prior to their presentation."*

Recommendations
- Greater guidance regarding curriculum goals and educational objectives should be provided to the RAC to inform the planning of the Regional Training.
- Increased networking opportunities for AOs to be provided by WAGPET.
- The Regional Development Funding process requires more information and criteria guidelines/deadlines from WAGPET in order to maximise its effectiveness.
- The annual RAC workshop should include discussion on how to improve coordination across regions to reduce duplication while still maintaining local relevance and independence.
- WAGPET roles on the RAC need greater consistency in order to provide the best possible support to the RAC.
- Any new requirements / responsibilities for the RACs need to be introduced with consultation, clarification and appropriate remuneration. Relevant training should also be provided to support RACs where needed.
- If more part-time/casual staff are employed at WAGPET, it would be advantageous if each regional AO was appointed only one as a contact.
- WAGPET website content changes need to be clearly identified and communicated to AO's.
- Remuneration for the AO role should reflect increased responsibilities and the number of doctors in training within the region.
- Funding arrangements for RACs need to be considered further.

- The role descriptions for the RAC roles should require all members of the RAC to be involved in the Education Program, i.e. planning and implementation.
- Consideration should be given to the SLO having a role in increasing the involvement of Regional supervisors in the Education Program.
- Clearer guidelines and communication need to be provided to RACs as to funding; how much is left, rollover of unspent monies, and deadlines for spending funding.
- The catering budget needs to reflect the number of doctors in training in the region.
- Consideration to be given to ensuring best use is made of session plans to support quality education.

What's Working?
The RAC agreed that the RAC model and structure was working well and that they were happy with the current model.

The Regional Training Program used local presenters who appealed to doctors in training and this helped to encourage attendance, especially for GPT3s (Subsequent GPRs). They were seen as a potential source for future program development. There were a high number of registrar presenters of the regional education sessions. This was seen as a positive overall as they chose relevant topics, although they often tried to fit too much information into their presentations.

The Network was described as being enthusiastic about its involvement within the RAC. The AO viewed the RAC responsibilities as a positive element of her job at the Network and the value in being able to meet Doctors in training; the future GPs in the region.

The RAC workshop was seen as a positive way to get all RAC members together, although POM North has the unusual situation as the RLO, SLO and RTA are from the same practice and therefore have some manpower issues, so not all representatives can attend the workshop. The RAC felt that one workshop per year was enough, even though not all members can attend, as if there were more workshops, and then the perception would be that members would have to attend both.

There was strong support for the regular contact provided by WAGPET to each practice in the region as it was considered *"better to have too much contact than not enough. "* There was an acknowledgement that most practices in the region are well established and have been involved in registrar teaching for many years, but new practices would require more support. The staff at WAGPET was reported as "*always very helpful".* The RAC felt they had the links they needed.

What's Not Working?
The RAC reported difficulties they had experienced in getting supervisors to present at sessions, as the supervisors felt that they did not have enough experience to be presenters. More support from Education Consultant is welcomed by RAC to encourage supervisor participation.

Sessions presented by specialists were described as "*adequate*" and "*a good alternative in lieu of no supervisors to present* "but there was some concern regarding their ability to link their presentations to a General Practice scenario. There was some concern about ensuring that the education program was suitable for Doctors in training, as it was often difficult to gain feedback from doctors in training as to their needs. RAC attempts to canvas them for feedback via email in the past has been unsuccessful as doctors in training had been unresponsive. A suggestion was made by one of the RAC members about asking the doctors in training at their first regional education session for input.

The process of writing the grant for the Regional Development Funding and the approval process was found to be very bureaucratic, and off putting for future proposals. The process of 'justifying' the activity was seen to be detrimental as it appeared to doubt the ability of the RAC to produce valuable regional activities. There was a need for further simplification of the process and for feedback to be provided in order to acknowledge the work that has gone into the proposal. There was some concern expressed regarding being required to complete the paperwork every year for the RAC's chosen activity (for 3+ years) of the exam workshop.

The current education administrative requirements were described as *"time consuming and hard to navigate and upload information"* which caused a backlog of data. The high number of doctors in training increased the amount of data to be uploaded, making it more time consuming for the AO. Further systems training was identified as a desirable option.

The demands on the AO role were identified as significant for the amount of time available and the Network was reported as believing that "*WAGPET is on a good deal for the amount of time provided for admin support. "*

This was particularly related to the fact that no additional funding is providing for the additional time that is needed in the role considering the high number of doctors in training in the region for administration required for workshops, with POM North having the *"largest number of doctors in training of any region."*

The delivery and organisation required for CAT was not factored in the funding received. It was very time consuming. *"The funding amount received was not enough to provide the desired session. RAC does not support regionalised CAT for metropolitan regions. The metro regions are so similar that running three separate programs is not beneficial to the Doctors in training. "*

There was a concern expressed re: some funding disparities across regions. Due to the large number of doctors in training in the region the catering/venue hire funding was not considered to be adequate.

In terms of the lack of clarity of roles and responsibilities within the RACs, the RAC agreed that full background and induction was needed, especially for the AO as they need to be able to coordinate effectively quickly. They suggested that WAGPET and the previous person in role provide induction/background to new people in the role. They also suggested that introductions by members and a summary of each position at the first RAC meeting should occur for a new member.

IHT plans were thought to be "*a waste of RAC time and WAGPET money. Very frustrating to do as had nothing to do with Doctors in training."* There was also some frustration expressed at the fact that there was no recognition, feedback or reward was provided for developing an IHT Plan. The RAC indicated they felt that they were being diverted from core duties of the RAC of being able to provide a regional education program.

Some concern was expressed regarding stipends not having changed even though responsibilities have been added to the positions. The workload had increased "*with no recognition."*

As for cost effectiveness and efficiency, the RAC identified that catering and venue hire amounts were no longer adequate. The stipends were reported as no longer reflecting the workload. The RAC also reported that they feel they do not have enough information about the overall cost of their regional program to be able to comment on cost-efficiencies.

Recommendations

- Local presenters should be used to support future program development.
- RAC supports more supervisors being involved in the RAC, especially those well recognised in the region.
- Simplification of the process for Regional Development Funding.
- Feedback to be provided on applications for Regional Development Funding.
- Preference for commitment every year to run the exam workshop (POM North's chosen innovate/development activity for 3+ years) instead of being required to complete the paperwork every year.
- One RAC workshop is sufficient per year.
- Further streamlining of the Education Program administration process needs to occur.
- More systems training to be provided for AOs.
- There should not be regionalised CAT in metropolitan regions.
- The amount provided for catering / venue hire should be determined according to registrar numbers.
- Induction for people newly into RAC roles should occur (especially for new AO). This should be provided by WAGPET and the previous role holder.

- Increased funding for catering and venue hire to be provided and linked to the number of doctors in training in the region.
- More support from WAGPET to provide a suitable regional education program is desired – a list of past sessions attended by doctors in training coming into the region would help plan for a program which was sensitive to the needs of the Doctors in training.
- Increased stipends to acknowledge extra demands and requirements of RAC roles.
- Clearer information regarding the overall costs of running the regional Education Program to be provided.

What's Working?
The regionalisation of the metropolitan area was identified as *"functional for education delivery for the doctors in training."*

Doctors in training were reported as being positive about the regional education model as *"they like teaching and learning in a smaller setting and feel they have a voice in their education. Doctors in training like the fact that they are asked to have input to the education program and think the quality of regional education is good."* GPs are the experts in General Practice and doctors in training benefit most from exposure to GP presenters – GPs are their preferred presenters of education.

The RAC reported that they were responsive to doctors in training' identified educational needs, based on feedback the RAC obtains from doctors in training at the end of each semester.

Having an Administration Officer (AO) from the Network was reported as being very positive as it has enabled the RAC to tie RAC work into that of the Network.

The new arrangements for Regional Program Funding were reported to have taken away the pressure to submit at a particular time of the year, but this has not necessarily lead to increased interest.

The RAC workshop was supported, as the opportunities for cross-fertilisation were considered to be *"really valuable – RACs have a sense of being 'satellites' and the RAC days help us to see ourselves acting as part of the whole."* The RAC was also described as a "*good bridge to have between doctors in training and WAGPET."* There were however, some issues around its current timing as expanded upon below.

WAGPET relationships with key stakeholders was agreed to be working well, as demonstrated by this comment: *"When we ring, we get so much support."* The RAC identified that holding RAC meetings at WAGPET had helped with forming these close connections.

The RAC did not agree that there was some lack of connection to people in the regions / RACs and identified it was more relevant to rural regions. They did not agree that WAGPET is invisible in the region.

What's Not Working?
The regionalisation of the metropolitan area was identified as *"an artefact for the metro area".* It was identified that the metropolitan regions should look at more opportunities for cooperative effort; especially around funding and expertise, as there was "*not much difference between the metro RACs."*

The RAC reported that they had experienced difficulties in getting GP speakers and identified a need to raise awareness of the importance of being involved in education amongst GPs.

The need for Cultural Awareness Training is not always understood by Doctors in training, especially those who don't get to apply what they learnt into their practice as they don't have Aboriginal patients. There is a need for them to be able to apply it.

Whereas there is only one GP Network covering a rural area, there are three Networks in POM South and including all three Networks in WAPGET work has not been done well.

It was felt that the timing of the RAC workshop at the end of the year was *"not good if we look at it from the perspective of RLO turnover. If the workshop serves as induction this needs to happen at the beginning of the year –*

end of the year is too late." The choice of a week-day was also not seen as helpful for supervisors who *"find it difficult to be released - it is not GP friendly and puts doctors under pressure in the practice as well as sending a message to practice staff that they not committed to the practice."*

The current education administrative requirements were identified as still needing the AO to monitor and remind presenters to provide invoices – *"Amazing how many presenters do not send in invoices, no matter how many reminders are sent out*."

The AO role was identified as an issue with the Network, in that the current AO learnt what the position entailed on the job, with some initial support from WAGPET. The current job being undertaken by the Network person performing the AO was reported as being too big for the position/time provided. The high staff turnover in the Network was also having an impact.

In relation to funding disparities within regions, the RAC suggested that this is unlikely to be an issue in the region, but if it should happen:

- For new doctors in training this would not be good – new doctors in training would definitely need guidance as they don't know what education is needed - "Don't know what they don't know" at this stage.
- Issue here is *not* the policy itself but how the policy is being implemented.
- When there are more doctors in training the RAC meeting becomes the event that the doctors in training come to in order to obtain RAC help to provide their independent education program. We must not lose this structure.
- Implementing the policy properly also enhances the Doctors in training' relationship with the RAC.

As for lack of clarity regarding roles and responsibilities within the RACs, the RAC indicated that *"some initial arm-twisting was done to invite current members to take up RAC positions."* The RAC identified that a formal job description was provided, but "*paradoxically, it was given along with the message not to worry too much about what was on it."* The RAC agreed that the job descriptions do need to be looked at again, but highlighted that the important thing was to pick the right people, with the formal job description then just providing guidance.

The RACs and RAG/SAG are largely invisible to new doctors in training and need to be promoted at events like orientation. These events could also be used as recruitment opportunities into the RLO positions as they arise.

The RAC reported that there are maturation and contextual differences between metropolitan and rural RACs, but not much difference between the metro RACs. The regionalisation of the metro area is an artefact for the metro area. It may be anti-regionalisation, but the metro RACs need to look at more opportunities for cooperative effort especially around funding and expertise. The differentiation between RACs was considered to be appropriate, given the regional differences.

There were concerns expressed regarding the evolution of the IHT and associated lack of clarity. There were also reported difficulties in getting doctors in training engaged/enthused with its implementation. "*There is a perception that too much came all at once eg IHT/CAT, Regional Development Projects (x 2) and RAC members felt the need to do all that was offered."*

The RAC suggested that the doctors in training were the best source of information as to measuring cost effectiveness of the model. The RAC reported that: *"doctors in training in POM S feel they're getting great value. Doctors in training think the regional education program is fantastic; however, a lot of doctors in training don't capitalise on the opportunities offered."*

The current stipend for RTA member of the RAC was considered to be adequate, but there was a disparity identified for RLOs and SLOs who have to attend RAG/SAG meeting in addition to RAC meetings. This could be taken into account. The stipend was described as *"minimal after tax."*

Additional Issues / Concerns

The morphing of networks into Medicare Locals is an issue – we need to look closely at the entities that arise out of this change. We currently don't access any of the resources the Networks, other than Canning, have to offer.
More work needs to be done with the three Networks that are part of POM South – may need to invite them to join the RAC.

Recommendations

- There is a need to raise awareness of the importance of being involved in education amongst GPs.
- Doctors in training to be offered an opportunity to apply their learning from CAT.
- Consideration needs to be given to clarifying and communicating the purpose of the RAC workshop and to changing its timing to earlier in the year to serve as an induction process for new people in the roles. Consideration also needs to be given to changing it from a week day.
- Recommend that WAGPET negotiates with the Network regarding the AO role and makes the Network accountable to support the AO. Possibly having KPIs for the Network in the contract will assist this.
- Care must be taken to ensure that doctors in training don't lose the structure and support provided by RAC meetings and the RAC, if the numbers in the region are low.
- 'Succession planning' needs to be added to the formal job descriptions for RAC roles.
- Greater clarity re: requirements for work such as IHT planning needs to be provided.
- The amount and timing of additional requirements of RACs needs to be carefully rolled out by WAGPET to avoid overload and disengagement.
- The RACs and RAG/SAG need to be promoted at events like orientation. These events could also be used as recruitment opportunities into the RLO positions as they arise.
- Disparity of stipends for RLO and SLO roles compared to RTA needs to be reviewed, due to extra demands for meeting attendance for RLOs and SLOs.
- Monitoring of the impact of Medicare Locals needs to occur.
- Consideration should be given to inviting the three Networks within the region to join the RAC.
- Consideration given by the metropolitan regions as to potential opportunities for increased cooperation amongst all three.

What's Working?
The ongoing two-way communication channels between the RAC and WAGPET are important, especially face-to-face meetings.

The RAC agreed that the Regional Training Program was generally of high quality and responsive to the needs of Doctors in training, with a variety of topics relevant to the local context being provided.

There was some reservation about the CAT, even though they believed it had been implemented successfully in the region. There was a perception reported that there was pressure to undertake the task. There were some ideas as to how improvements to the program could be made – refer to next section.

The involvement of the Division was described as *"excellent"* with recognition of the *"importance of a suitably qualified person, with dedicated time allowance to perform the role as vital to this success".*

The RAC agreed that the removal of the term "innovation" in relation to Regional Development Funding was a good decision, in that the term had been perceived as "*daunting".* The RAC indicated that it had addressed regional development each year that funding had been made available, so they did not agree that the re-labelling had lead to increased interest from the RAC. What was valued by the RAC was the increased flexibility around the arrangements. There was some perception reported that if the RAC passed up the opportunity of available money they were *"fearful that if we 'fail' to do what is expected, the reputation will be affected."*

The idea of the RAC workshop was supported by the RAC, but there were concerns regarding the timing of it, as it clashed with the RCS OSCE. It was also felt that the day could be improved by allowing time for questions and issues to be raised.

Relationships between WAGPET and organisations in the region were described as "now working very well together" with an increase in the amount of trust having occurred since the RAC has been in place. The RAC members' relationships in the region were described as assisting with WAGPET work, for example building the relationship with SWAMS; and providing feedback on practices applying for accreditation as a WAGPET Training Practice.

What's Not Working?
The RAC identified that RAC members needed greater understanding of the purpose and limitations of the Committee. The RAC reported that *"a lot of issues, especially from Doctors in training, go straight to central WAGPET and the RAC feels superfluous".*

There was a perceived disconnect reported between the effective operation of the RAC and the SAG and RAG as peak bodies. There were some concerns as to how adequately some issues were addressed by the relevant bodies and at times, some members reported feeling unable to make as valuable a contribution to the Regional Advisory Committee as they would have liked.

Despite the positive working relationships within the members of the RAC described earlier, there was some general agreement regarding some lack of connection between WAGPET and people in the regions and it was emphasised that WAGPET staff at <u>all</u> levels of the organisation (including the CEO) needed to be out in regions, connecting with people in the field.

The current education administrative requirements were agreed to be time consuming, as uploading to the WAGPET LMS was not considered to be user-friendly.

There was also a concern raised regarding the use of the regional education evaluation form, as it was not perceived to be helpful to improving the quality of regional education.

The invoice system was described as "*still confusing for Regional Medical Educators. Suggest invoice should have boxes indicating ECT Visitors fee is x; Regional Education Consultant's fee is x."*

Some disparity regarding travel allowances in the Regional Education Consultant's presentation fee was identified: *" those who have to travel distances to present are penalised as they receive the same fee as local presenters."*

There was agreement that a clear formal job description for the AO role needs to be developed, as well as a suggestion that the role could be centralised (out of Bunbury) to service regions where there is no suitable AO.

Inconsistency of supply was identified as the greatest obstacle to being involved in a practice taking on doctors in training in the region, as this was seen to have a direct impact on accommodation and often creates a financial burden to a practice, such as keeping up the rent on leased accommodation, but having no registrar to occupy it. The difficulty of getting good quality leased accommodation in some rural areas (outside regional centres) was also highlighted.

One of the issues raised by the RAC was that people in the regions do not know much about it, or about its role within WAGPET. This was linked to a concern that the positions on the RAC should be truly 'representative of' eg supervisors, rather than 'representing' them.

The IHT planning was considered to be complex and confusing when it came with CAT; processes were not concrete. The RAC wants quality and combines this with registrar needs. *"With things like IHT and CAT, felt it was imposed and didn't feel we had 'ownership of our destiny'".*

Intra-regional collaboration was identified as necessary for the RAC to feel part of the whole.

As for cost effectiveness and efficiency, the RAC concluded that current regional stipends are sensible, but that there is *"a need to increase the rate paid for Regional Education Consultants (e.g proceduralist specialists' time costs more than $1,000; also these specialists are used to giving an hour of their time, not 3 hours.) If trying to get new blood from other GPs, the current rate for GP presenters is adequate but not generous."*

Additional Issues / Concerns

Opportunity and Concern: The RAC suggested that with the advent of Medicare Locals and the coordination of GP education could well disappear and this has implications for the standard of support for all GPs; there may well be an opportunity for WAPGET to fill in providing education and training, other than for doctors in training, for example, Nurse Practitioners; Practice Nurses.

The theory that RAC positions are responsible for finding their own replacement is difficult.

Recommendations

- Continue with ongoing face-to-face meetings between RAC and WAGPET.
- Development of some strategies to increase members' understanding of the purpose and role of the RAC.
- Undertake some exploration of how to create a better connection between how the RAC , the SAG and the RAG operate.
- Consideration to be given to changing the timing of the RAC workshop to avoid clashes with RCS OCSE.
- The RAC workshop should include opportunities for question time and raising of any issues.

- WAGPET staff at all levels of the organisation (including the CEO) needed to be out in regions, connecting with people in the field.
- Further streamlining of the administrative requirements for the education program, including uploading of information and the invoice system.
- The registrar feedback form needs a thorough revision, with the inclusion of a section on whether or not the registrar would like the person to present again.
- Disparities in terms of travel expenses for Regional Education Consultants should be rectified.
- Formal job description developed for the AO role.
- Consideration given to centralising AO role (out of Bunbury) to service regions where there is no suitable AO.
- WAGPET creates a policy that it continues to pay the accommodation subsidy for the property when continuity of supply is broken. This could be more realistic if WAGPET was to tie gold standard practices (through QPC) to guaranteeing continuity of supply. The RAC suggests that with increased number of training places in the program, this is possible.
- Positions on the RAC need to be "representing" roles within the region, such as supervisors, rather than "representative of" them in order to ensure the maximum benefits of a regional model, where there is an accurate representation of the needs of key players.
- The RAC as representing WAGPET in the regions needs to be made clear.
- EC and RPM promote RAC when undertaking practice visits.
- Increased opportunities for intra-regional collaboration should be provided.
- Improvements to the Education Program should be considered, such as :
  - ECs to be notified of the Regional Medical Presenters scheduled and EC to contact each individually to assist with presentations. GPs put a lot of work into the education presentations and there is a lot of anxiety attached to it.
  - Support for Regional Education Consultants needs to be factored into the Admin function, e.g. help with doing Powerpoints.
  - New Regional Medical Presenters need to be given a good brief about presenting.
  - WAGPET needs to have a library of pictures etc to help out presenters and a subscription to an ME picture library for Powerpoints.
- A thorough review of the regional education evaluation form, with the following added: I would like this person to present again / I wouldn't like this person to present again.
- Strategies for succession planning need to be developed by WAGPET e.g. inviting more members onto the RAC.

The majority of the external stakeholders interviewed acknowledged the challenges for any organisation working across the size of Western Australia and responding to local needs that can vary considerably.

There was acknowledgement of WAGPET's expertise related to training safe and competent General Practitioners by several of the interviewees.

There was positive reinforcement of the RAC model and what it had been able to achieve in terms of supporting local regions. One interviewee commented: "*I have always admired the stance that WAGPET has taken in relation to the RAC model. Other organisations could learn something from this. It provides a good forum that keeps collaboration going and most issues are able to be resolved at the local level. It has worked well because of the individuals involved and the good team work within WAGPET. It is important that this is maintained for it to work."*

STRATEGIES USED BY OTHER ORGANISATIONS IN WORKING IN A REGIONAL CONTEXT

Most of the interviewees who had a regionally-based clientele identified similar strategies to those of WAGPET to deliver required services. This included such things as:

- Understanding their clients and their needs through gaining feedback (both formally and informally) and listening carefully.
- Recognising that different clients had different needs and therefore responses had to be customised to best meet those needs
- Acknowledging the importance of building and maintaining relationships with clients through personal contact and physical presence. Many commented upon the fact that they spend a lot of their time travelling out to the regions, but felt it was a critical strategy to learn what regions needed and to deal with any issues arising and reduce the sense of isolation. One organisation reported that all of the senior management team were actively involved in this process, but in an unstructured way.
- Using technology to support their work and connection with regions, with various degrees of satisfaction and effectiveness
- Believing regional people need to be in charge of what goes on in the regions, with the centre providing broad guidelines

Some individual strategies commented upon included:

Working with Staff

- Endeavouring to employ people who have a rural background was used by one organisation, in order to maximise their understanding of the challenges in the rural context
- Allocating "relationship managers" to set regions
- Keeping staff focused on the business aspect of the organisation and avoiding complacency regarding customer needs. One interviewee reported that this was an ongoing challenge.
- Choosing quality people with local connections and knowledge.

Providing regional back-up

- Ensuring that there is ample back-up to complete their tasks.
- Using key doctors in the regions who are influential and have spent a lot of time in the regions – local entities and good practices (similar to WAGPET).

Using strategies to build and maintain relationships

- Holding organisation-wide two day meetings (four times a year) to help people reconnect with each other and to maintain the relationships
- Developing mutual respect and trust
- Improving our web-site to make it more user-friendly

- Getting feedback to inform development
- Having Committees to help us identify the needs of others.

CHALLENGES AND OPPORTUNITIES FOR WAGPET IN THE FUTURE

The following represent the range of individual responses. It is not intended to imply that these were shared views.

Challenges

Increased numbers / demand and ensuring sufficient quality training placements

- Establishing more training places for the increased demand. Working with private practices who necessarily have a commercial interest was identified as a challenge by more than one interviewee. This can impact on the preparedness of practices in the regions to become involved if it creates some commercial hardship. Ensuring an adequate supply of practices prepared to take on doctors in training for training and adequately trained supervisors is central to quality education and training in the regions.
- Having sufficient infrastructure and resources to provide a regionalised service
- Running a larger organisation
- Ensuring quality control rather than increased numbers as the focus
- Ensuring adequate support is provided to doctors in training in the regions
- Increasing numbers of doctors coming into the system, but a change in the demographics and their interests
- Getting the job done of education for the future workforce needs
- Ageing population of doctors (especially in the rural areas) coupled with an ageing general population.

Building Relationships

- Establishing relationships with the Medicare Locals
- Improving and building relationships with other key agencies and stakeholders.

Workforce Demands

- Providing a better and clearer articulation of the Rural Preferential Pathway
- Getting more doctors into rural areas and keeping them there, although this may not be realistic and they may need rotations back to the metropolitan area
- Ensuring that quality training is occurring for all participants, regardless of the region.
- Dealing with the large turnover of staff in the north west of the state
- Ensuring that those representing their region are aware of what needs to occur to ensure there is true representation of regional interests, not just their own (Governance issues).

Opportunities and Strategies

Current reforms

- Being the only provider in WA and the current uncertainty in the health arena, means there is an opportunity to really adopt a very strategic approach and work with the key players. The Southern Inland Health Initiative through the Royalties for Regions Program has a large budget and education and training has a place in it.
- The Department of Health reforms and the progress on Telehealth
- Identifying a coincident focus on Primary Health Care
- Gaining appraisal data with a greater focus on patient / consumer views to inform planning and practice (Medicare Locals a useful source in the future)
- Increasing the use of Communication Technology to "*move from a 19th century training model and to reduce the concerns re: isolation."*
- Using Telehealth more for supervision in remote areas
- Using the Learning Management System to support and build regional education.

Specific partnerships and activities

- Working with the IMGs to help them to successfully transition into GPs
- Working more closely with ACCRM and supporting each other in the rural areas
- Working more closely with relevant agencies on the Rural Preferential Pathway
- Greater involvement of relevant agencies with the RACs to identify synergies and potential "hotspots".
- Holding an "education and integration workforce" discussion twice a year, with two formal agenda items of education and integration and then allowing a broader discussion.
- Meetings / teleconferences / shared values across key organisations.
- Building on from the synergies created between WAGPET and others in the Kimberley and in Albany.
- Creating a rural educational hub, with WAGPET, RCS and WACHS working together. This could be started by selecting a few opportunities where the agencies can do together, such as a weekly educational event. Working more with other agencies to look at the whole training experience and program over a year and combining efforts to provide mentoring support.
- Continuing with the recently commenced work on a joint project with the AMA (WA) to explore options for doctors in training to travel overseas
- Exploring the possibility of Rural Health West and WAGPET co-locating, as workforce and education should be inseparable. This would facilitate sharing of information and the development of a Primary Health Care entity with a state-wide focus.
- Increasing the training of the rural and remote workforce
- Working together on achieving the common interest in having more generalists in rural locations with financial support being provided.

The continuum of education and training

- Building on the innovative approach taken with the Community Residency Program, as it set a benchmark
- Developing an integrated lifelong learning approach that will require a lot of coordination
- Integrating the PGPPP and AGPT more fully
- Having a shared and clear vision with other relevant organisations of how education and workforce needs link and working together on the life continuum *("from 15 year olds to 75 year olds"*). The interviewee who identified this point indicated that WAGPET has the connection with those undergoing the training, but after they complete it, then they are part of the rural workforce if they stay in a regional role. There was an acknowledgement by one interviewee that WAGPET had demonstrated a clear understanding of this link, but other key organisations did not necessarily share this view. One strategy suggested was having a quarterly meeting in a region to link workforce and education at the local level.

Taking a strategic approach

- Recruiting the right people to achieve the vision and having the right mix of Board members to maximise strategic influence
- Developing some intellectual capital around how the processes work to achieve education and workforce demands
- Influencing the system and processes through a capital investment of leading the regions at a strategic level and not just leaving them in the regions to do the work.

Regional focus

- Ensuring that regional planning represents the differences across regions
- Being very explicit about the true cost (funding and time) of working with regions if a truly regionalised model is required.
- Letting people in the regions "*get on with it",* by providing them with the financial resources they need.
- Investing more in supervisors and their practices to recompense them for the quality training they provide and to ensure good supply.

There were few relevant articles that were located during the literature search, but the following provides a summary of some that had some relevance to this appraisal. They have been grouped under common topics. If there is further investigation of alternative models to be carried out, it may be more appropriate to explore the models of other Regional Training Providers (RTPs).

Canada and the USA

Marchildon's paper[6] that reviewed Canada's health reform agenda suggested that there were some close parallels to the current primary health care reform in Australia, with an emphasis on regionalisation to deliver services. Canada faces the same GP shortages, particularly in regional and rural areas and implemented reforms aimed at vertical integration. At the time of publication, there appeared to be some significant questions as to the future of the public system in Canada.

Lewis and Kouri [7] conducted a review of Canada's implementation of a regionalised model of health care and explored the concept of regionalisation in healthcare, its achievements and future directions. The shortage of doctors in regional areas was a primary driver for it being developed, along with concerns about the lack of continuity of care. They found that regionalisation had encouraged innovation to find creative solutions to meet locally identified needs. It was also reported as reducing barriers to continuity of care and duplication. They indicate that the changes have required significant time and lack of appropriate governance procedures in place that has resulted in a variable commitment at a provincial (regional) level due to lack of true accountability. They conclude by suggesting that regionalisation of a health care system requires a clear mandate, committed partners, outstanding leaders and a vision that mobilises providers and the public. They indicate that the challenge for the federal government in Canada is to decide what they think regionalisation should be and then leave the health authorities to get on with the job, being fully accountable. Although this is about an entire health system, these conclusions may have some application to supporting those regions who are interested in taking on a bigger role for GP education and training in Western Australia.

Norris et al [8] described how the University of Washington's School of Medicine extended medical education across five states without building new medical schools or campuses. Although its focus was on supplying sufficient places for the required number of medical students without a huge investment in infrastructure, they also reported on the benefits for the volunteer regional clinicians who were involved. They indicated that being involved in a regional educational model had kept them current and helped them to develop and enhance collegial relationships.

Ghemawat [9] focussed on how regionalised strategies in the corporate world have been shown to boost a company's performance. He outlines five key regional strategies - home base, portfolio, hub, platform and mandate that are used by successful companies. His premise is that to be very successful, flexibility and creativity is required, in order to identify which is the most appropriate strategy to use given the circumstances. When describing the hub strategy, he indicates that multiple hubs can be very independent of one another and the more the regions differ in their requirements, the weaker the rationale for hubs to share resources and policies. He indicates that the challenge in implementing a hub strategy is achieving the right balance between customisation and standardisation. He suggests that companies that are too responsive to inter-regional variation risk increasing costs or sacrificing too many opportunities to share costs across regions and therefore can become vulnerable to competition from others who use a more standardised approach. The flip side is that if there is too much standardisation across regional hubs, because they overestimate the degree of similarity across regions are vulnerable to competition from local alternatives. The platform strategy spreads fixed costs across regions. The idea behind a platform approach is to deliver variety more

[6] Marchildon, GP 2005 *Canadian health system reforms: lessons for Australia?* Australian Health Review, Vol 29 No 1 105 -19
[7] Lewis, S and Kouri, D 2004 *Regionalization: Making Sense of the Canadian Experience* Healthcare Papers 5(1) 12-30
[8] Norris TE et al 2006 *Regional solutions to the physician workforce shortage: The WWAMI experience* Academic Medicine, Vol 81, No 10 / October
[9] Ghemawat, P 2005 *Regional strategies for global leadership* Harvard Business Review Dec; 83 (12): 98 – 108

cost effectively by allowing customisation on top of common platforms that are engineered for adaptability. The fifth strategy is the mandate strategy where certain regions are awarded broad mandates to supply particular products or perform particular roles for the whole organisation.

Australia

Beaton et al [10] identified in their report on the reform of general practice training in Far North Queensland that there were significant benefits to be gained by collaboration and the development of a dedicated rural pathway and curriculum. They highlighted some key factors in successful implementation of a regionalised approach. These included local delivery, with sufficient manpower to teach at the local level, cooperation between key players and an innovative approach that is flexible to arising needs. The role of the coordinator was seen as critical in recruiting, developing training posts and coordinating rotations. They also emphasised the importance of listening to rural professionals and identifying organisations with common objectives so that joint strategic plans could be developed to ensure an integrated and efficient approach.

Campbell et al [11] suggested that regionalisation of general practice in Australia is not yet providing a sustainable general practice workforce to rural Australia. They suggest that this may be at least partially due to the competitive structure that was set up when GPET was established with Regional Training Providers (RTPs). The article placed an emphasis on the need for RTPs to contribute to the rural pipeline through collaborative development of shared programs and activities with rural medical schools, rural clinical schools and local hospitals. The authors called for a comprehensive review of general practice training to be undertaken.

Laurence et al [12] acknowledged that the regionalised model of general practice training had achieved some success, particularly in relation to the recognition and support of general practice as a vocational specialty, the increased numbers of junior doctors undertaking placements in general practice and increased numbers of registrars training in rural areas. The authors outlined the key changes in relation to governance and decision-making that have taken place over the last ten years and indicated that there are future challenges ahead for the regionalised business model as the complexity increases with the creation of a new framework that is inclusive of all key players.

[10] Beaton NS et al, 2001 *Regionalisation of rural medical training in far north Queensland: a learning experience for medical educators and managers* Australian Journal Rural Health Dec, 9 Suppl 1: S32-8

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