WAGPET

Briefing Paper

Date: 13 May 2021

Title: A First Review of the RACGP Profession-led, Community-Based Training Model

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Executive summary

Thank you for the opportunity to comment on this paper outlining the RACGP Profession-led Community-Based Training Model. We appreciate that we are being invited to comment now, before the model is subject to a grant opportunity process and the rigour that requires.

We believe that the RACGP Training Model requires significant revision and refinement if it is to be fit-for-purpose. There is limited evidence provided for what needs to change, what is within the authority and remit of the College and how we will know this approach will work better, is working better and how will we change it if is not.

There are few references to known facts or the need to review and verify the basis on which this current model rests. This failure to deliver the facts and to evaluate the impact and return on investment of the AGPT has been the vulnerability of the RTOs especially in the post-GPET area. In developing its training model, we caution RACGP to ensure that its model is built on evidence and not unestablished rhetoric and unsubstantiated causality. We recommend RACGP review and further study the progress to date in terms of the feasibility of using GP training, including targeting support and incentives, to fulfil the GP and RG needs of the community as well as review the current approaches to Aboriginal and Torres Strait Islander training.

There are some factual errors in the paper that require correction:

1. The AGPT program has been under-subscribed for several years p.1.It is not undersubscribed but rather under-filled.
   a. The AGPT numbers were raised from 1200 to 1500 in 2016 hence the greater likelihood of under-filling;
   b. Not all candidates are suitable for GP training or will not train where they are needed most;
   c. Less transparently, the RACGP is culpable for some of the 2017 fall in numbers. The RACGP limited the number of candidates WAGPET could interview, for instance, in the second 2017 from 61 to 24 – and so some of this lies at the feet of the way the College took on selection at first (email correspondence at the time).

2. The declining interest in general practice is hardly due to the GP training program. The reasons are deep and complex and there is research to describe with evidence why and how GP is and is not chosen by prevocational doctors.

3. The distribution of GPs across Australia mirrors that of the community better than for any other medical specialty and has significantly improved over the two decades the AGPT has been delivered.

4. The use of technology is adapted to the need it serves rather than the other way around. All RTO databases link to a nationally consistent database, RIDE. Ironically the shift to two Colleges risks a nationally consistent picture of GP workforce and training in Australia. Not all data belongs in a national database – much of it is very personal and private and must not be used for purposes other than for which it was collected. There are valid reasons why training data can / should and cannot / should not be shared (see reform section above).

5. Duplicated ‘organisational structure’ can mean smaller structures in preference to a few larger structures to ensure local relevance and service rather than the infuriation that follows a mass protocol-driven disconnected one. We have seen this happen as RTOs took on more registrars and practice facilities, and as some were collapsed into larger conglomerates. However, the thorough analysis of the return of investment, including the cost of idiosyncrasy on training continuity and service must be undertaken.

6. Regional and even more local workforce needs analysis is undertaken by the RTOs as part of the workup for training facility recruitment, selection, GP/ ACRRM / RACGP / PMC accreditation and then placement. It is incumbent upon RTOs to do so to meet their annual FSE weeks distributional contractual KPIs. It is simply not reported on to the Department or the Colleges, who have never asked for it.

We understand that the RACGP paper will undergo significant refinement and will be accompanied by:

1. Initial analysis of key cost savings and efficiencies
2. A provisional map of the approximately 16 regional hubs and 70 nodes
3. A proposed operating model beyond an outline including a governance map between the different layers of the model
4. An assessment of the practical implications of the proposed change for current and prospective participants
5. A consultation / co-design process to ensure all of the above is in accord with those whom we serve, that being the community whose health needs we are each charged with delivering upon affordably, practically, reliably, validly, affably and accessibly.

At present, we believe that there are fundamental problems with the governance and structure of the RACGP operational model and seek further clarification on the following key issues:

- Statements such as “local hubs will have high autonomy” needs to be described in action, policy, funding and processes.
- Absence of funding and training services continuity assurance in the time left.
- The placement process and the role of choice for practices and registrars.
- Over-reach where the College does not have authority undermining the core role of GP training.
- Reliance on activity with no accountability or defined agreed impact.

There are a number of changes that could be made now or in the foreseeable future without dismantling GP training and workforce infrastructure. Many of the current flaws in terms of AGPT performance stem directly from the RACGP Standards and the Departmental changes to program policies and requirements in 2015. We recommend that RACGP read the current RTO contract to develop KPIs to match (as occurred previously under GPET). RACGP’s leadership in terms of working collaboratively with the Department and RTOs to progress these changes would be welcomed.

Areas of proposed reform

Two major areas that RACGP has chosen in terms of reform are assessment and selection.

1. Progressive assessment to resource each registrar’s program around competence and capability, rather than just time, to more efficiently and effectively allocate education resources.

RACGP has always placed undue focus on summative assessment and a disconnect between assessment in training and the RACGP Examination, with completion of training entirely activity based. RACGP assessment does not drive learning and despite extensive educational research undertaken by the RTOs on behalf of the colleges, the focus remains on a high-stakes end-point exam. The RTOs have pivoted around these barriers by developing their own progressive assessment that starts in the first clinical year and intensifies in the early week of the first community based training. The performance of these progressive assessment methods and experiences of RTOs should be evaluated by RACGP prior to development and implementation of further summative assessment processes.

We recommend that RACGP review the work that has been undertaken and progress to date in terms of:

- Outcomes based standards
- Innovative supervision models including remote and 'rescue' supervision
- Scope of practice defined which will help inform development of national syllabus to achieve this
- Competency and capability mapping including cultural competency
- Programmatic assessment
- Leadership development for Aboriginal and Torres Strait Islander registrars

2. Redesign selection so it more ably chooses doctors who enter the program better able to complete it in the time allocated and can be applied flexibly and without disadvantaging Aboriginal and Torres Strait Islander applicants

Any work in redesign of selection needs to take into account the impact of the current RACGP selection process that has diminished quality and flexibility and applications (through decreased attraction and increased administrative blocks). At present there is little to no published evidence on the performance of the RACGP selection process. It will be important for RACGP to rectify this and we recommend that RACGP also review the RTO analysis of registrars who have withdrawn or fail to complete training as part of the analysis of the current selection process. We also recommend that RACGP review the GPET flexible entry process that took place in selected regions in 2010 as well as the extensive research undertaken by GPET into selection.

Whilst the two reforms proposed by RACGP in assessment and selection represent key areas in training, none of these reforms are new ideas. In all cases, they have each previously reached the stages of:

a. Discussion paper
b. Endorsed discussion paper
c. Minimum viable prototype
d. Single or multiple site pilot
e. Implementation then cessation without evaluation
f. Exemptions, exceptions, workarounds and precedents

Before embarking on major reform, RACGP is encouraged to reflect on what has worked well, what has not worked well and what were the unintended as well as intended consequences of failure to progress in terms of implementation of these new ideas.

There are a number of pain points that RACGP has been responsible for and needs to address.

There has always been a disconnect between AGPT and RVTS standards, as well as between prevocational and vocational training standards. When AGPT commenced, RACGP quickly formalised its training program operating guidelines into the 2002 VT training standards, maintaining for several iterations a strong focus on inputs and activity based

standards, centred around training practices and supervisors, registrars and training providers. The funding of a practice to host a registrar and the payment to teach was enshrined in the first RTO contracts and has changed little over time, despite the clear advantage to larger metropolitan practices owned by the supervisors and the disadvantage to smaller and more rural practices.

The impact on training practices, registrars and training deliverers of the tardiness to adapt to the new delivery model and its imperatives has been profound. Many smaller and rural practices have been excluded as they cannot meet the standards (such as an accredited supervisor onsite 80% of the time). Others cannot afford to take three hours each week away from patients to teach, even though they can ensure the registrar is providing safe quality care and is getting safe quality supervision. Practices with multiple registrars get the same per registrar teaching payment as if there were just one and run group teaching events multiplying the payments.

The RTOs have pivoted around these barriers by developing their own progressive assessment that starts in the first clinical year and intensifies in the early week of the first community-based training. They have built in additional services and payments to equalise and adjust for the more vulnerable practice in the most vulnerable communities. They have built business cases for non-GP training facilities to offer advanced and extended skills training without providing a lot of additional funding.

The RTOs have built robust relationships that inform valid, reliable, qualitative, timely workforce needs assessment. This is particularly important in vulnerable communities where there are often small practices and the loss or gain of one doctor significantly impacts safe quality care provision. They understand and manage the impact of national policies and especially unexpected changes in such policies in a way that minimises disruption. They streamline accreditation and other activities where the two Colleges and the Department have differing priorities and do not synchronise their demands on prospective and current participants and stakeholders.

RTOs have been remiss from a workforce driver point of view, but perhaps not from an efficiency and educational excellence point of view, in not accrediting new practices when they have enough current practices. Some RTOs work on the theory that registrars should be trained well by the more experienced and then seek work elsewhere. This limits the short and long term of the AGPT as we have shown where a registrar trains- especially where they complete their training- is the strongest predictor of subsequent retention.

There are numerous ways RTOs could have shared resources and expertise under the leadership of GPET, the Department and the Colleges. However the RTOs were set up under competitive terms and to collaborate was a breach of contract. It is not surprising they have found local solutions first, retrofitted later as RTOs amalgamated and cooperation allowed. What has not been articulated in the RACGP training operation model is how RACGP will mitigate issues that may arise if the Colleges are set up to be competitive and collaboration between the Colleges becomes a breach of contract.

There have been many conflicts created and others dismissed or ignored between key drives in GP training with no mechanism offered for their attention and resolution.

All of these conflicts are issues of governance, but first of all they must be recognised as conflicts in order to be managed transparently and effectively.

1. Managing the competing needs of the community, the training practices and the registrars is extremely complex. The RACGP paper does not bring these together, but instead makes contradictory statements that can be misunderstood; favourably and unfavourably. The paper misses the importance of expectation management and the

power of expectation violation, neither of which as a membership organisation does the RACGP do as well as it must. To fail is not to lose a member but potentially to lose a life.

2. Education and assessment being provided by the one entity is an inherent conflict of interest. Setting the standard to be met for all who would seek to be a GP deemed safe to work anywhere in Australia unsupervised and then designing not only the curriculum but the syllabus, with the clear statement the education will deliver successful result, lacks transparency and oversight. This argument is why in 2000 the RACGP was not invited to tender to deliver GP training.

3. Flexible local arrangements and national standards being approved by one entity is open to gaming. The relationship between the RACGP jurisdictional faculties and the national office has always been vexed due to different priorities and experience. The failure of the national office to adapt to demands for a more relevant and effective set of standards and processes till now is testament to this reality.

4. Membership-based organisations will always struggle to manage the conflicts that arise in a training scenario. This is why even when the RACGP ran the GP training program it had a different entity do so-and even then the conflicts were hard to manage well. The desire to keep a member too often overrode a safety and quality issue and even a breach of standards that threatened AMC accreditation. There is potential for the opposite to occur as well in terms of the GP training contracts toppling the membership-based priority of the College.

5. GP training funded and delivered as a workforce program is inherently community-centric; otherwise it cannot deliver safe quality care where it is needed most through this lever. The RACGP is unashamedly membership and profession centric and most members do not live and work where this training program most needs to deliver.

6. The added sophistication of qualitative and quantitative analysis of workforce needs short, medium and long term is very helpful but needs very careful interpretation and implementation. For instance, when fact meets local politics- especially among members- there will need to be an impact assessment, communication and an entry/exit strategy in place. Lost goodwill is extremely hard to replace or recover.

7. National consistency and contextual relevance without decision making authority, responsibility or accountability being defined is deeply troubling. We are concerned that the RACGP paper slips seamlessly from national to faculty to hub without explaining:

    a. How and why this model was chosen and the evidence for its suitability;
    b. The value of hubs in areas where training outcomes would be harmed through a hub model;
    c. The decision-making tree that allows decisions to be made that will have profound effect on participants and communities, without consultation and influenced by a desire for power and control at a national level in the name of “consistency” or “cost” or “risk management”- all of which differ depending on where you sit in the decision situation.

There are a number of systemic pain points that if addressed by the Colleges and the Department, would assist GP training to deliver a safe, quality, appropriately distributed GP services to all Australians:

1. A joined- up general practice experience with synergies developed and schisms managed across:
    a. Universities

   b. Prevocational settings e.g. the WA GP preparation program in private and public teaching hospitals urban and rural;
   c. Both GP Colleges
   d. Professional development to enhance capacity to teach, mentor, train and supervise once fellowship is acquired.

2. Information sharing and clear governance across:
   a. Sections of the Department with each other e.g. Aboriginal health, health needs mapping, health workforce;
   b. GP Colleges and other relevant Colleges;
   c. Regional training delivery sites;
   d. Workforce programs, e.g. RCS, AGPT, PEP, ACRRM IP, RVTS, MDRAP, JDRTIF, and various FGAMS arrangements;
   e. Accreditation entities and the MBA, AMC, APHRA.

3. Program synergy and coordination
   a. The greatest synergies are probably not in centralising activities and functions nationally but aligning them regionally. This can be achieved through joint funding, joint governance, joint information sharing arrangements and joint KPIs all pay for performance

4. KPIs individual and joint across all funded programs with pay for performance, e.g. pay for successful recruitment and placements with relative values depending on location and vocation.

We encourage RACGP to work actively with the Department to facilitate certain AGPT policies to be changed to ensure;

1. Flexible entry means registrars could enter when they were ready and able- not too soon or too late- and in line with selection processes for other medical colleges and hospital-based intakes- and not just once or twice a year;
2. The transfer policy would allow registrars to move freely between regions, between GP and RG training, whereas at present unforeseen and extenuating circumstances are required;
3. The general/rural pathway split is increased, replaced by a general practice/ rural general practice/ rural generalist pathway;
4. Regional quotas are dropped with a view to more precise training positions being made available to registrars who either compete for them or are placed in them.
5. There is no cap on training time and training time is able to be case managed on individual need.

The Department already has the contractual lever to drive a more precise version of workforce needs- based distribution of GP training and now has both local and national data to do so. The issue will remain the politics of gaining or losing priority status for being able to access GP registrars in a particular town, and in a particular practice.

The RACGP paper uses a great deal of qualitative descriptors and undefined terms with and for which no accountable or measurable elaboration is made. The words used with most frequency include:

- Reduce / decline / improve / better / increase / significant / meaningful / leverage / trust / relationships / flexibility / challenging / critical.

The language is very heavily activity and inputs based rather than on measured outcomes and impact. This reliance on activity in many sections of the paper continues the same axiomatic – rather than causal – argument, that activity ‘somehow’ delivers results and

impact – better results and impact – in terms of a more attractive, affordable, effective training program that results in a redistribution of doctors to vulnerable communities. It suggests lack of accountability or responsibility or expertise. For instance:

- *RACGP staff will use their relationships / strengthen their relationships / link applicants / work with government / collaborate with funders / advocate for / provide advice career counselling / attend events – but it is not clear how this activity will be measured in terms of a return on investment for government funds expended and the foregone opportunity costs of a more impactful approach.*

Appendices 1-4 provide more detailed discussion in regards to the unqualified and ambit claims, conflicting statements and ways in which GP training could be reformed without dismantling the infrastructure.

Conclusion

It is important not to assume the work of the RTOs is fully understood and analysed on all relevant metrics that would include:

1. Return on investment;
2. Relationship capital and transferability;
3. The impact of imposed challenges on a stressed industry;
4. The complexity of an art not easily transmitted as history has shown us;
5. Changes inside and outside that could improve in real terms the impact of the AGPT.

Most commonly in changes of this kind it is only in retrospect this wisdom is acquired.

Unfortunately, the price of such a discovery driven, empirico-inductive approach to change management can be extremely expensive for the people we are supposed to be serving. Change in this setting must be undertaken carefully, best through a series or small considered steps before embarking on wholesale change from which there is no return.

The Colleges and the Department still have a valuable opportunity to undertake extensive consultation and input from those on the ground, living now what is proposed to be changed dramatically and abruptly. But this needs to be done as a high priority. This feedback is critical to help inform the Colleges and the Department on what changes need to occur, can occur and should occur as a priority and without major transformational change. From this, a blueprint can be developed that will create sustainable and meaningful growth and vibrancy in training and in terms of medical workforce.

Appendix 1: Unqualified and Ambit Claims

Appendix 2: Reforming GP training without dismantling the infrastructure

Appendix 3: Conflicting statements without recognising the inherent disconnect

Appendix 4: The deep dive for consideration

Appendix 1

Unqualified and Ambit Claims

Some examples include:

1. *A stronger pipeline leading to a larger better trained general practice workforce will deliver a more effective and efficient health system* p.15

2. *This vision will achieve a sustainable pipeline of safe, competent GPs and RGs* p.1

3. *A RACGP service will leverage the RACGP membership base to increase supervision capacity and provide services in the most challenging locations* p.2

4. *The RACGP model will work to ensure GPs are available where they are needed, can meet the challenges of the future, and can work in the health services of the future* p.2

5. *The supervisor professional development program will enhance the quality and consistency of supervision, leading to better training outcomes, and improved attraction to the general practice specialty* p.13

6. *We have an opportunity to provide meaningful improvements in the quality and safety of training, the distribution of general practitioners for the long term benefit of the community and the profession* p.1

7. *The model is built on a foundation of high quality practices and supervisors with which we have established relationships and trust* p.2

8. *The approach of central development and local implementation (marketing and recruitment) will ensure consistency, strategic alignment, and strong recognition of the professional and personal benefits of general practice, whilst also ensuring local contextualisation and alignment with workforce need. This investment should ultimately lead to improve intake into the general practice training programs* p.15

9. *The model will deliver a high quality training experience that meets the expectations of registrars, supervisors and practices, attract candidates into the general practice training pipeline and retain GPs in areas of workforce need* p.7

Appendix 2

Reforming GP training without dismantling the infrastructure

The RACGP paper contains some positive elements in terms of the future operating model, particularly around improving the flexibility in training and tailored support and incentives, targeted to where they are needed in terms of better attraction and retention.

Many aspects of the proposed RACGP operating model are already in place in AGPT and being delivered by RTOs, in collaboration with regional and community stakeholders as well as the medical Colleges and Department, including:

- Personalised case management and career navigation for junior doctors and GP and RG registrars;
- Integrated Aboriginal and Torres Strait Islander education and support;
- Tailored support and incentives, matched with an understanding of community needs, to ensure safe, viable experiences in areas of workforce need.

There are a number of important initiatives that can be undertaken prior to transition to RACGP profession-led training and will address challenges faced by rural registrars in particular as well as increase the attractiveness of general practice as a career. Rather than transformative change and dismantling what is in place to rebuild, there are opportunities to reform training policies, at both College and Department level.

There are a number of barriers for rural registrars in particular, caused by conflicting policies at both College and Department level. The RACGP has the opportunity to redress this by reviewing and revising its vocational training policies and its assessment program to ensure that there is greater consistency and procedural fairness in terms of its fellowship pathways, as well as better clarity and procedural fairness in terms of decision-making in relation to its standards and training policies and its assessment processes.

Over the last two decades, there have been opportunities for RACGP to work together with the RTOs and local communities to address key issues such as:

- medical workforce distribution and training and workforce mapping;
- Aboriginal and Torres Strait Islander health training, including training and exam support for Aboriginal and Torres Strait Islander doctors;
- increasing the attractiveness of general practice as a career;
- vulnerable communities and their access to high quality general practice;
- better integration of the rural training pipeline.

Many of the key aspects of the RACGP operating model as outlined in the RACGP profession-led, community-based training paper could have and should have been addressed by RACGP over the last two decades, particularly as interest started to decline in GP training from 2015 onwards.

What is disappointing is the lack of recognition for what has been achieved to date, in terms of AGPT, in terms of:

- better understanding of community needs, with the building blocks now in place through the maturing of the RTO infrastructure and collaboration of the Department in terms of access to tools such as HeaDS UPP to concord local knowledge with nationally consistent workforce data;
- integrated Aboriginal and Torres Strait Islander education and support, as well as incentives and salary support, ensuring contextually relevant cultural mentoring,

education and support is available to all registrars, supervisors and training practices, medical educators and RTO personnel;
- personalised career navigation in terms of location and vocation for junior doctors, GP and RG registrars enabling recruitment and focused case management for registrars with rural intent;
- tailored registrar support and incentivisation to recruit and retain doctors in rural and remote areas.

What has not been addressed in the RACGP operating model is the slow progress to date on the part of RACGP in terms of ensuring that its curriculum and standards are fit for purpose and in line with the requirement for greater flexibility in training and best practice in terms of integrated education and assessment. The RACGP curriculum is meant to be reviewed and revised every three to five years and the current curriculum was released in 2016. The RACGP is currently in the process of recruiting for writers to develop a national training syllabus, based on a curriculum that is more than five years old and past its review date.

The RACGP operating model states that “flexible entry into the general practice training program and progressive assessment of general practice and rural generalist registrars to optimise their training pathway (avoiding over- and under-training). There has been little progress made to date, over the last two decades on the part of RACGP in terms of modernising its summative examination process and in terms of better integration of the assessment during training with the RACGP examination. It is only during the pandemic that a major change has occurred in terms of the RACGP examination, with the replacement of the OSCE with the online RCE. Registrars, supervisors and RTOs look forward to release of the external review commissioned by RACGP into the technical issues in the 2020 RACGP examinations. The major disruption and distress to registrars, supervisors, training practices and examiners cannot be easily dismissed and will have lasting effects throughout the sector.

RACGP has commissioned a number of Educational Research Grants with research delivered by the RTOs on key areas of assessment, including global assessment tools (2017), development of a framework for workplace based assessment for GP education and training (2018) and a patient encounter tracking and learning tool (2020) as well as research into the performance and utility of assessment tools used in GP training such as multisource feedback and external clinical teaching visits (2020). The outcomes of these research studies and/or recommendations for program improvements as a result of these research projects have not been communicated by RACGP to program participants and RTOs to date. It would be useful for RACGP and RTOs to have the opportunity to review the results of the work from the ERGs to date, as well as the results of the 2021 ERG grants to determine how program improvements can be made to AGPT and RG training, both now and in the future.

If RACGP wishes to optimise registrars’ training, avoiding over and under-training, a key area that it can address and provide better targeted support on is in the area of exam feedback. The lack of actionable, individualised exam feedback, particularly in the case of registrars who have been unsuccessful in passing the exam, impedes RTOs from providing targeted support for these registrars and creates additional stress and pressure for registrars, often leading to them seeking extra support from commercial exam providers, at their own cost. It is costly both at an individual registrar level and from a program perspective to have registrars repeatedly fail the exam and fail to progress through training. RTOs receive limited support from the College and little to no feedback and reporting in terms of how well their education programs are preparing registrars for the exam or how their registrars have performed in the exam, as a cohort and as individuals. Ensuring that there is increased exam support for Aboriginal and Torres Strait Islander doctors in particular is an important issue that RACGP needs to be prepared to work with the RTOs to address

and this should include exploring what alternative assessment approaches may be feasible, including workplace based assessment approaches for doctors who may struggle with online examinations. The restricted timing of the RACGP examination as a biannual process and the requirement to pass the AKT and KFP before enrolling in the RCE (previously OSCE) puts further pressure on registrars, stalling their training progress and creating anxiety and stress. The ability of RACGP to pivot and revise these requirements in terms of exam progression as a result of the pandemic and technical issues with the exam in 2020 was a positive move that needs to lead to further exam program improvement rather than reverting back to what is organisationally easier in terms of administration but less member-centric and community-centric in terms of engagement and support.

Flexible entry into the program will be an important quality improvement measure for AGPT and RG training but there are other major issues that RACGP must address in order to improve flexibility during training, particularly for rural registrars. Since the transferring of responsibility for selection to the medical Colleges in 2017, programs such as the Matched Selection Process (MSP) which helped identify, select and prioritise entry for doctors with rural intent have been lost. RTOs, through their relationship with local health services, and close working relationships with regional stakeholders, including rural clinical schools and local communities, have a working knowledge of medical students and junior doctors with a genuine interest and commitment to rural general practice. The means to utilise this knowledge to ensure a streamlined entry into general practice is an area where RACGP can look to improve its selection process.

In terms of flexible entry into the program, both AGPT and RG, RACGP needs to look at its conflicting policies in relation to hospital experience and RPL and RACGP fellowship. RACGP Vocational Training policy does not recognise general practice experience as part of its RPL process. Under the current RACGP VT policy, doctors training towards RACFP fellowship via AGPT cannot obtain credit for previous work in Australian general practice and in many cases, and are often forced to re-enter the hospital system to obtain further clinical experience as part of entry into AGPT and RG training. If they are not able to obtain relevant hospital experience (as determined by the prerequisites of medicine, surgery, ED and paediatrics), they are excluded from entry into AGPT and their only recourse is to enter the RACGP PEP program to attain RACGP fellowship. However, doctors training towards RACGP fellowship via RVTS, may be granted RPL for prior GP experience as well as prior hospital experience. This inconsistency in terms of recognition of prior learning is contradictory and acts as a barrier for doctors working in rural general practice who wish to enter AGPT to train towards RACGP fellowship. At the same time, RACGP has increased pressure on doctors by restricting enrolment to RACGP exams and hence RACGP fellowship, conditional to being enrolled in a RACGP fellowship training program (AGPT or PEP). There has been limited evidence published on the part of RACGP to justify the prerequisite hospital experience requirements, despite these requirements being in place since the RACGP Training Program. There is no published evidence on the outcomes of programs such as PEP to justify restricting attainment of RACGP fellowship to being enrolled in this program whilst being restricted from AGPT.

There are significant impediments to flexibility in training that are a direct result of conflicting training standard and policies on the part of RACGP. These have significant impact on the attraction and retention of registrars to work rurally, both during training and post fellowship. The RACGP practice diversity requirement, for example, positively disadvantages rural registrars from training and staying in a rural area. The impact of this practice diversity requirement (also sometimes called ‘the two practice rule’) has been discussed with RACGP by RTOs and registrar and supervisor stakeholders alike and whilst there have been some wording changes around the guidelines, the requirement remains in place. Whilst the intent of the practice diversity requirement is positive in terms of ensuring that registrars are able to experience the diversity of general practice in terms of patient presentations and practice management styles and approaches for example, the process of administering the

requirement is bureaucratic, cumbersome and activity based in nature. Registrars are required to request an exemption to the practice diversity requirement if they wish to stay in one practice for extended period of time. Even if the exemption is supported by the RTO, approval must be sought from RACGP via the State Faculty Censor and the registrar must undertake an activity such as an inter-practice visit, case studies or audit to demonstrate achievement of 'practice diversity'. Registrars in metropolitan and larger regional centres can more freely move around practices and remain professionally and personally based in a location than registrars in more rural and remote communities, who are often forced to relocate their families and move from that rural location for a period of time. This disruption to registrars and their families, to training practices and to local communities can readily be avoided by dismantling outdated training requirements such as this and looking to more innovative and evidence based ways by which registrars can demonstrate scope of practice relevant to community need.

The lack of transferability of movement between Colleges is another area where RACGP and ACCRM have failed to make significant progress during the last two decades. There is no formal policy agreement between the two medical Colleges in regards to transfer from one College fellowship pathway to another. Under current College policy, an AGPT or RG registrar who wishes to transfer training from ACRRM to RACGP must leave the program and re-enter under a different training pathway, with no formal recognition of their previous training experience. The desire for greater distinction and differentiation on the part of the two medical Colleges has played out in terms of increased inflexibility in terms of training for registrars and training practices alike. A registrar may make a request to transfer from one College to another but this is done on a case by case basis as an exemption, rather than acknowledging the value of the training already acquired, in the same medical speciality, albeit by a different College.

RACGP should look to address the inequities in terms of its standards and policies and in turn improve the clarity in terms of its decision making and determinations. It is not fair or reasonable to have standards and policies that are opaque and open to interpretation on the part of decision makers, based around the granting of exemptions rather than procedural fairness.

Addressing the inequities in these policies and improving the clarity in terms of decision-making and determinations will help:

- increase flexibility in terms of training opportunities for rural registrars;
- increase attractiveness of rural general practice as a career, enabling doctors with rural intent to be nurtured and supported throughout training, from pre-entry through to fellowship;
- improve retention of registrars in rural and remote areas;
- enable targeted exam support to be delivered by RTOs, reducing the need for more expensive and intensive remediation.

These changes are quality improvement changes do not require major transformative change, can start to be addressed now and will have maximal positive change for doctors in training and communities, with minimal disruption on the ground.

Whilst there has been significant sharing of resources and expertise on the part of RTOs to the College over the last two decades, there has not been the imprimatur on the part of RACGP to make changes where they are needed in a timely manner, to act on feedback received on the impact of its standards and training policies on the ground and to provide advocacy and support on a College level to review, refine and reinvigorate training.

The desire of RACGP, as expressed in the operating model paper, to become more actively involved in terms of provision of individualised management of medical students, junior doctors and GP and RG registrars is welcomed but what is also required is greater advocacy

and support from RACGP to assist rural registrars to attain and retain their advanced skills in areas where they are most needed. There has been a significant increase in the education and assessment requirements expected from registrars training towards FARGP and this has come with increased cost and pressure to fulfil the assessment requirements for each ARST. There are a number of advanced skills training opportunities in clinical and non-clinical disciplines (e.g. medical education) that are now recognised for FARGP but registrars still struggle to achieve credentialing to utilise their advanced skills training in rural and remote areas due to lack of recognition for credentialing at a jurisdictional level. The advocacy and support that RACGP could provide for RTOs to address their inequities in terms of specialised training recognition for RG registrars would be most welcomed in this space. Ensuring that GP and RG registrars have jobs at the end of their training and the opportunity to utilise their advanced skills training for the benefits of the communities that they serve requires the active involvement of RACGP now, working with the RTOs and the jurisdictions to ensure that there is accurate training and workforce capacity mapping being undertaken.

At present the sector is crowded the sector in terms of multiple agencies, aiming to improve workforce distribution in rural and remote areas, and recruit doctors to general practice. This can lead to confusing and conflicting career navigation messages being delivered to junior doctors, who can be overwhelmed by the wealth of information being delivered. At a community level, the community and the training practice, particularly those that are rural, need to deal with the competing demands of multiple agencies and Colleges, with different training requirements and administrative burden, converging in an uncoordinated manner. Rural practices training GP or RG registrars, together with medical students and/or junior doctors and doctors enrolled in MDRAP or RLRP may be dealing with up to 5 different organisations at any one time. This lack of coordination and cooperation at an agency and College level, places extra demands on the practice and community, impacting on patient care. What has not been addressed in the RACGP operating model paper is how RACGP will seek to reduce the impost on training practices and communities that is caused by two medical Colleges seeking to become more separatist in terms of programs requirements and training delivery and program requirements. The operating model, as described in the RACGP paper does describe the unintended consequences that may result from the disruption and damage that may result from the move to College led training. At the very least, the participants, communities, RACGP members and the sector as a whole require an explanation of what risk management strategies RACGP will implement to minimise disruption and damage on the ground.

Appendix 3

Conflicting statements without recognising the inherent disconnect

The RACGP acknowledges that it is uncomfortable – as it always has been – with the tension between the role of GP training in delivering safe quality general practitioners able to work anywhere in Australia unsupervised and the role it has through government funding to provide general practitioner services distributed according to population and community health need. These are not necessarily in contra-indistinction when considered more deeply.

Doctors train for a job for which the community are prepared to pay, both in terms of vocation and location. However, it is easy to overlook the tension and make poor decisions that impact the doctors, the practices and the community while at face value appearing to solve a vexed problem. The RACGP is right to ask for a review:

- *The RACGP will assess the feasibility of using general practice training, including targeted support and incentives, to fulfil the general practice and rural generalist needs of the community*

But one might argue the review should have proceeded this paper, and the operational model, principles, compromises and conflicts inherent within it.

There is a global statement that:

- The model will include *careful selection and placement of registrars by balancing and matching community needs, training needs and placement characteristics* – the holy grail of GP training, not always realised perfectly for all parties (or we would not be in need of reform) but this intention clearly will not be achieved through a top-heavy, 3-layer bureaucratic centralised structure that deploys to the local participants. We would need a detailed explanation and explication to be convinced otherwise.

The systemic (if not necessarily individual) unaddressed tension – or conflict – can be seen in the following statements which need a clear explanation urgently. They say that the model:

1. *Closely integrates workforce management throughout training to ensure that community needs are met* p.2
2. *Offers flexibility to more between the general practice and rural generalist pathway* p.2
3. *For registrars, the model will provide improved flexibility in their training pathway and region and a more personalised higher quality training experience making general practice a more desirable and rewarding career choice* p.2
4. *For the community, the model will work to ensure GPs are available where they are needed, can meet the challenges of the future and can work in the health systems of tomorrow* p.2
5. *Delivers outcome-focused training with experiences tailored to registrar needs* p.4
6. *Delivers a high quality training experience that meets the expectations of registrars, supervisors and practices* p.7

Further and more specifically:

1. *Case management will be central to guiding and supporting registrars into posts that have traditionally been hard to fill* p.16
2. *Placements will be prioritised on key characteristics including Aboriginal and Torres Strait Islander health, areas of high community need, and registrars with special requirements* p.16

3. *Registrar support includes maintenance of wellbeing and enabling a chosen training pathway both of which are central to a registrar's successful progression through the training program* p.17

It looks like pathway is freely chosen, but not placement. The gaming will be intense.

Appendix 4

The Deep Dive for Consideration

This section provides more detailed feedback on the RACGP profession-led community-based training paper, acknowledging the positive elements in terms of the future operating model, particularly around improving the flexibility in training and tailored support and incentives, targeted to where they are needed in terms of better attraction and retention, as well as the desire for transformative change.

RACGP has not provided any detail on the costing of the operating model but does suggest that many of the proposed changes and improvements can be made within the existing AGPT and RVTS funding envelope. This would seem to be dependent on:

- no changes to the current quota in terms of intake and funding between the two medical Colleges;
- all current responsibilities for GP training not already transitioned to the Colleges (including placement management and practice and supervisor payments) being given to the Colleges;
- no changes in terms of the current AGPT and RVTS KPIs, in terms of funding, workforce distribution;
- consolidation of the 3GA programs include transfer of all responsibilities and funding to RACGP (including rural workforce agencies and rural coordinating units).

There is an argument to be made that education and assessment, as well as supervisor training and practice accreditation are College 'core business' and a mandatory requirement of their AMC accreditation as specialist training College. This would also create significant savings to the program, reducing the need for Commonwealth investment in these core functions. At the same time the RACGP is asking for additional investment for increased support and incentives for placements as well as to pilot an unproven proof of concept RACGP Service model, it is unlikely that the RACGP operating model costs has considered how delivery of its core business of education and assessment may translate into savings from a Commonwealth investment and taxpayer perspective.

It is reasonable to expect that in development of the operating model, RACGP would have consulted widely, particularly amongst the participants of the training programs and key stakeholders and undertaken a comprehensive analysis of what has worked well in terms of GP training over the last two decades, what has not worked well and what are the gaps. Given that RACGP has also been involved in the delivery of AGPT and RVTS throughout that time period, working alongside the training providers, GPET and then the Department, it could in drawn on and reflect on its own experiences, progress made and challenges in terms of GP education, assessment and training as well. However, there is limited evidence presented that such an analysis has been undertaken by RACGP, particularly in terms of the current AGPT and RVTS training programs. Many aspects of the proposed RACGP operating model are already in place in AGPT and being delivered by RTOs, in collaboration with regional and community stakeholders as well as the medical Colleges and Department, including:

- personalised case management and career navigation for junior doctors and GP and RG registrars;
- integrated Aboriginal and Torres Strait Islander education and support;
- tailored support and incentives, matched with an understanding of community needs, to ensure safe, viable experiences in areas of workforce need.

What is disappointing is the lack of recognition for what has been achieved to date, in terms of AGPT, in terms of:

- better understanding of community needs, with the building blocks now in place through the maturing of the RTO infrastructure and collaboration of the Department

in terms of access to tools such as HeaDS UPP to concord local knowledge with nationally consistent workforce data;
- integrated Aboriginal and Torres Strait Islander education and support, as well as incentives and salary support, ensuring contextually relevant cultural mentoring, education and support is available to all registrars, supervisors and training practices, medical educators and RTO personnel;
- personalised career navigation in terms of location and vocation for junior doctors, GP and RG registrars enabling recruitment and focused case management for registrars with rural intent;
- tailored registrar support and incentivisation to recruit and retain doctors in rural and remote areas.

The RACGP operating model does not seem to have considered benchmarking the performance markers of the current programs, to determine how its own operating model will deliver in terms of success. There is no discussion of the KPIs and outcomes based performance measures that the RACGP will set for its operating model, and what is of greater concern, there is no discussion of how the introduction of such a model will be evaluated, including a comprehensive risk analysis of the impacts of introduction and implementation of dis-integrating GP training into two distinct College-led training models on the participants, including doctors in training, supervisors, medical educators, training practices and their patients, and communities. RACGP states that its operational model for GP training will be “community focused”. However, there is little detail on what is meant by ‘community focused, particularly in terms of the governance structures and outcomes based markers for success in terms of:

- the involvement of communities in the design and delivery of training to address their health needs;
- how the training outcomes will directly relate to patient outcomes and improved health care, matched to community need;
- how attainment and maintenance of scope of practice matched to community need will be addressed.

Over the last two decades, there have been opportunities for RACGP to work together with the RTOs and local communities to address key issues such as:

- medical workforce distribution and training and workforce mapping;
- Aboriginal and Torres Strait Islander health training, including training and exam support for Aboriginal and Torres Strait Islander doctors;
- increasing the attractiveness of general practice as a career;
- vulnerable communities and their access to high quality general practice;
- better integration of the rural training pipeline.

Many of the key aspects of the RACGP operating model as outlined in the RACGP profession-led, community-based training paper could have and should have been addressed by RACGP over the last two decades, particularly as interest started to decline in GP training from 2015 onwards.

Education

The RACGP operating model is built on an educational framework that provides the conceptual overview for RACGP education and training. It is positive to see RACGP making progress in terms of recognising the need for better integration of the lifelong career journey. However, the underpinning elements of the educational framework remain uncompleted or in serious need of revision:

- The competency profile is incomplete and does not capture the competency profile during training or provide a clear articulation of scope of practice, matched to community need.

- The vocational training standards are overdue for review and revision and contain a hybrid of inputs and outputs measures, open to interpretation and creating significant barriers and inflexibility for doctors wishing to work rurally.
- The RACGP curriculum is meant to be reviewed and revised every 3-5 years and the current curriculum was released in 2016.

What has not been addressed in the RACGP operating model is why there has been such slow progress to date on the part of RACGP in terms of ensuring that its curriculum and standards are fit for purpose and in line with the requirement for greater flexibility in training and best practice in terms of integrated education and assessment. It is difficult to build a fit for purpose training operating model, without the key building blocks of a relevant and current curriculum and training standards and yet, RACGP is moving forward to recruit for writers to develop a national training syllabus, based on a curriculum that is more than 5 years old and past its review date. Why these key components of curriculum and standards have not been completed, especially given the lead-up from the 2017 announcement to the rapidly approaching handover date has not been articulated by RACGP.

RACGP has not demonstrated a good understanding of its own training policies and fellowship requirements, let alone the impact that these policies have on reducing flexibility and creating barriers in rural training in particular. Centralised education is a more cost effective method of delivery but it runs counter to the RACGP's own training standards (Standard 2.1), which emphasises the requirements for teaching, learning and assessment strategies to be matched to the variety of training settings and contexts as well as learning needs of the registrar. This may be a timely opportunity for RACGP to revise its inputs-based and non-evidence based requirement for "125 hours of peer/group learning delivered in the most appropriate way for the context", particularly as it seems highly likely that its own operational model and centralised education delivery could not accommodate this requirement.

The RACGP operating model discusses the use of distributed education and training delivery, with "streamlined service delivery through distributed training that is locally contextualised and supported by centralised services where appropriate". How the formula of 16 regional hubs and 70 local teams has been derived is unclear, but on face value it appears that RACGP has chosen to replace the current regionalised training infrastructure with 9 RTOs with 16 regional hubs, based around faculty infrastructure, whilst at the same time reducing the availability of a local point of contact for training sites and communities. 70 local teams do not seem sufficient to provide training sites, supervisors and registrars help and support when it is needed the most, in an effective and timely manner.

Assessment

The RACGP operating model states that "flexible entry into the general practice training program and progressive assessment of general practice and rural generalist registrars to optimise their training pathway (avoiding over- and under-training). There has been little progress made to date, over the last two decades on the part of RACGP in terms of modernising its summative examination process and in terms of better integration of the assessment during training with the RACGP examination. In its 2013 accreditation report of RACGP, the Australian Medical Council, placed conditions on RACGP to satisfy accreditation standards, including the need to:

- develop a comprehensive blueprint that maps assessment content to the entire curriculum
- review and report on the potential role of summative workplace based assessment, based on the development of a comprehensive assessment blueprint
- develop a systematic process for reviewing examination performance data, with a view to identifying regions, training pathways and vocational training providers that may benefit from additional support

Given the passage of time that has occurred since publication of this AMC report, it would be good to hear from RACGP what progress has been made in terms of the assessment blueprint as well as the process for reviewing and sharing examination performance data and exam reporting.

Since the 2013 AMC accreditation of RACGP, the alternative summative workplace based assessment process (Practice Based Assessment or PBA) has been phased out by RACGP and mandatory longitudinal progression through the online AKT and KFP as pre-requisite for undertaking the OSCE has been introduced. From 2021 onwards, RACGP will require all doctors who wish to enrol in the College Exam and attain Fellowship to be enrolled in an RACGP training program. During the pandemic major change has occurred in terms of the RACGP examination, with the replacement of the OSCE with the online RCE. Registrars, supervisors and RTOs look forward to release of the external review commissioned by RACGP into the technical issues in the 2020 RACGP examinations. The major disruption and distress to registrars, supervisors, training practices and examiners cannot be easily dismissed and will have lasting effects throughout the sector.

RACGP has commissioned a number of Educational Research Grants with research delivered by the RTOs on key areas of assessment, including global assessment tools (2017), development of a framework for workplace based assessment for GP education and training (2018) and a patient encounter tracking and learning tool (2020) as well as research into the performance and utility of assessment tools used in GP training such as multisource feedback and external clinical teaching visits (2020). The outcomes of these research studies and/or recommendations for program improvements as a result of these research projects have not been communicated by RACGP to program participants and RTOs to date. It would be useful for RACGP and RTOs to have the opportunity to review the results of the work from the ERGs to date, as well as the results of the 2021 ERG grants to determine how program improvements can be made to AGPT and RG training, both now and in the future.

If RACGP wishes to optimise registrars' training, avoiding over and under-training, a key area that it can address and provide better targeted support on is in the area of exam feedback. The lack of actionable, individualised exam feedback, particularly in the case of registrars who have been unsuccessful in passing the exam, impedes RTOs from providing targeted support for these registrars and creates additional stress and pressure for registrars, often leading to them seeking extra support from commercial exam providers, at their own cost. It is costly both at an individual registrar level and from a program perspective to have registrars repeatedly fail the exam and fail to progress through training. RTOs receive limited support from the College and little to no feedback and reporting in terms of how well their education programs are preparing registrars for the exam or how their registrars have performed in the exam, as a cohort and as individuals. Ensuring that there is increased exam support for Aboriginal and Torres Strait Islander doctors in particular is an important issue that RACGP needs to be prepared to work with the RTOs to address and this should include exploring what alternative assessment approaches may be feasible, including workplace based assessment approaches for doctors who may struggle with online examinations. The restricted timing of the RACGP examination as a biannual process and the requirement to pass the AKT and KFP before enrolling in the RCE (previously OSCE) puts further pressure on registrars, stalling their training progress and creating anxiety and stress. The ability of RACGP to pivot and revise these requirements in terms of exam progression as a result of the pandemic and technical issues with the exam in 2020 was a positive move that needs to lead to further exam program improvement rather than reverting back to what is organisationally easier in terms of administration but less member-centric and community-centric in terms of engagement and support.

In the RACGP operating model, RACGP flags an intention to develop and implement progressive assessment. How this will relate to the current assessment during training is unclear and it is disappointing that there has not been progress made by RACGP in terms of

evaluating the range of assessment during training methods and their results in GP training and exploration of how to better integrate the results of this progressive assessment into a comprehensive assessment program for RACGP fellowship. Over the past few years, the added pressures and costs of the various exams and assessments for rural registrars in particular have become more acute, especially with the recent introduction of additional assessments for the FARGP. Given that assessment is core business for any specialist medical College, presumably funding for the development and implementation of progressive assessment should be borne by the College and must not lead to even more cost to participants.

Flexible Entry and Flexible Training

Flexible entry into the program will be an important quality improvement measure for AGPT and RG training but there are other major issues that RACGP must address in order to improve flexibility during training, particularly for rural registrars. There are a number of barriers for registrars training rurally in particular, caused by conflicting and contradictory policies at both College and Department level. The RACGP has the opportunity to redress this by reviewing and revising its vocational training policies as well as its assessment program to ensure that there is greater consistency and procedural fairness in terms of its fellowship pathways, particularly in relation to the decision-making processes in interpretation and rulings on exceptions and exemptions to standards and policy.

In terms of flexible entry into the program, both AGPT and RG, RACGP needs to look at its conflicting policies in relation to hospital experience and RPL and RACGP fellowship. RACGP Vocational Training policy does not recognise general practice experience as part of its RPL process. Under the current RACGP VT policy, doctors training towards RACFP fellowship via AGPT cannot obtain credit for previous work in Australian general practice and in many cases, and are often forced to re-enter the hospital system to obtain further clinical experience as part of entry into AGPT and RG training. If they are not able to obtain relevant hospital experience (as determined by the prerequisites of medicine, surgery, ED and paediatrics), they are excluded from entry into AGPT and their only recourse is to enter the RACGP PEP program to attain RACGP fellowship. However, doctors training towards RACGP fellowship via RVTS (as stated in the RVTS Training Handbook), may be granted RPL for prior GP experience as well as prior hospital experience. This inconsistency in terms of recognition of prior learning is contradictory and acts as a barrier for doctors working in rural general practice who wish to enter AGPT to train towards RACGP fellowship. At the same time, RACGP has increased pressure on doctors by restricting enrolment to RACGP exams and hence RACGP fellowship, conditional to being enrolled in a RACGP fellowship training program (AGPT or PEP). There has been limited evidence published on the part of RACGP to justify the prerequisite hospital experience requirements, despite these requirements being in place since the RACGP Training Program. There is no published evidence on the outcomes of programs such as PEP to justify restricting attainment of RACGP fellowship to being enrolled in this program whilst being restricted from AGPT.

There are significant impediments to flexibility in training that are a direct result of conflicting training standard and policies on the part of RACGP. These have significant impact on the attraction and retention of registrars to work rurally, both during training and post fellowship. The RACGP practice diversity requirement, for example, positively disadvantages rural registrars from training and staying in a rural area. The impact of this practice diversity requirement (also sometimes anecdotally called ‘the two practice rule’) has been discussed with RACGP by RTOs and registrar and supervisor stakeholders alike and whilst there have been some wording changes around the guidelines, the requirement remains in place. Whilst the intent of the practice diversity requirement is positive in terms of ensuring that registrars are able to experience the diversity of general practice in terms of patient presentations and practice management styles and approaches for example, the process of administering the requirement is bureaucratic, cumbersome and activity based in nature.

Registrars are required to request an exemption to the practice diversity requirement if they wish to stay in one practice for extended period of time. Even if the exemption is supported by the RTO, approval must be sought from RACGP via the State faculty censor and the registrar must undertake an activity such as an inter-practice visit, case studies or audit to demonstrate achievement of 'practice diversity'. Registrars in metropolitan and larger regional centres can more freely move around practices and remain professionally and personally based in a location than registrars in more rural and remote communities, who are often forced to relocate their families and move from that rural location for a period of time. This disruption to registrars and their families, to training practices and to local communities can readily be avoided by dismantling outdated training requirements such as this and looking to more innovative and evidence based ways by which registrars can demonstrate scope of practice relevant to community need.

The lack of transferability of movement between Colleges is another area where RACGP and ACCRM have failed to make significant progress during the last two decades. There is no formal policy agreement between the two medical Colleges in regards to transfer from one College fellowship pathway to another. Under current College policy, an AGPT or RG registrar who wishes to transfer training from ACRRM to RACGP must leave the program and re-enter under a different training pathway, with no formal recognition of their previous training experience. The desire for greater distinction and differentiation on the part of the two medical Colleges has played out in terms of increased inflexibility in terms of training for registrars and training practices alike. A registrar may make a request to transfer from one College to another but this is done on a case by case basis as an exemption, rather than acknowledging the value of the training already acquired, in the same medical speciality, albeit by a different College.

RACGP should look to address the inequities in terms of its standards and policies and in turn improve the clarity in terms of its decision making and determinations. It is not fair or reasonable to have standards and policies that are opaque and open to interpretation on the part of decision makers, based around the granting of exemptions rather than procedural fairness.

Addressing the inequities in these policies and improving the clarity in terms of decision-making and determinations will help:

- increase flexibility in terms of training opportunities for rural registrars;
- increase attractiveness of rural general practice as a career, enabling doctors with rural intent to be nurtured and supported throughout training, from pre-entry through to fellowship;
- improve retention of registrars in rural and remote areas;
- enable targeted exam support to be delivered by RTOs, reducing the need for more expensive and intensive remediation.

These changes are quality improvement changes do not require major transformative change, can start to be addressed now and will have maximal positive change for doctors in training and communities, with minimal disruption on the ground.

The transferring of responsibility for selection to the medical Colleges in 2017, programs such as the Matched Selection Process (MSP) which helped identify, select and prioritise entry for doctors with rural intent have been lost due to lack of corporate knowledge about processes and programs developed over time by GPET and the RTOs in terms of quality improvement and to help identify and support committed registrars to work where they are most needed. RTOs, through their relationship with local health services, and close working relationships with regional stakeholders, including rural clinical schools and local communities, have a working knowledge of medical students and junior doctors with a genuine interest and commitment to rural general practice. The means to utilise this knowledge to ensure a streamlined entry into general practice is an area where RACGP can look to improve its selection process.

Whilst there has been significant sharing of resources and expertise on the part of RTOs to the College over the last two decades, there has not been the imprimatur on the part of RACGP to make changes where they are needed in a timely manner, to act on feedback received on the impact of its standards and training policies on the ground and to provide advocacy and support on a College level to review, refine and reinvigorate training.

Supervision

The RACGP states that its operating model for training is "built on a foundation of high quality supervisors and training sites with which we (RACGP) have established relationships and trust". It is not clear on what evidence RACGP bases this statement, given that:

- RACGP has not had a direct working relationship with supervisors and training sites for several years.
- Many supervisors are College members but some are not.
- The RTOs (and formerly RTPs) have had direct responsibility for education and training delivery of AGPT and RG and established working relationships with supervisors and training sites in their regions, for the last twenty years.
- In 2010 RACGP delegated authority to the RTPs and now RTOs for accreditation and training sites. This enabled development of a Bi-College Accreditation Agreement, streamlining the accreditation of training practices into an integrated, efficient process with less administrative burden for practices and supervisors alike.
- RTOs are responsible for ensuring supervision is matched to the registrar's competence and context, training posts are evaluated to maintain quality and supervisors and training sites are trained and supported as part of the RACGP Accreditation Agreement (RACGP Training Standard 1.1)
- In a recent GPSA survey, 83% of respondent identified that they did not feel adequately consulted about the proposed changes in the AGPT program

Supervisors and training sites value the trusted relationship they have with the RTOs and the ability to access and receive support when needed. Supervisors and training sites capabilities are dependent on the well-established support network of medical educators and training program personnel of the current regionalised training infrastructure of AGPOT as well as the close working relationships built up over time by the RTOs and RVTS. Training sites, supervisors, medical educators and training personnel will have to decide whether or not they join RACGP and become part of the operating model. Maintenance of training capabilities is heavily dependent on the human resource capital currently residing with the RTOs and it is hoped that RACGP has a contingency plan in place should this human resource capital be diminished or damaged as a result of the change to College-led training.

Streamlined Process and Technology

The RACGP paper states that "RACGP will leverage the existing system capabilities developed by the training organisations and progressively migrate them to a nationally consistent technology platform". There is already a nationally consistent reporting system called RIDE and all RTOs are required to have systems that integrate with RIDE. The streamlining of processes and reporting takes place at the training site level, with reporting requirements and access to data integrated for supervisors and registrars on the one RTO level platform. The move to College led training and the increasing separation and distinction between the two medical Colleges, means that integration and streamlining of reporting will no longer be possible at a training practice level. For rural practices in particular, the training requirements for the differing fellowship pathways and workforce programs (e.g. AGPT, RVTS, RACGP PEP and/or ACRRM IP, MDRAP, RLRP etc) is already cumbersome. Adding the requirement to utilise separate reporting platforms for each College will be an added impost on the ground. What the RACGP regards as streamlining may be true from an organisational perspective but it will not be the case on the ground, where it is most needed to protect safe quality training and not compromise safe quality care.

The pipeline of training

The desire of RACGP, as expressed in the operating model paper, to become more actively involved in terms of provision of individualised management of medical students, junior doctors and GP and RG registrars is welcomed but what is also required is greater advocacy and support from RACGP to assist rural registrars to attain and retain their advanced skills in areas where they are most needed. There has been a significant increase in the education and assessment requirements expected from registrars training towards FARGP and this has come with increased cost and pressure to fulfil the assessment requirements for each ARST. There are a number of advanced skills training opportunities in clinical and non-clinical disciplines (e.g. medical education) that are now recognised for FARGP but registrars still struggle to achieve credentialing to utilise their advanced skills training in rural and remote areas due to lack of recognition for credentialing at a jurisdictional level. The advocacy and support that RACGP could provide for RTOs to address their inequities in terms of specialised training recognition for RG registrars would be most welcomed in this space. Ensuring that GP and RG registrars have jobs at the end of their training and the opportunity to utilise their advanced skills training for the benefits of the communities that they serve requires the active involvement of RACGP now, working with the RTOs and the jurisdictions to ensure that there is accurate training and workforce capacity mapping being undertaken.

At present the sector is crowded the sector in terms of multiple agencies, aiming to improve workforce distribution in rural and remote areas, and recruit doctors to general practice. This can lead to confusing and conflicting career navigation messages being delivered to junior doctors, who can be overwhelmed by the wealth of information being delivered. At a community level, the community and the training practice, particularly those that are rural, need to deal with the competing demands of multiple agencies and Colleges, with different training requirements and administrative burden, converging in an uncoordinated manner. Rural practices training GP or RG registrars, together with medical students and/or junior doctors and doctors enrolled in MDRAP or RLRP may be dealing with up to 5 different organisations at any one time. This lack of coordination and cooperation at an agency and College level, places extra demands on the practice and community, impacting on patient care. What has not been addressed in the RACGP operating model paper is how RACGP will seek to reduce the impost on training practices and communities that is caused by two medical Colleges seeking to become more separatist in terms of programs requirements and training delivery and program requirements. The operating model, as described in the RACGP paper does describe the unintended consequences that may result from the disruption and damage that may result from the move to College led training. At the very least, the participants, communities, RACGP members and the sector as a whole require an explanation of what risk management strategies RACGP will implement to minimise disruption and damage on the ground.

The RACGP operating model does state that further information will be made available in terms of further detail and costing. This information is critical to enable the sector to make an informed decision on the viability of further progress in terms of transitioning. As discussed there are a number of positive changes that can be made now, by RACGP and the Department to increase flexibility in training, improve consistency and clarity in terms of policy and decision-making, and increase attractiveness of GP training and general practice as a career. These initiatives are quality improvement measures that will have significant positive benefits without causing major disruption for participants and communities alike.

Dr Janice Bell
Chief Executive Officer