Queensland Medical Workforce Whitepaper: Template for feedback

Please use this template to provide comments and feedback on the Queensland Medical Workforce Whitepaper.

The template is in three parts:

- **Part A** requests personal details from individual and/or agencies submitting feedback on the Queensland Medical Workforce Whitepaper.
- **Part B** outlines 10 broad discussion questions in which the project team seeks your views on. These are free text questions relating to the medical workforce. Please write as much as you require in this section to ensure that your viewpoint is well represented.
- **Part C** relates to six specific strategic directions and their corresponding recommendations. The project team would like to know whether or not you support these specific pre-populated recommendations.

Please email your submission to the Office of the Chief Medical Officer, Department of Health at OCMO-MWP@health.qld.gov.au by 12 February 2016.

Use of this template will greatly facilitate the review and analysis of submissions. Options for recommendations will be compiled into a draft plan for consideration by the Minister for Health and Ambulance services.

Thank you for your feedback.

Queensland Medical Workforce Project Team

OCMO-MWP@health.qld.gov.au / (07) 3328 9473

Part A: Contact details of individual and/or agency submitting feedback

Name of Individual completing this form	Dr Matthew Cheng Dr Katherine Gridley Dr Bavahuna Manoharan Dr Richard Kidd Dr James Finn Dr Shaun Rudd
Name of organisation / department / college / agency you are representing (if applicable)	AMA Queensland
Postal Address	88 Lestrange Terrace, Kelvin Grove, Queensland
Email	cdt@amaq.com.au

Contact number	3872 2203
Endorsed by	

NB: Personal information provided (e.g. postal address) will only be used for the purposes relevant to this consultation phase and will not be disclosed outside of members of the Queensland Medical Workforce Project Team or its committees. Such information will not be used or disclosed for any other purpose, without prior written consent.

Part B: Discussion Questions

	Discussion Question	Response
1	Are there any other issues occurring in the wider context of healthcare that may impact on the supply of the medical workforce?	• The nature of changing population demographics in Queensland, with an older population with more healthcare needs, longer lifespans, older retirement age and more time spent in independent living (and more services to cater for the home help required for this) • A surplus of medical graduates and junior doctors without a surplus in their supervising consultants and the need to find adequate supervision and training during PGY1 and 2 • The projected shortfall in funding for the valuable Specialist Training Program (STP). There is scope to do more • Limited specialist training positions against increasing medical graduate and junior doctor numbers • A greater emphasis on training in primary care and community based settings, reflected by increasing numbers of applicants to RACGP • Pressure placed on the hospital and health services to provide sufficient internship placements with the appropriate mixture of rotations to allow for adequate clinical experience while also satisfying the requirements of general registration • The current length of specialty training and the consideration of option to shorten length of training to meet medical workforce

		shortages, as well as the emergence of college programs (e.g. RACS's JDOCs program) and models of PGY2 / 3 that encourage early streaming ● Current media around junior doctor working conditions, both in Australia and NHS, and the attraction of the Australian system to overseas trained doctors (particularly those who may deflect from the NHS as has already happened in some major Queensland hospitals) ● A change to from the MBBS to the MD program for medical students in Queensland, with the future graduating doctors to have a greater research knowledge and skills base to their current colleagues ● Increasing age of medical graduates with postgraduate entries and movement to an MD program meaning ● Generalism is re-emerging as an important and valuable recalibration in the Medical Workforce, not just for regional and rural areas but also in tertiary hospital and metropolitan community settings. This phenomenon is particularly important and worthy of deliberate policy support in addressing access issues in Queensland – the most decentralised and regionalised state ● Lifestyle related health issues are also having an enormous impact on the demand for health services ● There is a need for better and/or more efficient use of the medical workforce through better integration and reduction of services which requires a whole of system collaboration ● There is an unknown unmet demand with marginalised or disadvantaged groups who have significant access issues - such as CALD, Indigenous, Refugee, lower socioeconomic populations and

		substance users. An increased workforce with targeting of these groups especially around early childhood and early lifestyle health education / intervention and better access to services at earlier stages in their trajectories of chronic complex diseases. ● Junior doctor wellbeing and mental health, particularly regarding; ○ Stress related to career progression in an increasingly competitive environment ○ Fatigue related to physical working conditions and the large amount of unclaimed overtime worked by junior doctors ○ The alarmingly high statistics for junior doctor suicidality, as per the recent Beyond Blue report ○ Workplace harassment and bullying of junior doctors, and the overall culture of silence for the sake of not jeopardising future job options
2	What strategies need to be adopted at the local, regional, state and national levels to address current and future issues associated with medical workforce supply?	Local - Improve supervision to training by increasing relative numbers and quality of training. Include career development advice to ensure doctors make suitable career choices and aid in progression through training. This will make the training period more efficient for doctors. Regional - Support educational programs and training sessions in various health districts for career advice, training in clinical and non-clinical leadership skills, communication and resilience programs. Quality training and education in rural areas should be sought to encourage the medical workforce from metropolitan areas to consider training in regional/rural communities.

		There needs to be an absolute increase in well supervised and supported training positions, particularly in regional settings. We need to develop more 'Generalist Specialists' with desire and support to work in regional settings (Ophthalmologists, Physicians, Surgeons etc) State - Create a statewide body (ie QMETI) responsible for workforce planning, training accreditation and education/curriculum programs. Improve portability of credentialing system allowing more efficient transfer between different HHS/hospitals during training. Accreditation and quality assurance of all prevocational rotations and terms. National - Work towards a national body standardising workforce planning, training and education. This includes tracking of internship and residency placement. This will allow for efficient placement and access to data on distribution and trends of doctor placement. This can inform future workforce planning strategies. Supporting and incorporating the current and proposed modelling work of National Medical Training Advisory Network (NMTAN) into future Queensland workforce modelling. Expansion and funding for Specialist training posts. HWA projections of a national shortfall of 569 first-year advanced specialist training places by 2018, rising to 689 places in 2024, and rising further to 1,011 places in 2030.
3	What is working well and why in the current training system and should be continued?	The current form of internship is fit for purpose, as internship remains critical to the ongoing success of junior doctor development, and consequently the long-term success of the health system. The relationship between training and clinical work in internship is synergistic, providing the intern has reasonable access to further develop their clinical skills during their day to

		day practice, and has access to ongoing professional education. When an intern is and provided opportunities to practice procedural skills in a supervised environment, the intern year is highly effective in developing the requisite skills for future independent practice. It provides a transition period between the final clinical years of medical school and the start of the journey into vocational training. This supervision associated with internship is essential in building confidence and competence. Through their daily interactions with peers, senior doctors, allied health, administration staff, patients and their families, the intern year is also vital in the development of interpersonal communication skills, resilience and professional identity. The ongoing accreditation of Intern terms as well as the expansion of this accreditation to PGY 2 and other pre-vocational training terms is critical. Accreditation should be against national benchmarks and the ACFJD. Some hospital education programs work well in providing useful information on career development and training. This is important to guide junior doctors on suitable career pathways. Others also provide good non-clinical training opportunities such as leadership and communication development workshops. These programs are important to ensure doctors train and give appropriate advice to their juniors.
4	Should all RMOs have rural, regional, general practice, private health and/or community based experiences during prevocational training?	Rural, general practice, private and community based experiences have the potential to enhance professional and personal growth by allowing the intern to integrate their clinical skills and knowledge into the healthcare needs of the greater community outside of the public hospital settings. The rural, general practice and private patient populations vary greatly in demographics, location, access to resources and income, which has a dramatic effect on their health status, particularly the ongoing management of comorbidities and the ease at which they access acute medical care when required. Experience with these different populations (for any length of time)

		helps to foster and develop the trait of generalism. For an RMO to get the most benefit from these terms, there must be adequate support and resources to ensure ongoing availability of teaching and supervision in conjunction with clinical work, and that the curricula and learning requirements should still meet the competencies outlined in the AMC Australian Curriculum framework for Junior Doctors. Entry into such terms should be voluntary within reason, as engagement with such diverse population groups would not be best handled by an ambivalent and otherwise unenthusiastic RMO, which also increases the risk of disengaging community based practitioners from providing medical training and supervision. . Any model incorporating community-based intern training must be accredited and must meet the requirements of the R*egistration Standard - Granting registration as a medical practitioner on completion of intern training* and accompanying AMC National Internship Framework accreditation standards and guidelines for intern training. Any model considered must also include complete onsite supervision for all interns at all times. Interns should not be placed in a position where they are not adequately supported by senior medical staff and registrars and we do not support supervision of interns in community-based settings by non-medical professionals. While non-medical professionals may be involved in the immediate supervision of some teaching and training activities, they should not assume the role of term supervisor. The gap left by the defunding of the PGPPP has led the AMA to recommended the establishment of a Community Residency Program. The AMA proposal sets out the design and funding principles that would support opportunities for JMOs to undertake rotations of up to 13 weeks into general practice - helping them to experience life as a

		GP and to enhance their clinical experience. https://ama.com.au/submission/community-residency-program
5	Should Queensland adopt a formal curriculum or accredited system of training for PGY2?	AMA Queensland supports ongoing accreditation of both PGY1 & 2, with the current intern model deemed to be fit for purpose. This ensures ongoing structured training for RMOs and also provides an opportunity for career guidance when choosing specialist paths. Non-clinical teaching opportunities such leadership, communication and management skills can also incorporated. These skills form an important part in a senior medical officer's duties, and training has traditionally not been widely available. The subsequent expansion of accreditation to encompass all pre-vocational terms and establishments of structured frameworks for career pathways would ensure the ongoing quality of Queensland based training.
6	Are additional pathways required to ensure the effective and efficient progression of vocational trainees?	AMA Queensland wants to see action at every level of the training pathway, from internship through to retirement, to ensure that Queensland trains, recruits and retains the best doctors in Australia. AMA Queensland's *Health Vision* advocates for a culture in Queensland which encourages robust debate, expert engagement, best-practice innovation and a culture of compassion towards fellow health professionals and patients. This would be done by establishing a new medical workforce training body called the Queensland Medical Education Training Institute (QMETI) which will be responsible for the development and execution of innovative workforce training strategies. This may include additional pathways to ensure effective

		and efficient progression of vocational trainees via accredited pathways.
7	What training measures could be applied to achieve a better distribution of the workforce both geographically and across specialties?	We believe the QMETI proposal contained within Part 2 of the AMA Queensland Health Vision could be one avenue to help achieve this. Our vision for QMETI is that it should should have focused competencies that respond to pressing workforce concerns and broader patient outcomes, one of which would be developing, coordinating, overseeing and evaluating education and training programs to ensure they support service delivery needs and meet health sector requirements. More broadly, the AMA supports the establishment of regional training networks for training. Whilst excellent clinical training infrastructure and networks exist at an undergraduate level e.g. rural clinical schools and University departments of rural health, there are only a small number of coordinated rural training strategies during prevocational and vocational medical training. Regional training networks (RTNs) offer a potential solution to improving medical workforce maldistribution by enhancing generalist and specialist training opportunities, and supporting prevocational and vocational trainees to live and work, in regional, rural and remote areas. https://ama.com.au/position-statement/regional-training-networks-2014

8	What can be done to maximise distribution of medical practitioners to Queensland Health hospitals outside of south east Queensland?	AMA Queensland believes QMETI can provide significant value by providing expert assistance to the Colleges and Queensland Health in establishing network training programs in rural and regional areas of need. The additional support offered by a dedicated QMETI team will allow these regions to access resources to establish a critical mass of trainers and trainees, ensuring that future workforce needs can be met.
9	How do we overcome perception that an internship and prevocational training must be completed in a major tertiary hospital in Brisbane in order to proceed to vocational training opportunities?	The intern year should provide sufficient breadth of clinical experiences to enable interns to make informed decisions about entry into specialty training, even if that only means differentiating the general areas of medicine, surgery, critical care and general practice. This is currently met by the ability to take elective terms in addition to core medical, surgical and emergency rotations, which may have a sub-specialty component depending on the tertiary level of the hospital involved. Providing doctors finish their internship with a broadly similar set of clinical skills and professional competencies, the variation in clinical exposure based purely on hospital site during internship is moot.
10	What can be done to influence career decisions of junior doctors to stimulate interest in and commitment to rural and regional practice and to specialties of need?	A junior doctor is, anecdotally, more likely to return to any hospital in which they had an overall positive experience. If this can be catered for by an area of need, particularly a rural site, then there is potential to attract doctors to continue their career in that particular area. We do not support models where inappropriate incentivisation or penalties

		are applied to meet workforce maldistribution. Such 'carrot & stick' methods are not beneficial in the long term to ensure a sustainable and engaged medical workforce in areas of workforce need. The former Prevocational General Practice Placements program (PGPPP), allowed a good opportunity for interns and junior doctors to undertake well supervised placements in general practice as part of their training. The unfortunate abolishing of this program has meant the loss of a valuable method of attracting doctors into regional general practice. We strongly recommend a replacement program be established to allow for both interns and PGY-2 exposure to general practice in a safe, professional and supervised manner. Education of medical students and junior doctors on the situation of the medical workforce and likely projections may be of benefit in influencing career pathways early. Utilisation of data from the HWA 2025 report as well as ongoing NMTAN modelling projects should inform this.

Part C: Potential Strategic Directions

Potential strategic directions for the medical workforce plan for Queensland

Direction 1 - Training, supervision and assessment models

Maintaining quality clinical supervision and assessment represents a significant investment for Queensland Health. Increasing numbers of medical graduates, the demands of service delivery and changing funding models in public hospitals are challenging the capacity of clinicians to undertake supervision, teaching and training.

Education and training are critical elements in a contemporary health service. Effective education strategies improve patient safety, health service performance and supports development of the future healthcare workforce.

Direction 1 - Training supervision and assessment		**Support, Support in Principle, Do not support**	**Comments**
1.1	Advocate for the continuation of the Commonwealth Specialist Training Program (STP) to increase the number of available training positions in regional Queensland as well as other expanded settings.	Support	The continuation of the Commonwealth STP would help to address the current issue of 'bottlenecking' in the Australian system, while also providing as an incentive for community-based practice provided that adequate clinical experience was available. We recommended that the Government expand the number of places in the STP from 900 to 1,400 places by 2018 and to 1,900 places by 2030 to help address the looming bottleneck in specialist training places.

1.2	Explore and understand existing issues for junior doctors related to prevocational training and education.	Support	AMA Queensland has a Council of Doctors in Training primarily for this purpose, as does most other AMA branches. The CDT includes RMO and registrar representatives of a wide variety of hospital and health services, training experience and research backgrounds. Collaboration with the relative CDTs in each state would be highly advantageous in understanding the major issues affecting junior doctors in the prevocational training. Supporting the recommendation by the The Australian Health Ministers' Advisory Council (AHMAC) National Intern review for a National Training Survey will can add valuable and granular data to aid our understanding of issues faced by junior doctors.
1.3	Identify strategies to enhance the delivery and coordination of prevocational and vocational medical education and training.	Support	QMETI, if established, would ideally undertake this task as one of its core functions.
1.4	Investigate different modalities to undertake and share information relating to medical education, supervision and assessment.	Support in principle	Full support would depend on the form of modalities involved.
1.5	Identify strategies to enhance the distribution of new fellows to senior medical officer positions in regional, rural and remote settings.	Support in principle	AMA Queensland is open to discussion regarding this, provided that the needs of the new fellows are also taken into consideration. Forcing a new fellow to work in a regional area against their will, with little

			room for professional development or in a situation that places undue stress on their mental health or family commitments would only serve to disenfranchise them, with a loss of engagement with the community involved (of no benefit to the doctor or the patients). Identification of these strategies need to involve discussion with the senior registrars and future fellows to ensure compliance and appropriate working condition terms are met. We have also attached the AMA Rural Health Issues Survey which contains a section with the Top 10 policy proposals which we believe may be worthy of consideration in this context.
1.6	Undertake a review of medical specialty training programs to identify the specialty and/or specialties suitable for remote supervision of trainees.	Support in principle	A review of specialty training is a worthy undertaking, however it has the potential to become (or seen to be) a cost saving exercise. This proposal should be seen as an opportunity to grow and improve the uptake and distribution of such programs. Remote supervision should not compromise patient or trainee safety, access to timely assistance, peer mentorship, nor be dependant on vulnerable electronic systems. Sufficient clinical, electronic and physical infrastructure, with redundancy systems, must exist to support trainees as required.

1.7	Determine the hospital locations in Queensland that would be suitable to host a vocational trainee being supervised remotely.	Support	We wish to note that the hosting of a vocational trainee will require consideration of the living conditions available to the trainee in that area (e.g. appropriate accommodation, car / travel allowance, internet access etc) as well as the clinical suitability of the hospital and health service itself.
1.8	Collaborate with identified medical specialty colleges to potentially redesign curricula supervision requirements to include use of remote supervision.	Support	We support an open discussion between colleges and AMAQ to redesign curricula if required. Ensuring quality of training as well as not compromising the length of time it would normally take a trainee to complete training is vital.
1.9	Identify opportunities to apply a pathway coordinated approach to the management of vocational training in specialties where there is no coordinated pathway in Queensland.	Support	We believe development of a coordinated pathway has benefit in making training more readily accessible and efficient which will assist in workforce management.
1.10	Identify opportunities across the sectors (i.e. public private primary care) to expand training capacity and skill development.	Support	We believe in additional clinical training, that non-clinical training in skills such as communication, leadership and managerial are crucial and currently not well developed. There is a need for training in these areas as they form a significant part in the role of a senior medical officer who fill leadership positions. This will aid in terms of more efficient and effective clinical training, as well as in the administration and management of departments.

1.1 1	Continue to partner with key stakeholders to develop innovative locally initiated and maintained models of training that targets specific workforce priorities.	Support	An open discussion and collaboration with AMAQ is encouraged to target specific workforce priorities.
1.1 2	Continue to explore, support and encourage uptake of opportunities to increase generalist training.	Support	There is benefit to generalist training especially in regional areas.

Direction 2 – Career pathway counselling for medical students and junior doctors

There is evidence to suggest that career pathway counselling can influence the vocational pathway direction of medical students and medical officers in their early pre-vocational training years. The main influence of career choice for medical graduates appears to be the prestige and lifestyle friendliness associated with that career option. There is potential to promote career options early in the undergraduate and prevocational years in a way that aims to address the perceptions of various career choices and encourage graduates into vocations where there is a workforce need.

There is also potential to influence demand for specialty training options during the early prevocational years to promote choices into those specialties that are perceived as less prestigious compared to others.

Direction 2 - Career pathway counselling strategies		**Support, Support in Principle, Do not support**	**Comments**
2. 1	Promote prevocational and vocational training opportunities within Queensland, with a focus on encouraging career choices within areas of current and predicted areas of workforce shortage.	Support in principle	AMA Queensland respects the need for greater workforce in areas of deficiency. However, the provision of training opportunities in these areas should not be against the will of the trainee and must also respect their need for adequate supervision, clinical experience and working hours that do not

			jeopardise their physical or mental health.
2.2	Publish training figures and workforce data for key specialties to inform careers decisions.	Support in principle	While these figures may be useful for some junior doctors, they should not be published in a way that appear to be unfairly biased towards particular specialties. This should be informed by the HWA 2025 report data as well as ongoing NMTAN modelling projects.
2.3	Scope a Queensland Medical Careers Expo for current and prospective medical students and junior doctors.	Support	A careers expo would be an excellent way to assist medical graduates in choosing a career pathway, so long as there was adequate and equal representation from the collages and other training providers (e.g. the defence force). The ability for potential trainees to discuss their concerns and questions with college selection committee members and advanced trainees would also be highly advantageous. Ideally there should be multiple expos held around Queensland to ensure there is equal opportunity for regional, remote and urban medical students and junior doctors to attend. AMA Queensland and the CDT would be willing to assist in providing information, advice and assistance in planning and promoting these expos where possible.

2.4	Publicise and promote the positive experiences and career opportunities of those working in current and predicted areas of workforce shortage.	Support	The positive experience of those working in predicted areas of shortage would be useful, but even more so if it included a range of specialties (e.g. surgery, obstetrics, general medicine) rather than only focusing on general practice and rural generalism.
2.5	Investigate the different modalilties for communication of information that may influence career decisions.	Support	There already are a number of modalities to communicate to medical students (med socs, QLDMSC etc.) and junior doctors (hospital groups, AMAQ CDT). AMA Queensland suggests finding ways to collaborate with these organisations to streamline the communication process.
2.6	Tailor recruitment campaigns to ensure maximum advantage at the decision time (PGY2/3) with respect to career choices into areas and/or specialties in need.	Support	We are supportive of this but question why this would not also be offered to PGY1 and medical students.

Direction 3 – Service and workforce reforms

A number of countries have responded to the challenges associated with ageing populations, the increased burden of chronic disease and systemic issues by undertaking primary care reform focussed on health promotion, chronic and complex disease management, improved integration between primary and specialist services and a focus on patient engagement and motivation.

The use of mobile technologies may also assist to provide timely and culturally appropriate health information to vulnerable and hard to reach population areas in Queensland. Investigation of this strategy will include medical officer access to technologies which enhance clinical skills, teaching and research.

The recent innovative models of care and workforce reforms that have been explored by Queensland Health are:

- Primary Care Amplification Model – 'Beacon' Practices
- Physician assistant
- Nurse practitioner
- Advanced practice allied health professionals
- Telehealth and other technologies

Direction 3 - Service and workforce reform strategies		**Support, Support in Principle, Do not support**	**Comments**
3.1	Work collaboratively with healthcare facilities and the other clinical leads to identify opportunities to progress expanded scope of practice into the workplace and to establish the necessary training opportunities to support role	Do not support	AMAQ does not support extending scope of practice without: ● An evidence base of effectiveness and safety ● Transparent and robust indemnity arrangements

	development.		• Analysis of capacity to resource extended scope of practice and longer term sustainability • Consideration of costs of achieving enhanced skills, which includes potentially reduced capacity for existing medical , allied health and nursing training Overall, AMA Queensland believes that the current balance of care is working effectively, maximising patient safety while preserving patient access. We do not yet see a convincing case to change a system that is not broken, especially when there is still a need for the current non-medical health practitioners scope of practice to be completely fulfilled in order for it to realise its current and future potential. We strongly oppose proposals which would diminish training quality, opportunity and capacity for pre-vocational and vocational doctors.
3.2	Implement innovative service delivery models such as Beacon Practice Models, Nurse-led clinics and Allied Health clinics.	Do not support	AMA Queensland is supportive of the central role of the doctor as the leader of a multi-disciplinary healthcare team. We can never support substitution of medical practitioners with other classes of health practitioners for workforce reasons or cost savings.
3.3	Identify models of service delivery successfully being used in Hospital and Health Services and spread the innovation to other similar facilities.	Support in principle	We would support models, that are supported by peer-reviewed literature and have a strong evidence base,that enhances patient care as long as it does not compromise patient safety and as long as it does not introduce role substitution of medical practitioners with

			other classes of health practitioners for workforce reasons or cost savings.
3.4	Partner with PHNs to increase the capacity of GPs to manage patients within the community.	Support	AMA Queensland recently advocated for a trial of the medical home concept in Part 3 of its Health Vision. We recommend the committee consider this proposal.
3.5	Identify the elements of service and workforce reform that will require inclusion into healthcare facility clinical governance policies and processes.	Support in principle	It is a worthy exercise to undertake the identification of these elements but AMA Queensland would like to see the results of this process before commenting more fully.
3.6	Work in partnership with healthcare facilities to establish suitable technologies and opportunities for the introduction or expansion in the use of technology in the delivery of culturally appropriate patient care, particularly in vulnerable and hard to reach populations.	Support	We support the use of evidence based technology to improve healthcare delivery
3.7	Evaluate completed rural service and workforce design projects to elicit learnings that can be applied to other areas.	Support	Identifying successful projects and achievements in remote and regional centers is vital to encouraging their ongoing development as well as applying learning from those successes elsewhere. understanding the root cause of projects that fail is also vitally important and necessary to ensure appropriate resourcing.

Direction 4 – Regional workforce strategies

Queensland is a decentralised state with healthcare facilities ranging from tertiary to remote. There is no 'one size fits all' model for the provision of healthcare services.

It is recognised that quality education experience and the opportunity to achieve vocational training are essential components for building a rural and regional medical workforce. There is a need to investigate the potential to increase supported quality training opportunities outside of the regular public care settings, to grow a workforce with an interest in working in regional locations.

The experience with the Rural Generalist Pathway (RGP) Program has shown that supporting trainees in a coordinated training pathway involving the medical specialty college has increased the number and retention of rural generalists.

Direction 4 - Regional workforce strategies		**Support, Support in Principle, Do not support**	**Comments**
4.1	Support regional HHSs in the development of strategies that may assist in growing a sustainable medical workforce:	Support in principle	We would support this strategy overall as long as role substitution is not considered, and that this does not jeopardise the clinical experience and access to training opportunities of doctors in these regional areas.
4.2	Collaborate with regional healthcare facilities to identify specialty areas where partnerships may be established.	Support	

4.3	Investigate the elements of a positive promotion campaign and the existence of regional training opportunities to challenge the myth that regional career pathways are a secondary option: ● Offer extended contracts (2 years) ● Emphasise and promote existing incentives ● Offer a positive career endpoint.	Support	Promotion in combination of ensuring high quality training and education will provide solid incentive to encourage the workforce to move into regional and rural areas
4.4	Collaborate with rural and regional HHSs on the feasibility of the developing a rural rotational pathway for PGY1-3 medical officers.	Support in principle	We maintain that increasing capacity for intern places must not come at the expense of a quality intern training experience. Establishing evidence to determine whether community based models deliver an undifferentiated doctor capable of independent medical practice to meet the needs of the community is necessary. Streaming should be reserved for PGY2 and 3 and must include the option to change streams if they wish to choose a different career path. The use of streaming in intern year is only appropriate with elective terms, so as not to disrupt diversity of experiences achieved in medicine, surgery and emergency terms. It is this diversity that allows interns to develop a good generalist foundation on which they can begin their transition into a specialty or GP training. This

			generalist year allows interns to maintain and reinforce their broad medical knowledge and improve technical expertise. It is important to ensure good senior supervision if rotations are to occur in rural locations for PGY 1-3 doctors in a similar manner to a tertiary centre. The AMA proposed a model design and funding principles to support opportunities for JMOs to undertake rotations of up to 13 weeks into general practice - helping them to experience life as a GP and to enhance their clinical experience. https://ama.com.au/submission/community-residency-program
4.5	Develop a matrix of the range of terms and specialties required to assist in articulating the junior doctors (PGY1-3) on the rural rotational pathway into specialty vocational training programs.	Support	Compulsory core terms in emergency medicine, surgery and medicine, of fixed duration (no less than 10 weeks), should remain part of the intern year, independent of the location of the term. These core terms are vital to the internship experience, not only because they are often busy areas in which junior doctors can be a valuable manpower asset but also because they provide an essential combination of

			experience in history taking, examination, appropriate investigation and different approaches to management (i.e. medical versus surgical), which are at the crux of medical practice.
4.6	Establish the concept of “run-through training” and engage with specialty colleges and healthcare facilities to determine the possibility of increasing training opportunities in regional locations, e.g. to develop multiple/cross facility training posts.	Support but with provisions	A recent review published in the BMJ by John Jolly and colleagues has shown that surgical trainees take up to three years ***longer*** to complete their training and are more likely to take time out of their program, which does not adequately address the current needs in the Queensland climate. However, a pilot program for ‘run through’ training has been implemented in the UK since 2014 to address a lack of doctors specialising in emergency medicine. While ‘run through’ training has the apparent advantages of streaming, it disadvantages a trainee if they are unsure about their career path or decide to swap paths all together, as certain pathways (like obstetrics and gynecology in the UK) do not allow for entry into the ‘run through’ program later in training. A run through training could be trialled in Queensland but only with extensive

			collaboration with colleges and ability to change streams if required, with recognition of prior learning, particularly if this advantages a specialty and workforce area of need.
4.7	Review viability of intern placements in rural and regional settings and ensure that placements are sustainable by providing a framework for interns to articulate to JHO/SHO posts.	Support in principle	Refer to point 4.4
4.8	Identify champions who can effectively promote and market opportunities and advantages associated with practice in regional and rural settings.	Support	
4.9	Identify opportunities to sequester training positions for graduates who have indicated an interest in meeting the specific workforce need (e.g. psychiatry, general surgery, obstetrics and gynaecology).	Support in Principle	We do not support Bonding of Medical students or doctors. We do not support the quarantining of training positions and limiting access to vocational training as a part of incentivization for regional/rural practice.
4.10	Investigate development of a risk management plan to be activated in the event the number of specialists in an area decreases below an	Support in Principle	

	accepted standard.		

Direction 5 – Attraction, Recruitment and Retention (public sector)

The medical workforce is largely centred in the south east corner of Queensland and historically recruitment and retention in rural and regional areas has been problematic, compared to metropolitan areas. This is due to perceived difficulties with career advancement and work/lifestyle balance for families. The experience with the RGP has shown how a targeted and supported program has resulted in building a medical workforce specifically trained to work in rural and remote areas, and reduced the critical vacancies in rural hospitals.

Direction 5 – Attraction, recruitment and retention		Support, Support in Principle, Do not support	Comments
5.1	Identify issues that may affect the appeal of practice in regional and rural settings and develop strategies to address the issues.	Support in principle	
5.2	Review evidence relating to attraction and retention of medical practitioners to regional and rural areas with a particular focus on modifiable factors to improve recruitment outcomes.	Support in principle	
5.3	Engage with professional colleges around 'bonding' of specialists to public services for a period of time following fellowship.	Support in principle	
5.4	Engage with professional colleges to identify and promote training opportunities for specialties with a growing demand or specialist	Support in principle	

	shortage across the state.		
5.5	Create non-financial incentives for specialists to work in the public sector such as involvement in innovation programs, teaching and leadership opportunities	Support	We believe this is an important direction, and as further incentive, recommend support for specialists to work in both public and private sector.
5.6	Investigate regional networked training that enables trainees to complete their training in the shortest possible time	Support in principle	Advancement through training programs is a key bottleneck to providing areas of need with appropriately trained specialists. However, advancing a trainee quickly through a program for the sake of 'ticking a box' without necessarily providing enough clinical experience for safe scope of practice as a specialist is fraught with danger. Support for this principle relies on adequate supervision and professional development to allow for safe independent practice.

Direction 6 – Data collection, analysis and evaluation

The key policy issues that should be examined as part of a medical workforce planning process are:

- Is the number of practitioners currently adequate?
    - Will it be adequate in the future?
- Is the distribution of practitioner services appropriate?
    - Will it be appropriate in the future?

With the stated aim of achieving 'self-sufficiency' in relation to the medical practitioner workforce, successive Australian, state and territory governments have made significant investments over the previous decade to address the issue of shortages and maldistribution of Australian trained medical practitioners.

The Department of Health will continue to work with key stakeholders to maintain a robust workforce intelligence and data evaluation system. The data will be updated and refreshed regularly to contextualise and support the implementation of the eventual plan.

Direction 6 – Data collection, analysis and evaluation		**Support, Support in Principle, Do not support**	**Comments**
6.1	Track the progression of priority 1 graduates to ascertain the consequential movement throughout Queensland or interstate and into specialty training.	Support	A nationalised system to track internship and residency placement would be beneficial to ensuring efficient and coordinated placement. Important data will be easily collated and used for workforce planning.

6.2	Investigate the development of mechanisms which will enable the rapid identification of workforce imbalance to influence the supply of doctors.	Support	A nationalised system tracking placement would be able to provide this data.
6.3	Establish protocols for data sharing between, the Department, HHSs, medical specialty colleges, universities, primary health networks and other key stakeholders.	Support in principle	With suitable regard for privacy provisions.
6.4	Improve the collection and analysis of data and information that shapes medical workforce planning.	Support	Collaborations with the NMTAN may be helpful here.

Thank you for completing the feedback form. Please submit the form as per the instructions on page one.