

FATES 2

Rural Training Models

Evaluation Report

June 2026

Royal Australasian College of Surgeons FATES 2 (Rural Training Models) Evaluation Report (Final)

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Abbreviations

ABiGS - Australian Board in General Surgery	RACS - Royal Australasian College of Surgeons
ANZCA - Australian and New Zealand College of Anaesthetists	RANZCO - Royal Australian and New Zealand College of Ophthalmologists
ASPS - Australian Society of Plastic Surgeons	RANZCP - Royal Australian and New Zealand College of Psychiatrists
FATES - Flexible Approach to Training in Expanded Settings	RANZCR - Royal Australian and New Zealand College of Radiologists
GSA - General Surgeons Australia	RHESC - Rural Health Equity Steering Committee
HREC - Human Research	RRIPM - Rural and Remote Institute of Palliative Medicine
NGT - Nominal Group Technique	RRR - Regional, rural and remote
NHMRC – National Health and Medical Research Council	RTA - Reflexive Thematic Analysis
NT – Northern Territory	RUFUS - Rural facing urban specialist
RACGP - Royal Australian College of General Practitioners	SET - Surgical Education and Training
RACMA - Royal Australasian College of Medical Administrators	SMC - Specialist Medical College
RACP - Royal Australasian College of Physicians	STP - Specialist Training Program

Introduction

For health care professionals, gaining experience in a rural setting during training increases the likelihood of working in a rural location when training is completed. Enabling surgeons to be trained in rural areas can help improve the distribution of the specialist medical workforce and contribute to meeting community need in under-serviced areas.

The purpose of the Flexible Approach to Training in Expanded Settings (FATES) program is to support specialist medical college projects that address priority areas identified in the National Medical Workforce Strategy and other Government priorities. This includes addressing maldistribution and undersupply issues in regional, rural and remote (RRR) areas, as well as building capacity in the Aboriginal and Torres Strait Islander specialist medical workforce. FATES grants are available from the Commonwealth Government Department of Health and Aged Care and provided as part of the Health Workforce and Rural Access program.

The Royal Australasian College of Surgeons (RACS) was awarded a FATES 2 grant in a consortium with ANZCA, RACMA, RACP, and RANZCO. The purpose of the grant was *to research and design rural training models* that shall support quality specialist medical training in regional, rural, and remote Australia, reduce barriers to practice rurally, improve maldistribution and provide culturally safe training experiences.*

Funded at \$2,347,816 the project commenced in January 2023, a time when significant events were occurring in the external regulatory environment relating to specialist medical accreditation. There were also internal changes at RACS where measures were being taken to restore its financial stability. These and other factors had an impact on project activities and the original timeframe nominated for deliverables.

Project Evaluation

A requirement of FATE grants is that project outcomes be evaluated. Evaluation is described as the systematic collection and analysis of information to highlight achievements and to identify areas for improvement. An independent evaluator with experience in rural health was engaged to undertake the work. An evaluation plan for the project was provided to the Department of Health, Disability and Ageing by RACS in December 2024 and a risk management plan developed. Data was collected and managed in accord with NHMRC guidelines.

The primary sources of data for the evaluation were: documents pertaining to the RACS FATES 2 *Rural Training Models Final Report*, interviews with informed commentators nominated by RACS. This included Fellows, project team members and stakeholders (n=15). Also reviewed were reports from project workshops and focus group discussions, summaries of project outputs, records of meetings related to project administration and governance as well as notes from project evaluation discussions held with FATES project managers.

* Within the RACS FATES 2 documentation, the term 'models' has been applied to components of the teaching/learning process (such as orientation, supervision and mentoring) and also to the arrangements within the clinical learning environments where training occurs. Where it has been applied to the latter, a 'rural training network' is one example of a 'rural training model'.

Project Activities and Outputs

The project produced a number of outputs including four literature reviews, three research reports and a compilation of short case studies of rural training networks. These are outlined in the following section and, for this evaluation, conceptually book-ended by two significant project workshops. The first workshop set the stage for project activities. The second workshop provided additional impetus for an important project outcome – the selection of a general surgery trainee who commenced their SET in 2026 with the newly established NT Training Pathway.

Workshop 1 *National rural training and retention workshop*

RACS and the Office of the National Rural Health Commissioner co-convened this *workshop* in Melbourne, February 2024. It brought together 57 stakeholders representing government, regulatory bodies, professional interest groups and specialist medical colleges to discuss actions that could address workforce maldistribution and improve access to surgical care in regional, rural and remote areas of Australia.

A well-crafted [10 page] *Issues and Outcomes Paper* was produced that drew on the literature reviews undertaken and workshop discussions. It listed ‘agreed actions’ that needed to be taken to address problems and barriers to rural based surgical training. These actions were prioritised and grouped under five main themes: Flexibility in accreditation, supervision and support for accreditation; Opportunities for training selection; College leadership in workforce planning; Governance and resources to operationalise rural surgical training and; Collaboration and partnership.

In a statement that clearly summarised the imperative for the RACS FATES 2 project, the report concluded that:

Effective implementation of the solutions and actions identified in the workshop will result in positive long-term impact for rural and remote Australians and increase their access to specialist surgical services closer to home. Inaction will further diminish access and future specialist surgical care will be limited to major urban centres. This will cost Australia more and provide less care where it is needed most.

Literature Reviews

Four literature reviews were produced (annotated below). Each review was presented as an independent piece of work and appeared in an appendix whilst extracts were cited in the various sections of the *Final Report*. There are benefits to this approach. It allows the reader to peruse the main findings and conclusions when reading the full report with an option and, if they choose, to gain a more in-depth understanding of the work undertaken on the topic by reading the full review as appended.

Two reviews were completed on the topic of rural training networks (a rapid review and a review of the grey literature). The other two reviews were on orientation, supervision and mentoring (a review of the grey literature then a systematic search and review of published research studies). The reviews were generally thorough, followed established search and review protocols and well written. Three of the 4 reviews were either of (or close to) a publishable standard.

No clear explanation was provided in the Final Report to explain why these different approaches were adopted to investigate the literature. Was it simply for comprehensiveness or did the findings from one type of review prompt a review on the same topic using a different approach such as a 'gap' in literature being identified? There was no report of an analysis of either the similarities and differences or a synthesis of the findings from the two high quality reviews on the topic of rural training networks. This was an opportunity for an output may have offered additional insights for the project and for future work in this area.

Rural Surgical Training Networks: A rapid review. March 2025 [48 pages]

This review aimed to identify the critical elements of rural surgical training models that contribute to their success. Fifty studies were selected and assessed for quality with a Mixed Methods Appraisal Tool. Data were analysed thematically. The findings highlight the importance of elements such as institutional oversight, leadership, partnerships, support mechanisms, flexible work arrangements, social networking and technological support.

Rural Training Networks, FATES 2 Grey Literature Review. November 2025 [32 pages]

This review starts with a comprehensive introduction to and definition of a 'network' in the context of specialist medical training programs. The review aimed to complement the rapid review by drawing on grey literature to examine and identify key components of successful networks. Thirty reports were included and most assessed to be of high quality. Eight key features of a rural training network were identified and explored further using thematic analysis. Five themes emerged (Establishing a rural training network; Governance, funding and sustainability; Guidelines and operational framework; Comprehensive supervision and trainee support; Ongoing monitoring) and their contribution to the success of a rural training network discussed in more detail.

Grey Literature Review Supervision, mentoring and orientation in Australian and New Zealand Medical Colleges. Sept 2024 [11 pages]

A review of a very limited amount of grey literature on the topic of supervision, mentoring and orientation in postgraduate medical training programs. Whilst lacking procedural detail, the report states that data was sourced from websites, data bases and stakeholders in the field of medical education. The review suggested that: *In many cases...policies [across these areas] appear to be based on tradition or institutional preferences rather than on rigorous research or outcomes data.* It noted that supervision in rural settings presented unique challenges such as fewer experienced supervisors. Whilst medical colleges recognised these challenges, additional support may be needed to address them. The report observed that medical colleges do have mentoring programs though these programs may not have been evaluated to assess their impact on trainee outcomes. The review also found there was a range of orientation programs used by colleges. Some more comprehensive than others.

FATES 2 – Rural training models. Peer-reviewed literature review: Supervision, mentorship, orientation. April 2025 [158 pages]

Using a systematic search strategy, this review investigated evidence for models of supervision, mentoring and orientation of postgraduate specialist medical trainees. The review interrogated 9 research questions such as: *What are the different models of medical specialist training supervision in regional, rural and remote settings?* A large number of studies were located.

These were largely descriptive, observational or comparative (not experimental) in design. A thematic analysis was applied to draw together and summarise the findings.

Overall, the review found that models of supervision, mentorship and orientation were varied and developed to suit the specific requirements of each context. Despite a comprehensive search strategy, a best practice model was not located though models were reported to be successful, regarded highly by participants, and led to improved training outcomes.

Rural models were described in most detail for supervision where it was found that rural supervisors face additional challenges such as workload and demands on their time when compared with their metropolitan counterparts. Commonly reported components of models of supervision included characteristics such as flexibility, allowing each site to develop collaborations and relationships to augment or supplement local supervision; adopting a pragmatic approach responsive to the setting; and being proactive with coordination and the provision of support.

It was observed that access to formal mentorship programs for postgraduate specialty trainees is varied and can be particularly difficult for trainees in rural hospitals where there are fewer specialists. Additionally, trainees may not always receive the comprehensive orientation needed to work in rural areas due to limited resources.

Research Studies

Three qualitative research studies were conducted that contributed to project outcomes. One was directed to the broader FATES purpose of building capacity in the Aboriginal and Torres Strait Islander specialist medical workforce and investigated ways to provide culturally safe experiences for trainees. This study was funded by the STP Support Project scheme and appears in an appendix of the RACS FATES 2 *Final Report*.

The other two interrelated research studies drew data from stakeholders to investigate their experience and views on models of rural training (orientation, supervision, mentoring) as well as rural training networks. Data from the latter contributed to the rural training network case studies included in the Final Report. Components of these two research studies was embedded in the *Final Report* in preference to each study being reported in full in an appendix.

All 3 studies received separate approval from a HREC though comments were made during the interviews for the evaluation about the challenges of submitting a human research ethics proposal to and receiving approval from authorities in different jurisdictions. This contributed the delay in the commencement of some studies.

Towards culturally safe environments for Aboriginal and Torres Strait Islander medical specialist trainees and Fellows. May 2025 [10 pages]

This qualitative study investigated the perceived barriers, challenges and obstacles to completing surgical training and remaining in surgical practice for Aboriginal and Torres Strait Islanders. Semi-structured interviews were conducted with ten staff and one Aboriginal Fellow from seven medical specialist colleges, as well as the Australian Indigenous Doctors' Association. Transcribed interviews underwent Reflexive Thematic Analysis (RTA) to identify, analyse, and interpret patterns within the data.

The findings are summarised in dot-point form. The study report identified a number of issues and recommended changes that could be implemented to increase the number Aboriginal and

Torres Strait Islander medical school graduates applying for, and completing, surgical training. These included: wrap-around pipeline with one-on-one tailored support for Aboriginal and Torres Strait Islander medical students/doctors; addressing financial barriers; greater flexibility with placements; support and resourcing for formal and informal mentoring.

The recommendations generated from the study were not listed in the Executive Summary of the RACS FATES 2 *Final Report*.

Stakeholder interview study [7+pages]

Semi-structured interviews were held with project stakeholders (n=51) and trainees (n=4) to explore the experiences, barriers and solutions to the challenges of supervision, mentorship and orientation associated with specialist training in rural areas. Data was also collected from interviews and a focus group on rural training networks (n=10). These findings were incorporated with the rural training network case studies.

A 'hybrid thematic analysis' was applied to the data using NVivo software. Themes identified pointed to a 'lack of diversity', experiences of an 'anti-rural bias', a 'lack of support systems' for women and rural surgeons, as well as the impact short duration rural rotations had on trainees and families. The analysis also conveyed a level of frustration felt by stakeholders about the lack of progress made to establish rural surgical training pathways. It was reported that participants expressed a strong desire 'to make things happen'.

Expert appraisal of proposed evidence based rural surgical training models [42 pages]

Models of rural training (orientation, supervision, mentoring) and rural training networks generated from the literature reviews and the *Stakeholder interview study* were subsequently refined through an iterative process of expert appraisal and consensus building. This approach was justified given that the large majority of papers cited in the literature reviews were studies that would be considered to represent lower levels of evidence (eg. cross-sectional studies, case reports, expert opinion or anecdotal reports) and not always from Australia or New Zealand. Thus, an approach that sampled a good number of well-informed local experts would have helped contextualise the findings as well as encourage the adoption of best practice.

A 3-Phase study was designed that used a hybrid Delphi and Nominal Group Technique (NGT). In Phase 1, and building on previous work, four virtual NGT sessions were conducted to obtain an appraisal of the four models (n=9). Phase 2 involved two focus group sessions. One with surgical trainees (n=4) and the other with participants from RACMA (n=4).

Phase 3 was conducted as part of a project workshop held in Darwin where participants (n=92) were provided with prior readings about each of the four models and then, in groups, were asked to reflect, discuss and appraise each model. From this activity, the 59 'essential elements' of supervision, mentoring, orientation and rural training networks that were generated in Phases 1&2 were prioritised by participants for 'implementation in the short term'. An additional 26 'themes' also emerged from written comments submitted by workshop participants on each model. In the Final Report, it was asserted that addressing these themes will contribute to a 'robust and effective' model in each area.

Despite generating a large number of well-considered and sound high-level principles (essential elements and themes) with the potential to impact training programs, the findings were not

summarised or consolidated to a form in which they could be more readily disseminated and subsequently considered for adoption and implementation by specialist colleges.

Case studies of rural training networks

The RAC FATES 2 *Final Report* refers to three different models of rural surgical training: a (well established) urban hub–rural spoke model, a rural facing urban specialist (RUFUS) model and, rural training networks. It notes that: *of the 3 rural training models, rural networks are expected to have the greatest impact on building a rural medical specialist workforce.*

At various stages of the RACS FATES 2 project, examples of successful and some well-established rural training models were identified and information about each collated to help inform project activities. The aim was to document elements of each model such as their purpose, leadership, organisation, communication, strengths and limitations, and to examine how a rural training network could be created, sustained and expanded.

Information was collated from a variety of sources including a desk-top search of relevant college websites, workshop presentations and the literature reviews undertaken as part of the project. This was augmented by semi-structured interviews (n=6) and one focus group discussion (n=4) conducted as part of the *Stakeholder Interview* research study. From the interviews and discussions held, it was reported that: *participants provided a complex and multifaceted narrative centred around what they saw as challenges and opportunities within rural surgical networks.* Themes extracted emphasised:

- The importance of network leadership and building relationships that help build connectivity including rural–urban collaborations.
- Integrating rural training networks into existing healthcare networks
- Ensuring that training in rural areas is well coordinated and comparable to urban training whilst recognising that rural exposure helps trainees develop a wider skill set more better suited to the broad scope of rural practice (generalism).

These case studies are described in the *Final Report* and include examples of drawn from ANZCA, ASPS, ANZSPM, RACMA, RACP, RACS (South West Victoria Regional Training Hub for General Surgery), RANZCO and RANZCP. Importantly, each case study demonstrated strong and effective engagement with rural sites as a part of the training pathway

Other project reports

Two other project reports were produced. *An Aboriginal and Torres Strait Islander cultural safety framework* [4 pages] which was also presented and discussed at workshop held in Darwin (Workshop 2). The paper draws on the *Aboriginal and Torres Strait Islander Health Curriculum Framework* produced by the Australian Government Department of Health and Aged Care (2014) and elucidates the five key aspects of cultural safety: respect, communication, safety and quality, reflection and, advocacy. It was anticipated that this work would inform and help enable culturally safe remote, rural and regional outreach practices for both surgeons and trainees.

The second output was a business case and position description for a *Rural Career/Training Coordinator* to be established with the RACS and that would support the *proposed NT training pathway*. The role would involve *coordinating all elements of rural workforce strategy, training and careers, internal and external stakeholder engagement and collaboration.*

Workshop 2 *National rural training models solutions for rural training. What works and why.*

Ninety-two stakeholders were reported to have attended the *National rural training models workshop* in Darwin, held over 2 days in October 2024. The *Aboriginal and Torres Strait Islander cultural safety framework* was presented and discussed together with the feasibility of implementing a NT General Surgery training pathway.

Workshop time was spent discussing and working through the ‘essential elements’ of best practice for supervision, mentoring, orientation in rural training and for rural training networks. A consensus produced (Phase 3 of the *Expert appraisal* research study) and graphically presented in the *Final Report*.

Over the course of the workshop, delegates presented case studies of pathways that included rural training sites and spoke to various models that had been implemented. This under-scored some of the research work completed on supervision, mentoring and orientation. It also demonstrated the readiness of some rural sites to host and support surgical trainees. For example, in one case study, the *Final Report* refers to delegates who:

...described trainee and supervisor perspectives on the trainee orientation provided by Alice Springs Hospital, which replicates almost all the features of the best practice model identified. Key features include contacting the trainee up to a month before arrival, including information and advice to support relocation and trainee and family integration into the community, and getting to know the trainee, providing contextual information and starting the conversation early regarding how best to tailor training goals and the experiences available.

Local stakeholders were keen to establish end-to-end training in the Territory, emphasising the importance of place-based selection of trainees to promote long-term retention and to meet community need such as enabling more Aboriginal and Torres Strait Islander doctors to train close to or on country. It was also noted that this model of training could help reduce health care costs through savings gained from a reduction in expenditure on locums.

The Australian Board in General Surgery (ABiGS), RACS and GSA presented a proposed (new) Northern Territory (NT) Rural Training Pathway. The pathway mapped where a trainee’s time would be spent over the five years with 60% of time spent in the NT. An NT Training Pathway Working Group was formed at the workshop to progress and implement the proposal.

This collaborative work culminated in the selection of a general surgery trainee who commenced their SET in 2026 with the newly established NT Training Pathway. Commentators interviewed for this evaluation were optimistic about its success, looked forward to the program growing with local support and to additional rural training networks being established for surgical training in other areas of need.

The Final Report

The RACS FATES 2 (Rural Training Models) *Final Report* is a little over 500 pages, including appendices. The ‘Executive Summary’ is readable, offers some excellent background/contextual material and, arguably, is presented in a way that should be accessible

to a wide range of stakeholders. It lists 47 key recommendations consistent with the findings reported. These are grouped under 11 'domains' as well as an *additional* 8 recommendations grouped under 4 'other' domains.

Somewhat confusingly, there are 6 'domains' listed in the body of the report (p26) from which the recommendations listed in the 'Executive Summary' have been extracted. The first two domains (Leadership, visibility and accountability; Collaboration and coordination) highlight the importance of these elements for the successful delivery of outcomes in the more project specific domains (rural training models, orientation, supervision and mentorship). There was no 'domain' listed in the 'Executive Summary' that directly referred to the performance indicator: *research and design culturally safe and effective outreach models*. Recommendations listed with this purview appeared under the domains *Aboriginal and Torres Strait Islander and Māori workforce* and *Rural focused urban specialist skills*.

Commendably, for each recommendation, an authority (such as a college or a committee) responsible for implementation is identified, together with a short list of the 'resources required'. The recommendations, extracted from and supported by the material presented in the body of the report, are not prioritised beyond being listed as either 'key' or 'additional' in separate tables.

Missing, was a description of these how recommendations (or principles) had been applied to a specific network or context such as the development and implementation of the NT rural training pathway. Illustrating their application would have demonstrated their utility and could have included a commentary of such things as practical challenges, resource requirements, governance structures, and any policy changes necessary for successful implementation.

Issues related to the sustainability of rural surgical training networks was not well addressed though principles important to the establishment of a rural training network were clearly identified.

Editorial improvements could be made to the organisation and structure of the report such as the removal of content not essential to the purpose of the report, including an introduction to and summary of each major section, as well as providing a conclusion at the end of the report.

The limitations associated with the project as a whole were not clearly identified or discussed. A summary of these together with some practical suggestions for how these could be overcome would have strengthened the report and provided more direction for expansion and further roll-out of additional rural training networks and outreach programs.

The reach and effectiveness of the key recommendations from the project could be enhanced by developing a strategy for communicating project findings, outcomes and recommendations. This may include production of abridged versions of the executive summary such as a 'one-pager' of take-home messages, better suited to a particular audience for whom the findings and recommendations may be directly relevant (such as a training site, college committee, stakeholder group or jurisdictional authority).

Additional suggestions for improvement of the *Final Report* have been listed in the Supplementary file to this evaluation.

Project Governance

The *Final Report* states: *the project was managed via RACS Education Pathways and Education Partnership Portfolios, including the STP and FATES manager. Fellowship governance was provided by the RACS RHESC. Financial oversight was initially provided by the RACS Project Management Office and later moved to a more traditional model under the RACS FATES RRR funded Steering Group.*

The RACS RHESC met regularly and discussed FATES projects, noting achievements, reporting requirements, organisational and personnel changes as well as disruptions to project activity schedules. The FATES Manager as well as some project team members attended RHESC meetings as observers and responded to questions and comments from members of the Committee.

There was continuity in principal leadership of the RACS RHESC from project commencement to completion. This ensured some level of project oversight and that the work associated with FATES was profiled as important to the interests of the College as well as to improving rural health outcomes. However, it was evident that at times, lines of communication between the project team and project governance structures did become fractured and a level of disassociation was reported to have been experienced by some commentators. Whilst generally cohesive as a team, the membership of the project team did change across the life of the project. This resulted in some discontinuity and loss of knowledge about the project, with components having to be picked up by others less familiar with the work.

Commentators have advised that a re-structure in the allocation of portfolios and responsibilities within the RACS has been implemented to address these concerns going forward. Also, a Stakeholder Engagement Strategy has been developed. This document lists a range of key external and internal stakeholders, includes a project specific team engagement strategy and details operational details related to implementation. The most recent iteration of the strategy was produced in January 2026.

Summary of Achievements Against Performance Indicators

The RACS FATES 2 project aimed *to research and design rural training models to support quality specialist medical training in regional, rural, and remote Australia, reduce barriers to practice rurally, improve maldistribution and provide culturally safe training experiences.*

Within the FATES grant agreement, project aims and purpose translate into six *performance indicators* and associated outcome measures. An overall assessment of achievement against each indicator follows:

Performance Indicator: Research and design models for rural training networks.

Literature reviews and research projects were completed that contributed to the design of models for rural training networks. The report includes well investigated descriptions of a network, guidelines for implementation and differentiates between a rural training network and other models that can support trainee exposure to rural practice (the Urban Hub-Rural Spoke and the RUFUS model). The 'case studies' drawn from different colleges, demonstrate examples of ways in which rural experiences may be successfully built into specialist training pathways.

Performance Indicator: Research and design models rural/remote supervision

Interviews with project stakeholders and an 'expert appraisal' were undertaken to identify and assess key components for rural/remote supervision in specialist medical training. This research was underpinned by a very thorough systematic search and review of the peer-reviewed literature related on the topic.

Performance Indicator: Research and design models for culturally safe and effective outreach to Indigenous communities for specialist trainees.

Culturally safe and effective outreach models was discussed in the *Final Report* where it was also affirmed that cultural safety was embedded in the project through the contributions of a consultant and the Indigenous Health Committees of RACS and the RACP. A generic framework for cultural safety was produced for medical training and practice and a research study more specific to surgical training was completed (see previous comment on *Towards culturally safe environments for Aboriginal and Torres Strait Islander medical specialist trainees and Fellows*).

Work across this area has led to revisions being made to the RACS policy paper *Outreach Surgery in Regional, Rural and Remote areas of Australia and Aotearoa New Zealand* as well as changes to the RACS *Rural surgery professional skills curriculum* and the *Remote, rural and regional professional skills eLearning course*.

The *Final Report* noted that: *outreach experience is rarely part of training curricula or training requirements/rotations*. It elaborates on this issue further stating:

Trainees may have access to curricula and resources but little exposure to training experiences to enable contextual competence in the provision of outreach services to Indigenous communities and/or within Indigenous health settings/facilities

The report recognises that an outreach experience for trainees, embedded within public hospital networks, would be an important component of the NT and other rural training pathways. It fails to provide examples or case studies of specialist medical outreach programs that may have illustrated how this could be done.

A number of recommendations are made about outreach models in the Executive Summary. Whilst most of these relate to the RUFUS training model, many could also apply to Rural Training Networks.

Performance Indicator: Research and design models for mentorship and orientation for trainees,

A systematic search and review of the peer-reviewed literature on these topics was undertaken in conjunction with the review of 'supervision' though fewer papers were located. Project stakeholders were also interviewed, and an 'expert appraisal' was undertaken of the key components for models of mentorship and orientation in specialist medical training. The expert appraisal enabled some key features of each model to be prioritised and 'themes' pertaining to each area identified.

Performance Indicator: Set up a consortium of stakeholders (jurisdictional partnerships) required to establish a pilot network in the Northern Territory

An MoU was signed between RACS and the NT Department of Health in April 2022 to [inter alia] *Facilitate the establishment of an environment and structures to support the training of an Australian qualified workforce which is locally trained within the Northern Territory.*

In late 2024, a Northern Territory Training Pathway Working Group (for General Surgery) was established in collaboration with stakeholders. The group was formalised by the RACS through endorsement, of the Working Group's objectives, membership, powers and reporting relationships.

A pilot training network was established in the NT.

Performance Indicator: Evaluate deliverables for their effectiveness and relevancy to addressing community need, and meeting FATES objectives.

Project work activities and outputs contributed to promoting a positive rural and remote medical education culture in ways that supported specialist medical training being established across these areas, most notably in the NT. Commentators interviewed were very supportive of the FATES grant program and believed that many of the projects would provide learnings and exemplars of initiatives that would contribute to addressing the maldistribution of the specialist medical workforce.

The project generated a set of recommendations that would help reduce some of the barriers for specialist medical training in rural areas. Their adoption would contribute to the broader range of initiatives required to address the maldistribution and supply of the specialist medical workforce in rural and remote areas of Australia. Recommendations were also generated that may create opportunities for trainees to participate in outreach programs during their training and help meet community need for surgical services.

Conclusion

The project completed a number of research and other activities directed to the *design of rural training models to support quality specialist medical training in regional, rural, and remote Australia, reduce barriers to practice rurally, improve maldistribution and provide culturally safe training experiences.*

The report is particularly strong in its emphasis on, place-based training, rural training networks, end-to-end rural pathways, place-based selection of trainees, context relevant orientation, supervision, mentoring, and rural career/training coordination as key elements to achieving a rural specialist workforce.

Much of the research (including the literature reviews) was of a high academic standard. The information collated on rural training pathways provided evidence that these pathways could be implemented successfully. In this project, the broader rural health training agenda was promoted by engaging with other medical colleges in project activities, workshops and research studies.

This evaluation was conducted consistent with the approved protocol. Interviews were held with 'informed commentators' about the project and the contributions made by this project to

help achieve FATES objectives. The evaluation considered a range of reports and other documents, though a full audit of project documentation was not undertaken. Some data sources relevant to this evaluation may therefore have been omitted from the review process.

Out of scope for this evaluation was an assessment of project 'value for money' and whether resources could have been distributed more effectively to achieve more practical outcomes in areas such as the design of culturally safe and effective outreach services to Indigenous communities.

Major project achievements and recommendations from this evaluation are highlighted below.

Project Commendations

- The rigour of the research components of the project and quality of many of the reports produced,
- The use of workshops as a mechanism to engage with a large number of stakeholders for consultation and consensus building.
- The establishment of the NT Training Pathway and then selection of a general surgery trainee who commenced their SET in 2026.

Recommendations

- Work be undertaken to synthesise the major findings from the literature reviews and the research studies to consolidate the 'best practice' features and attributes of the models investigated (orientation, supervision, mentorship and rural training networks). These could then be summarised as a resource and shared with other colleges and stakeholders (as recommended in the *Final Report*).
- The merits of 'placed based selection' of trainees was a strong and recurrent theme across the Final Report as one strategy to respond to workforce maldistribution. Specialist Medical Colleges are encouraged to actively pursue opportunities to accommodate placed based selection in ways that do not compromise the integrity of the selection process or the calibre of trainees who enter surgical training programs.