



FPM

Faculty of Pain Medicine
ANZCA

Developing flexible accreditation pathways for pain medicine training in rural settings

Evaluation report
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FACULTY OF PAIN MEDICINE (FPM), AUSTRALIAN AND NEW
ZEALAND COLLEGE OF ANAESTHETISTS (ANZCA)

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ANZCA acknowledges the traditional custodians of Country throughout Australia and recognises their unique cultural and spiritual relationships to the land, waters and seas and their rich contribution to society. We pay our respects to ancestors and Elders, past and present.

Key abbreviations and definitions

FPM	Faculty of Pain Medicine
ANZCA	Australian and New Zealand College of Anaesthetists
SPMP	Specialist pain medicine physician, also known as an “FPM fellow” or “pain specialist”. SPMPs have completed the FPM fellowship pain medicine training program and have the designation of FFPMANZCA (Fellowship of the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists).
MMM	Modified Monash Model – a remoteness classification system used by the Australian government to define whether a location is metropolitan, regional, rural (small, medium or large), remote or very remote.
FATES	Flexible Approach to Training in Expanded Settings
FTE	Full-time equivalent
Rural	In the context of this evaluation report, the term “rural” is used to encompass all MMM2-7 areas, including regional, rural and remote locations.

Introduction

In 2024, the Faculty of Pain Medicine (FPM) of the Australia and New Zealand College of Anaesthetists (ANZCA) was successful in its application to the Australian Department of Health, Disability and Ageing for funding to explore flexible accreditation pathways for pain medicine in rural settings through its Flexible Approach to Training in Expanded Settings (FATES) program (the “project”).

From 2024-2025, FPM explored the barriers within the FPM accreditation standards that impact rural-based pain medicine training and to subsequently identify flexible models of rural training and accreditation pathways to pilot in several rural Australian locations.

The [flexible accreditation options](#) developed for pilot were:

- **Training locations and networks.**
 - Settings were able to consider applying as an individual site or a network of sites).
- **Blended and remote supervision.**
 - Considering blended remote supervision or remote supervision models, with supervision provided onsite and/or supplemented by remote supervision
- **Multidisciplinary team input.**
 - Supplementing the available onsite multidisciplinary team with telehealth options where required, through onsite, telehealth or a blend of both onsite and telehealth input.
- **Scope of practice.**
 - By adapting to the context of each rural setting and its available resources, the training experience and scope of practice can be tailored to trainees.

FPM undertook an evaluation to assess the effectiveness, feasibility and sustainability of the project and flexible accreditation models. Through the evaluation, FPM has developed recommendations to inform future activities and continue to support the project and FATES aims. The findings and recommendations of this evaluation are the subject of this report.

Background

Approximately 27 per cent of Australia’s population live in regional, rural or remote areas (categorised as MMM2-7 areas as defined in the Modified Monash Model) yet Australians living in these areas disproportionately account for 34.4 per cent of those who live with chronic pain.^{1,2}

In rural areas, access to specialist pain medicine physicians (SPMPs) to support and manage people experiencing pain is limited, a similar experience across many specialties.³ Across Australia, 10 per cent of SPMPs work in regional, rural and remote areas (noting the figure decreases to 1 per cent when narrowed to rural and remote areas only).⁴ This limited access to specialist pain care further compounds the impact of pain and its consequences on quality of life and broader society.⁵

Chronic pain costs the Australian economy an estimated \$139 billion annually, with rural Australians experiencing greater impacts due to travel, limited access to pain medicine

services, and delayed treatment.¹ These inequities are compounded by higher rates of opioid prescribing and opioid-related harm in rural settings, where fewer alternatives to specialist pain care exist.⁶ Strengthening rural pain medicine training and workforce capacity is therefore critical to reducing the health, social and economic impacts of chronic pain in rural communities.

FPM conducts the education, training and continuing professional development of SPMPs primarily in Australia and New Zealand. The two-year post-speciality training program takes place in settings accredited by FPM that provide pain care as part of a multidisciplinary team consisting of nurses, clinical psychologists, occupational therapists, exercise physiologists and physiotherapists.⁷

Prior to the commencement of this project, Townsville, Queensland and Hobart, Tasmania were home to the only accredited Australian pain medicine training settings outside a classified MMM1 region.⁸ There are currently 41 accredited training settings in MMM1 regions across Australia. Settings are accredited as Level 1 training settings to provide the full two-year pain medicine training program, or as Practice Development Stage settings, accredited to provide the second year of training only.

Having fewer rural-based training opportunities creates challenges and disadvantages for clinicians and their communities. For rural-based clinicians seeking a career in pain medicine, this often results in a requirement to relocate to a major city (MMM1) to train for at least two years. When this is not feasible, the opportunity to become an SPMP is severely impacted. Moving from a rural area to a major city is a challenge, but it also limits the opportunities to practice pain medicine within rural communities where there is strong demand.¹ For the community, a clinician moving away means that their local healthcare provider is lost temporarily, and sometimes permanently.

Longstanding barriers for accrediting settings outside capital cities relate to limited local supervision capacity, workforce and the ability to give trainees breadth of exposure to the complexity of pain medicine.⁹ Accreditation of pain medicine training settings relies on the presence of a multidisciplinary team with integrated processes who practice within a sociopsychobiomedical framework. Key to this is the requirement for settings to have SPMPs who can directly supervise trainees.

Specialist medical colleges including the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the Royal Australian and New Zealand College of Ophthalmologists (RANZCO) and the Australasian College of Emergency Medicine (ACEM) face similar challenges relating to workforce imbalances across rural areas. They have explored opportunities and developed models to adapt and offer training in rural settings with demonstrated success.^{10,11}

Through provision of the FATES grant by the Australian government, FPM has been able to explore innovative ways to expand accreditation to pain medicine training settings beyond major cities, while maintaining quality and safety standards, and to build local capacity and provide communities with much-needed specialist pain medicine services.

Project aim

The aim of this project was to expand access to pain medicine training beyond major Australian cities into rural areas, building the capacity of rural settings to provide high-quality, specialist pain medicine training and grow the presence of SPMPs in rural areas, through the development of suitable flexible accreditation models.

Appendix 1 outlines the project approach and core activities.

FATES grant objectives

The project was funded by the federal government's FATES program which has the following objectives:¹²

- Improve and promote a positive medical education culture and support quality specialist medical training in regional, rural, and remote Australia.
- Reduce barriers and improve incentives for entering regional, rural, and remote medical practice.
- Improve the imbalance of distribution of the non-GP specialist medical training arrangements and workforce, particularly in areas of unmet need.
- Attract and support First Nations trainees to grow the First Nations workforce towards population parity.

Intended outcomes of the project

The outcomes identified by FPM to achieve the FATES grant objectives were to:

- Understand the barriers within the FPM accreditation standards that impact rural based pain medicine training.
- Determine suitable options for flexible FPM training accreditation.
- Pilot flexible FPM training accreditation options in several rural locations.
- Increase the number of accredited FPM rural training settings.
- Ensure support to each individual rural site and network to successfully train and support trainees without diminishing training quality and safety.

Evaluation objectives

Evaluation is “the systematic and objective assessment of the design, implementation or results of a government program or activity for the purposes of continuous improvement, accountability and decision-making.”¹³ The primary purposes of this evaluation as identified in the grant funding requirements are to measure the impact of the project against the FATES grant objectives and the extent to which the intended outcomes were met.

Through an objective assessment of the project, we can inform decision-making for future projects, document, apply and share learnings, and uphold transparency and accountability to government and key stakeholders.

In alignment with funder needs, the evaluation report includes:

- Post-project analysis, including feasibility and recommendations, of ongoing sustainability without FATES funding, scalability of the project in other locations and for other colleges/specialties, and effectiveness for rural recruitment and retention.
- Analysis of the impact of the project against the FATES grant objectives and outcomes.
- Experiences of participants to determine what worked well and where additional support is required.

Evaluation design and methodology

Design and approach

A process and summative evaluation with a focus on the short-term outcomes was used. Given that there are longer-term outcomes and impacts of this project that are yet to be actualised and therefore are not yet meaningfully measurable, a further review of the project will be required complete a comprehensive assessment of the project's success in achieving these outcomes and their impact. To facilitate the evaluation, a logic model (**Appendix 2**) was developed to articulate the theory of change and support the development of targeted evaluation questions and indicators.

Evaluation questions and indicators were selected based on evaluation scope, funder guidance and measurability, and considered the following categories:¹⁴

- Appropriateness.
- Effectiveness.
- Efficiency.
- Impact.
- Sustainability.

Evaluation scope

The evaluation assesses project successes, linking to objectives and deliverables as detailed in the 2024 and 2025 activity work plans. Given the timing of this report, a process and a summative evaluation of the short-term outcomes were conducted.¹⁴ This is limited to the project activity period of April 2024 – December 2025.

Data collection methods and sources

Quantitative and qualitative data collection methods were employed to collect data required to evaluate the appropriateness, effectiveness, efficiency, impact and sustainability of the project.¹⁴ Quantitative measures such as the number of settings visited and/or accredited, as well as qualitative measures of experiences and perceptions of stakeholders who engaged with the project and consultations and feedback received, are examples of two key indicators that enable measurement of change and reflect the project's theory of change outlined in the logic model (**Appendix 2**).

Data sources utilised to answer the key evaluation questions included:

- Document review (standards, internal data).
- Program data (including informal correspondence with project team).
- Focus groups and written responses to question guides where unable to attend.
- Surveys (initial stages of project, pre- and post- accreditation visit) for supervisors, unit directors and accreditation team members and external stakeholders.
- Administrative and internal workforce data.
- Environmental scan – including a review of both academic literature and grey literature of approaches to specialist medical training in rural areas.

Ethics and data governance

The project team determined that this evaluation was low-risk with respect to data governance and ethics, so separate ethics approval was not required. Principles of upholding participant autonomy and confidentiality were prioritised during data collection by ensuring participation in focus groups and surveys was voluntary, and participants informed about data handling processes – with summary and thematic data presented and individual responses de-identified.

Participants were given information on the purposes of data collection, which was for the development of flexible options and project needs, for evaluation and reporting. To facilitate open discussion, focus groups for trainees were held separately to those with SPMPs and pain unit directors, and discussions were facilitated by an external consultant (Health Management Advisors).

Approaching the data collection in this way facilitated open and honest dialogue and feedback, resulting in more meaningful information that was gathered.¹³ Data collected for the purposes of the accrediting new settings was managed under standard operating procedures for the college.

Evaluation questions

Key evaluation questions to be answered by this evaluation are outlined table 1 below. Questions have been designed to evaluate the project against the five categories of appropriateness, effectiveness, efficiency, impact and sustainability. **Appendix 3** includes a summary table of the key evaluation questions, corresponding indicators and data sources.

Table 1: Key outcome and process evaluation questions.

Evaluation category	Outcome evaluation questions	Process evaluation questions
Appropriateness	<p>To what extent did the project appropriately meet the needs of rural pain medicine setting/s?</p> <p>Have there been any unanticipated outcomes (desirable or undesirable)?</p>	<p>To what extent is the project responding to the identified need/problem?</p> <p>To what extent is the project design suitable to meet desired outcomes?</p>
Effectiveness	<p>To what extent did the project contribute to the program aim?</p> <p>Has it delivered the outcomes sought for participants?</p> <p>Are participants satisfied?</p>	<p>To what extent is the project being implemented as expected?</p> <p>Is the project understood by rural pain medicine settings and SPMPs, governance committees and accreditation teams?</p> <p>To what extent are the rural settings, SPMPs and trainees responding positively to the project?</p>
Efficiency	<p>To what extent did the project have sufficient resources to implement as originally planned?</p>	<p>To what extent are the budget and resources sufficient for effective program implementation and delivery?</p>
Impact	<p>To what extent did the project contribute to the desired change mapped out in the program theory/logic model?</p>	N/A
Sustainability	<p>Have the flexible accreditation options been recognised and endorsed by the relevant governance or authorising bodies?</p> <p>Are key stakeholders supportive of the program and proposing ongoing offering of flexible options to rural settings?</p> <p>Is there a continuation of funding?</p>	N/A

Findings

Appropriateness

FPM conducted a survey across Australian SPMPs and trainees to understand the then current level and distribution of pain medicine service provision, attracting more than 70 responses. The number of responses received was pleasing given this was targeted towards the rural subset of SPMPs and trainees out of the total number of active SPMPs Australia-wide (420) at the time of the survey. The survey responses indicated that access to pain medicine services is greater in major and capital cities, often correlating with locations of accredited pain settings (see **Figure 1**).

Data collected indicated that most pain medicine services were being provided in capital and major cities by metropolitan-based pain specialists. SPMPs who were providing pain medicine services in rural Australia described this service being delivered in a variety of ways:

- Through telehealth.
- Outreach every one to three months.
- Local face-to-face service delivery.

Figure 1 summarises pain medicine service delivery location data collected through the survey and internal data overlaid with the number of accredited pain medicine training settings. At the time that the survey was conducted in 2024, FPM had 420 active Australian-based SPMPs.

As pain medicine is a post-specialist qualification, it is common for SPMPs to practice pain medicine alongside their primary specialty. It is important to note that the number of SPMPs and trainees does not directly correlate to the FTE of the pain medicine workforce in Australia.

Data was therefore triangulated with the then-latest available 2023 National Health Workforce Data Set which reported that there were 246 individual SPMPs in Australia who listed pain medicine as their main speciality or the specialty they worked in the most.⁴

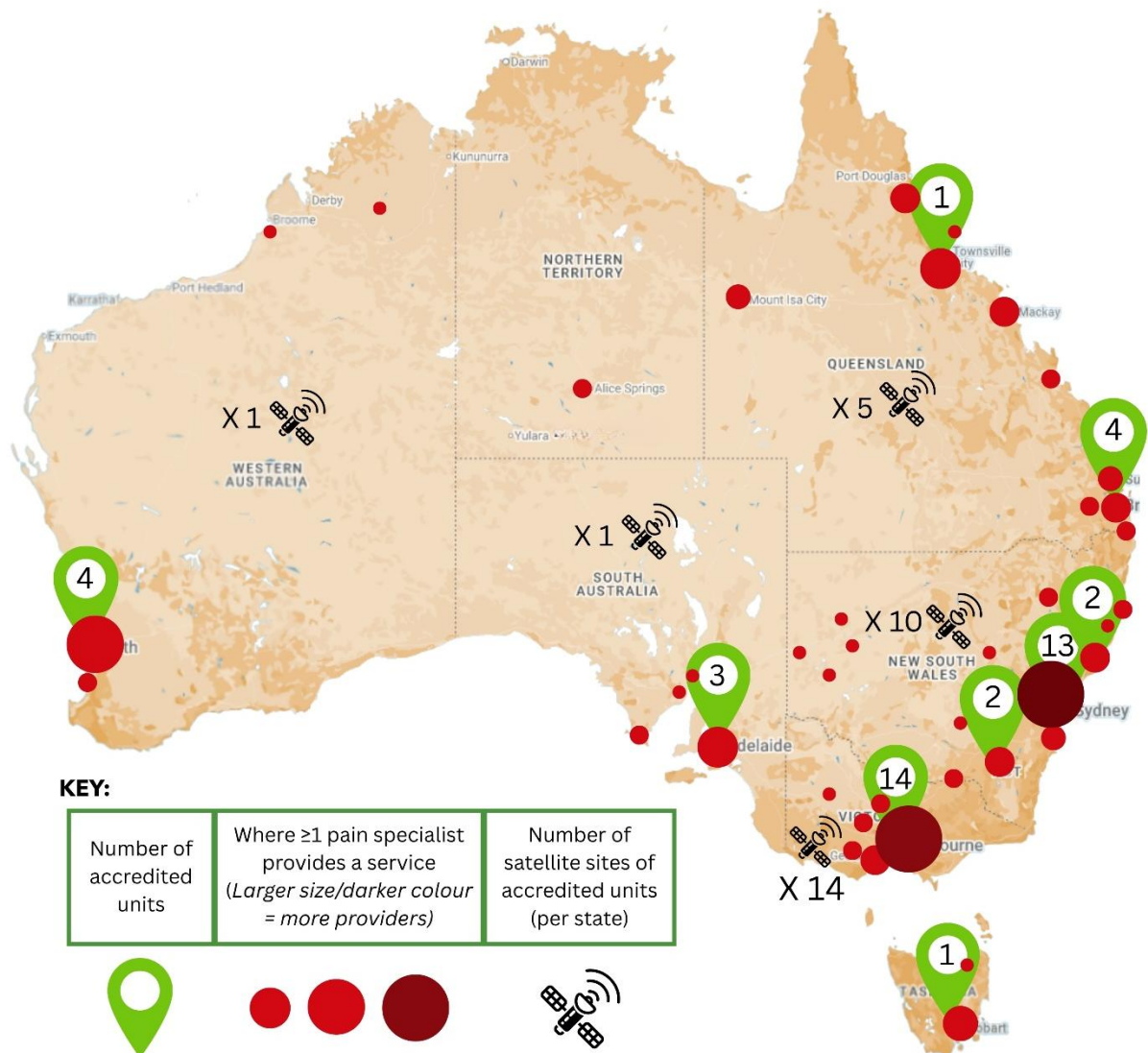


Figure 1: Accredited pain medicine training settings and locations where surveyed pain specialists provide pain medicine services in Australia. Data collected in 2024.

Relevant stakeholders were engaged in the design and review of the flexible options prior to approval. This involved pain settings, unit directors, SPMPs and trainees, across rural and metropolitan areas to get broad input from those who are to be involved in the outcomes and benefit from the project to ensure that the options developed were relevant and acceptable.¹⁶

Similar challenges around rural specialist accreditation were identified through consultations and the environmental scan, with the following key themes (supported with consultation quotes):

- There are scarce SPMPs located in rural areas for supervision.
- There is different access to multidisciplinary team members and resources across rural contexts.
 - *“Regional pain practice is different to [the] city. I have worked in a regional pain set up...few pain specialists, different access to all allied health, different access to imaging.” (direct quote from FPM trainee)*

- There are often insufficient/different patient cohort exposures at individual rural settings.
- There are funding challenges both for rural settings and for prospective trainees.
- Flexibility for trainees is an enabling factor.
 - *“Having a flexible training option for rural doctors in SA will definitely increase interest in pain training.” (direct quote from FPM trainee)*

Appendix 4 contains the environmental scan and consultation outcomes.

Together, the background research and consultations culminated in the development of four flexible opportunities that prospective rural training settings could request:

- Training locations and networks.
- Blended and remote supervision.
- Onsite and telehealth-provided multidisciplinary team members.
- Scope of pain medicine practice, enabling sites to adapt to the rural context.

There were differing views around offering flexibility to rural settings to provide training in the first year or whether this should be limited to training in the second year of the pain medicine training program. This difference stemmed primarily from concerns around maintaining training quality, safety and ensuring trainees received a training experience aligned to the full curriculum.

The flexible options developed did not supersede the FPM accreditation requirements that apply to all training settings, negating the risk of *“lowering standards”* or creating a *“two-tiered system”*. The options were also developed to enable a spectrum of flexibility based on a unit’s needs.

Applications primarily originated from MMM2 areas and one from an MMM3 area. MMM2 settings which were visited by accreditation teams gave positive feedback around the suitability of the flexible options to their settings.

- *“Very valuable...[the] pilot program put our process into fast track.” (direct quote from rural pain unit director)*
- *“It will assist in incorporating pain medicine services in [MMM3 and MMM4 satellite sites] into a more integrated service.” (direct quote from rural pain unit director)*
- *“Flexible options were appropriate in our setting.” (direct quote from rural pain unit director)*

Two positive unanticipated outcomes were observed as a result of this project:

- **Funding:** One newly-accredited setting was successful in a state-based grant to partially fund a pain medicine trainee salary for two years. This was subject to accreditation and addressed an identified barrier for the unit to fund a trainee and therefore be able to recruit.
- Settings which expressed interest and those who were visited expressed that the offer of flexibility to achieve the accreditation standards was in itself was beneficial and encouraged them to apply at the time they did.
 - *“The pilot scheme was the primary reason why we decided to apply for accreditation for flexible training at this point of time. If the pilot scheme was*

*not there, I do not believe that we would have gathered the courage to apply.”
(direct quote from rural pain unit director)*

Conclusion:

The project directly responded to a clearly identified need. The cohort of SPMPs is small, and there are even fewer SPMPs providing specialist pain care in rural settings where there are limited rural opportunities to train. The project sought to address the accreditation element as an opportunity to grow the number of rural-based SPMPs.

The project delivered practical and realistic flexible accreditation options that were able to be operationalised and assisted rural pain medicine settings to achieve accreditation.

Effectiveness

All activities FPM outlined in the activity work plans were completed as intended and on time. **Table 2** summarises the intended project outcomes and how these have been achieved through the project.

Table 2: Summary of intended project outcomes and how this has been achieved.

Intended outcome	How this has been achieved
<p>Understand the barriers within the FPM accreditation standards that impact rural based pain medicine training.</p>	<ul style="list-style-type: none"> • An environmental scan reviewed the FPM accreditation standards, peer-reviewed and grey literature and other specialist medical colleges’ rural training initiatives. • Wide consultation with pain medicine SPMPs, trainees, pain unit directors and rural settings. • These approaches enabled identification of relevant barriers and enablers to rural pain medicine training. A detailed report is contained in Appendix 4.
<p>Determine suitable options for flexible FPM training accreditation.</p>	<ul style="list-style-type: none"> • Four flexible options were developed and piloted in rural training settings following consultation with key stakeholders and based on the environmental scan. • All flexible accreditation options were approved by FPM governance bodies for pilot.
<p>Pilot flexible FPM training accreditation options in several rural locations.</p>	<ul style="list-style-type: none"> • Five expressions of interest in the pilot (from MMM1-4 regions) were received, translating into four applications. Two settings (MMM2) were visited for accreditation purposes (located in Victoria and Queensland), employing elements of blended supervision and multiple training locations. <p>Notes: One application was from a setting based in an MMM1 region with periodic outreach to an MMM3 location. This application was deemed ineligible for this pilot but will be progressed under the standard FPM accreditation process.</p> <p>One application from a MMM3 setting was identified as not meeting the accreditation standards via the initial paper review. The setting has been provided with support and guidance on the standards it needs to achieve to allow them to re-apply when they meet the standards.</p>
<p>Increase the number of accredited FPM rural training settings.</p>	<ul style="list-style-type: none"> • The number of FPM-accredited MMM2+ settings increased from two (prior to project commencement) to three, with a potential fourth unit pending decision by the accreditation committee in March 2026. • One Victorian setting was accredited as a Level 1 training site. This will allow a trainee to complete the full pain medicine training program locally with a pain medicine training position now established.

This project demonstrated its effectiveness in supporting the accreditation of an MMM2 setting to provide the full pain medicine training program, representing an increase of rural FPM-accredited settings from two to three, with a potential fourth setting pending decision.

Feedback from rural stakeholders and settings involved in the project was positive. Settings felt aware and supported through the pilot process.

- *“We were well informed about the flexible accreditation pathway. And also well supported by the officers and the staff in charge.” (direct quote from rural pain unit director)*
- *“The support during the accreditation application process was simply superb.” (direct quote from rural pain unit director)*
- *“[The] process went very smoothly.” (direct quote from rural pain unit director)*

There was also a sense of appreciation expressed that FPM was exploring ways to make accreditation achievable for rural pain medicine settings. This sentiment was shared between settings involved in the pilot and stakeholders who engaged in consultations. Engagement with rural external stakeholders including emergency medicine fellows and general practitioners at conferences also provided an opportunity to increase awareness of the demand for chronic pain services and hear first-hand experiences from rural-based clinicians.

- *“Thanks for exploring more opportunities for rural training and services.” (direct quote from rural emergency medicine specialist conference survey respondent)*
- *“Thank you for specifically considering regional/rural training. Access to pain services particularly for chronic pain is very difficult in my setting.” (direct quote from rural emergency medicine specialist conference survey respondent)*

FPM stakeholders and governance committees received regular communications around the progress of the project and key milestones to encourage engagement in the consultations and attract applications from rural settings. Indications of project understanding based on feedback type and queries received, suggested that there was a good understanding of the key project aim to support and expand rural pain medicine training.

Conclusion:

The number of FPM accredited rural pain medicine training settings increased for the first time in several years and a new rural training position has already been established, demonstrating early success in achieving the overall project aim.

Feedback from stakeholders has been positive. Settings reported feeling well-informed, supported, and encouraged and there is broader appreciation that FPM is taking initiative to address rural needs.

The project met all its intended outcomes and activities it set out to do as outlined in the activity work plans.

Efficiency

All activities laid out in the activity work plans were completed on time and within budget. Some activities were completed earlier than anticipated, such as the first accreditation process, enabling the setting to apply for and secure funding for a trainee to begin training at the start of the 2026 hospital training year.

Adaptation from in-person to online governance meetings reduced time and travel costs for the project working group, enabling funds to be reallocated with funder approval to develop additional resources to enhance delivery against project objectives:

- A cultural safety training resource for accreditation teams was delivered.
- Video and media series developed with rural-based SPMPs to encourage potential trainees to consider rural pain medicine training.

Conclusion:

The efficient use of resources enabled the completion of all planned activities on time and deliver additional valuable resources to support rural settings in recruitment and retention, supporting rural pain medicine training beyond accreditation of settings alone.

Impact

The timing of this evaluation permits an assessment of the short-term outcomes rather than the longer-term impacts illustrated in the logic model (**Appendix 2**). The early measurable impacts of the project have been evaluated with respect to each of the FATES grant objectives, described in table 2.¹²

Table 3: Impacts of the project with respect to the FATES grant objectives.

FATES grant objective	Impacts
FATES grant objective 1: Improve and promote a positive medical education culture and support quality specialist medical training in regional, rural, and remote Australia.	<p>The project increased visibility and awareness of rural training possibilities. Rural-based SPMPs and settings articulated feeling “encouraged” and “valued” through the focus on supporting rural pain medicine accreditation. Engagement with this project identified opportunities for rural rotations for several metropolitan-based accredited training settings.</p> <p>Trainees’ engagement enabled concerns and challenges from potential trainees to be identified and managed, and benefits of rural training and practice experiences to be platformed.</p> <p>FPM developed a high-quality video series with three rural-based SPMPs as part of this project to use as a promotional tool to attract and recruit pain trainees and specialists by providing insight into what it means to be a rural-based pain physician.</p>

<p>FATES grant objective 2: Reduce barriers and improve incentives for entering regional, rural, and remote medical practice.</p>	<p>Through identifying barriers and opportunities for rural accreditation, several implementable flexible options were developed consultatively. The offer of flexible options through the pilot reduced perceived structural barriers to accreditation which has been described as traditionally developed with a “metro-centric” lens and opened opportunities that are being explored in other specialist medical colleges.^{9,10,11}</p> <p>The offer of flexibility itself was an enabler for rural settings to apply for accreditation at the time they did, and this also addressed the barrier to accessing funding through a state-based grant for one setting, enabling at least one rural trainee salary to be funded.</p> <p>Funding challenges were regularly raised by trainees, settings and SPMPs as a barrier. Exploring and managing this challenge was not within the scope of the project and remains a challenge to employment and growing the rural pain medicine workforce.</p>
<p>FATES grant objective 3: Improve the imbalance of distribution of the non-GP specialist medical training arrangements and workforce, particularly in areas of unmet need.</p>	<p>It is too early to substantially measure the impact against this objective, however there are early positive signals.</p> <p>Two accreditation processes were undertaken during the pilot with one setting (Victoria) receiving accreditation and the decision on the second setting (Queensland) pending the next accreditation committee meeting. The settings visited are based in MMM2 locations, and do not include any remote sites. It was anticipated that applications would not be received from more remote areas as we do not have any remote-based SPMPs to provide supervision or settings that could provide a multidisciplinary training experience.</p> <p>For the accredited rural Victorian setting, three satellite sites (up to MMM4) form part of their accreditation where a trainee will have the opportunity to practice in a “hub-and-spoke” model. This model links smaller sites (the “spokes”) with a larger centre (the “hub”), and over time the capacity and service delivery across those satellite sites can be strengthened.¹⁷</p>
<p>FATES grant objective 4: Attract and support First Nations trainees to grow the First Nations workforce towards population parity.</p>	<p>The Medical Board of Australia’s 2025 Medical Training Survey findings report that Aboriginal and Torres Strait Islander trainees disproportionately report experiences of racism and discrimination, therefore ensuring cultural safety in training, assessment, and accreditation processes is key to increased attraction and retention.^{3,18}</p>

	<p>During the project, a targeted training opportunity was identified and supported within the existing funding for the project. FPM worked with Karabena Consulting to produce cultural safety resources to support accreditation teams.</p> <p>The work builds on resources that FPM currently uses as part of its cultural safety training. More specifically, the resource aims to reduce the possibility that accreditation teams unintentionally contribute to “cultural unsafety” during an accreditation visit. The resource is intended to equip clinicians to address potential gaps and opportunities to improve cultural safety for First Nations’ doctors and doctors in training through their role during accreditation visits and assessments.</p> <p>Continued support to encourage First Nations’ clinicians into pain medicine training pathways is guided by ANZCA’s Reconciliation Action Plan. This work supports growing our First Nations’ workforce, increasing cultural safety and responsiveness and strengthening relationships.¹⁹</p>
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Sustainability

The flexible accreditation options were endorsed for pilot by FPM governance committees in February 2025.

Stakeholders including SPMPs, trainees and rural settings expressed support for the program and initiative to improve access to rural pain medicine training.

- *“Accreditation for training is the opportunity for the faculty to support potential training units develop the evidence-based multidisciplinary [care] to [be able to] assess and manage patients with a variety of pain presentations.” (direct quote from accreditation team member)*
- *“This will create the opportunity to expand pain medicine services and help deliver clinical services closer to home – a key health objective.” (direct quote from rural pain unit director)*

Beyond the pilot, the offer of flexibility itself does not require specific funding as the costs for the accreditation process are covered by FPM. From this perspective, continuing to offer the flexible accreditation options to rural settings is feasible and sustainable.

Key to success of this project has been the funding to cover a dedicated staff member to support and engage SPMPs and rural settings. This additional support will not be continued beyond this project which may result in a reduced number of accreditation applications from rural pain medicine settings.

The flexible accreditation options were developed in tandem with the National Health Practitioner Ombudsman (NHPO) model accreditation standards. FPM will implement the

standards in 2027, and it is anticipated that the flexible accreditation options piloted during this project will align and be able to be offered under the model accreditation standards.

The nature of the flexible accreditation options means that settings choose the flexibility that suits their context and needs. The flexible options are not prescriptive, rather they are designed to exist on a spectrum for settings to tailor accordingly. Employing remote supervision for instance may be for fractional FTE support or to support satellite sites, and fractional FTE support across multiple settings or sites may potentially be provided by one centralised supervisor. This flexibility in how the options are implemented by rural settings lends itself to expanding the availability of those flexible options to include both Australian and New Zealand rural settings, aligned with the binational college within which FPM operates.

Leading clinicians at the newly-accredited setting have established relationships with larger tertiary centres for other specialist disciplines from which they have benefitted and have expressed desire to do the same for pain medicine. Rural settings accredited through the pilot for standalone accreditation may consider establishing a relationship with a larger tertiary hospital to strengthen the setting and build long-term sustainable accreditation. Through the offer of flexibility and promotion of the project, interest was also attracted from metro units seeking to include regional satellite sites, demonstrating that there is some appetite to collaborate across regions.

In the context of the project and FATES aims, it is appropriate to consider the accreditation of rural settings alongside the prospective recruitment of a trainee given that the purpose of accreditation is to enable training. Funding to support trainee positions as well as relocation, travel and other costs were cited by participants as other related challenges to rural training.

- *“Specialists are stretched, and it’s not financially viable to take a trainee on.” (direct quote from FPM trainee)*
- *“I would love to go back to training and provide a service. However, lack of access to supervisors and support of state government funding pain services limits this.” (direct quote from FPM trainee)*

Funding is therefore an ongoing consideration to support settings to recruit and assist trainees.

Conclusion:

Flexible accreditation options were endorsed for the pilot by governance committees and are now under consideration for long-term ongoing availability.

Stakeholders including rural settings, SPMPs and trainees expressed support for the program and initiative to improve access to rural pain medicine training.

There is no ongoing cost barrier to offering the flexible options to rural settings.

Beyond accreditation, funding of trainee positions and costs is an ongoing barrier.

When there is dedicated FPM staff resourcing to engage and support rural initiatives, there is a positive contribution and input from SPMPs and trainees.

Limitations

This evaluation provides important insights into the early effectiveness and feasibility of the flexible accreditation options, however several limitations should be acknowledged which affect the generalisability of findings and the certainty with which longer-term conclusions can be drawn.

Timing of the evaluation

The timing of the evaluation constrained the ability to assess medium- and long-term outcomes. At the time of data collection, only one rural setting had been accredited to deliver the full pain medicine training program, and one further setting was pending decision. The newly-accredited setting had successfully established its first training position but as a trainee has not yet progressed through the training program, it is not possible to evaluate trainee experiences, training quality, or the impact of the flexible accreditation options on training outcomes or workforce retention. Ongoing monitoring through the ANZCA's existing college-wide framework and annual monitoring submissions to the Australian Medical Council will facilitate capturing these outcomes.

Utilisation of flexible accreditation options

Only two of the four flexible accreditation options were utilised by participating settings (training location and networks, and remote supervision). No settings requested flexibility for telehealth-based multidisciplinary team input or scope-of-practice adjustments as they had the capacity on site. This may suggest where flexibility is most valuable, however the small sample prevents firm conclusions. As a result, this evaluation cannot assess the impact of the unutilised flexible options. Their effectiveness may become measurable if adopted by future rural settings.

Geographic distribution of participating settings

The geographic distribution of participating settings also limit generalisability. All applications were located in MMM2 regional centres in eastern Australia, with affiliated satellite sites extending to MMM4 areas. No applications were received from MMM5–7 regions which was anticipated as there are no pain medicine settings currently in these locations. This means the evaluation cannot determine the suitability or effectiveness of flexible accreditation options beyond MMM4 regions, where staffing, case-mix and supervision and service capacity differ significantly.

Perception of training quality

Perceptions on whether rural settings could ensure training quality varied among stakeholders. While many stakeholders expressed support for the project and appreciation for FPM's efforts to grow rural capacity through accreditation, some stakeholders expressed uncertainty around the capacity of rural settings to deliver the full training program. This highlights the importance of ongoing communication, education and visibility of successful rural training outcomes.

Data collection

The evaluation encountered some data collection challenges. A formal survey distributed to consultation participants attracted no responses, limiting access to standardised process-related feedback. As a result, the evaluation of these elements relied on data including informal communications, email and phone feedback, conference discussions and relevant themes from focus groups. While feedback received across these sources was broadly positive, the implication is that this may not be representative of all the full scope of stakeholders' perspectives.

Sample size

Finally, the sample size of participating rural settings was small, with two settings visited and three rural applications in total (excluding the MMM1 applicant). This reflects the small number of active SPMPs nationally, particularly outside MMM1 settings. The implication of the small sample size of settings meant that not all flexible options were piloted as they were not perceived to be required by the settings which applied. Evaluation findings should therefore be considered as early signs of success.

Conclusion

The evaluation demonstrates that offering flexible options for pain medicine accreditation in rural settings is effective for expanding access to pain medicine training outside of major (MMM1) Australian cities. The offer of flexibility itself encouraged rural settings to take the step forward to apply for accreditation, resulting in the accreditation of the first rural pain medicine training setting in several years.

Remote supervision and training locations were consistently requested areas of flexibility, highlighting elements where there may be the most need. The project has demonstrated early successes and expanding access to flexible options to rural settings beyond the pilot is a cost-effective opportunity. Continued support of rural settings will support building capacity in rural areas and work towards addressing workforce distribution challenges through accreditation, ultimately enabling greater access to specialist pain medicine services.

Recommendations

The project identified three recommendations.

1. Extend availability of flexible accreditation options

That FPM makes the flexible accreditation options available for utilisation beyond the pilot period, extending them to all rural pain medicine settings.

Link to findings: The lack of rural pain medicine training opportunities is contributing to the lack of rural-based SPMPs. The flexible options have had positive feedback from rural settings and demonstrated feasibility and effectiveness in increasing the number of rural accredited training sites.

Resources required: In itself, extending the availability of the of the flexible accreditation options does not attract direct additional costs. Additional funding to support dedicated staff

would sustain the high level of rural engagement, visibility and support for rural settings that were fostered through the project.

2. Continue to strengthen engagement to address rural pain medicine workforce needs

That FPM collaborates with relevant health departments, organisations and other specialist medical colleges, to continue addressing rural specialist pain medicine workforce shortages and promote these initiatives to ensure visibility and engagement across stakeholder groups. This includes:

- Promoting and encouraging positive perceptions around rural training and practice. Cultural shifts and changes in perceptions take time, and consistent efforts across the sector are needed to progress this.
- Exploring opportunities to collaborate with other specialist medical colleges and potential pain medicine trainee cohorts including general practitioner colleges and fellows who often manage people experiencing pain in rural settings when there is minimal or no access to SPMPs.
- Developing project proposals to create and enable additional rural training opportunities.
- Ensuring visibility of these efforts, projects and rural initiatives with rural stakeholders; this grows trust in FPM's prioritisation of rural training and service needs and encourages contribution to projects and opportunities to collaborate are identifiable to stakeholders.

Link to findings: Develop and build on activities in alignment with FATES objectives (and ANZCA's rural workforce strategy) and rural workforce priorities.

Resources required: In alignment with ANZCA's rural workforce strategy, efforts to implement this recommendation apply to activities carried out across the whole college, requiring staff capacity. Advancing potential future projects to continue to grow and support rural pain medicine will require funding.

3. Engage with and provide ongoing support to rural settings considering accreditation

That FPM supports aspiring rural training settings, including those that applied during the pilot but were not yet able to meet accreditation requirements, by offering guidance, planning support, and facilitating collaboration across services if appropriate.

Link to findings: Builds future rural training capacity where there is appetite and supports access to the accreditation process and subsequent access to funding supports.

Resources required: FPM staff capacity is required to sustain engagement with rural settings that were involved in the project and continue to grow interest and build capacity in potential future settings.

Next steps

This project has confirmed that targeted investment in rural pain medicine is both necessary and strategically aligned with broader rural health workforce priorities. Consultation findings, conference engagement and the environmental scan have identified practical, scalable opportunities to strengthen rural pain capability across the care continuum.

To translate the gains of this initiative into sustained impact, continued partnership and targeted funding will be required.

1. Strengthening rural specialist training capacity

A consistent finding across jurisdictions was that rural training expansion is constrained not by demand, but by structural and funding limitations.

Key barriers identified include:

- Limited funded trainee posts in rural services.
- Insufficient resourcing to support SPMP supervision.
- High clinical demand in private and mixed practice settings, limiting capacity to absorb training without financial support.

Dedicated funding to establish and maintain accredited rural training posts, alongside structured support for supervisory time, would directly strengthen the regional specialist pipeline. This would improve workforce distribution and contribute to long term sustainability of specialist pain services outside metropolitan centres.

Without targeted investment in these areas, rural training growth will remain constrained despite clear interest and need.

2. Building pain management capability across the rural workforce

The project also highlighted the central role of general practice and other rural specialists in the management of chronic pain.

General practitioners are typically the first and often ongoing point of contact for patients living with chronic pain in rural communities. While experience and confidence vary, there is appetite among rural clinicians to develop their skills further in ways that align with local service models, career stage and workload realities.

This presents a strategic opportunity for government-supported development of a flexible, tiered education model that:

- Enhances pain management capability without requiring completion of a full specialist fellowship.
- Provides modular, evidence-informed training aligned to priority areas of rural need.
- Supports tailored learning pathways based on scope of practice and community context.
- Strengthens integration with specialist referral pathways.

Potential delivery models may include blended learning, short accredited courses, micro credentials, regional supervision hubs and digitally enabled case-based networks.

Implementation of such models would require dedicated and sustained funding to support curriculum development, faculty engagement, supervision frameworks, digital infrastructure and evaluation. With appropriate investment, this initiative would represent a cost effective, system level intervention to improve early management of chronic pain and reduce inequity in access to care.

3. Diversifying the rural specialist pipeline

The project identified an additional, practical opportunity to expand the rural specialist workforce through improved visibility of specialist pain medicine training pathways.

Historically, pain medicine evolved within anaesthesia, and this legacy continues to influence perceptions of eligibility. Engagement with rural clinicians revealed that some non-anaesthetist specialists with an interest in pain medicine were unaware that they were eligible to apply for training.

Targeted promotion of the training pathway to eligible rural specialists represents a low cost, high impact strategy to:

- Diversify entry pathways into the specialty.
- Increase regional uptake of specialist training.
- Strengthen interdisciplinary breadth within pain medicine.
- Improve geographic distribution of the specialist workforce.

This initiative would complement funded training expansion and contribute to a more resilient and locally embedded rural pain workforce.

Continued government support would enable:

- Expansion of funded rural training posts and supervisory capacity.
- Development of flexible, evidence informed rural education pathways.
- Diversification of the rural specialist pipeline.

Together, these measures would strengthen rural workforce sustainability, improve equity of access to pain care and deliver long term value to regional communities.

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