



Support Scheme for Rural Specialists



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## SUPPORT SCHEME FOR RURAL SPECIALISTS

# Round FIVE Final Report

May 2005 to 30 April 2006

**Committee of Presidents  
of Medical Colleges**



**Australian Government**  
**Department of Health and Ageing**

Report produced by the CPMC appointed Project Management Unit

**SSRS PMU**

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# TABLE OF CONTENTS

## Section ONE

- 1.1 Background
- 1.2 Project Objectives
- 1.3 Contractual Arrangements
- 1.4 Project Management Committee
- 1.5 Project Management Unit

## Section TWO

- 2.1 Communication Strategy
- 2.2 Website
- 2.3 Newsletters
- 2.4 Annual Scientific Meetings
- 2.5 Promotional Material
- 2.6 SSRS Forum
- 2.7 SSRS Forum Media Release

## Section THREE

- 3.1 Round Five Project Assessment Panel
- 3.2 Round Five Projects
- 3.3 Round Five Project Statistics
- 3.4 Round Five Project Results
- 3.5 Round Five Project Limitations and Constraints
- 3.6 Round Five Project Recommendations
- 3.7 Project Extensions

## Section FOUR

- 4.1 Program Results
- 4.2 Program Recommendations

## Section FIVE

- 5.1 Project Expenditure
- 5.2 Project Management Unit Expenditure
- 5.3 Future Direction of the SSRS

## Tables

- Table One** SSRS Projects and Project Funding Rounds One to Five
- Table Two** PMC Meetings held during Round Five of the SSRS
- Table Three** E-Newsletters in Round Five
- Table Four** Printed Newsletters in Round Five
- Table Five** SSRS representation at College and Faculty Annual Scientific Meetings
- Table Six** Round Five SSRS Projects
- Table Seven** Statistics on the type of events, mode of delivery, level of activity and number of participants for each project
- Table Eight** Leap Framework
- Table Nine** Project Resources developed during Round Five
- Table Ten** Round Five Projects: Budget and Expenditure
- Table Eleven** Project Management Unit Budget and Expenditure

## ATTACHMENTS

1. Funding Agreement between the Australian Government and Committee of Presidents of Medical Colleges
2. Funding Agreement between the Commonwealth Department of Health and Ageing and Specialist Medical Colleges (Held by DHA)
3. Funding Agreement between the Committee of Presidents of Medical Colleges and Royal Australasian College of Physicians
4. Project Management Committee Membership and Terms of Reference
5. Agenda and Minutes of the Project Management Committee
6. SSRS Communication Plan
7. Rural Specialist Website Traffic Reports
8. Rural Specialist Website Pages
9. SSRS Electronic Newsletters
10. SSRS Printed Newsletter
11. SSRS Promotional Postcard
12. SSRS Blue Bag (Not included)
13. Sticky Note Pad
14. Copy of SSRS Forum Workbook
15. SSRS Forum Media Release
16. Principles and Guidelines for Accessing Project Funding and Application Form
17. Round Five Project Assessment Panel Report and Project Assessment Panel Membership
18. Final Report Project Abstracts
19. Audited Financial Project Statements (to be sent by CPMC)
20. Audited Financial Statement PMU

## ACRONYMS

CPD	Continuing Professional Development
CPMC	Committee of Presidents of Medical Colleges
DHA	Commonwealth Department of Health and Ageing
HIMH	Hunter Institute of Mental Health
PMC	Project Management Committee
PMU	Project Management Unit
SSRS	Support Scheme for Rural Specialists

### Colleges

ANZCA	Australian and New Zealand College of Anaesthetists
ACD	The Australasian College of Dermatologists
ACEM	The Australasian College for Emergency Medicine
RACMA	The Royal Australasian College of Medical Administrators
RANZCOG	The Royal Australian and New Zealand College of Obstetricians & Gynaecologists
RANZCO	The Royal Australian and New Zealand College of Ophthalmologists
RCPA	The Royal College of Pathologists of Australasia
RACP	The Royal Australasian College of Physicians
RANZCP	The Royal Australian and New Zealand College of Psychiatrists
RANZCR	The Royal Australian and New Zealand College of Radiologists
RACS	Royal Australasian College of Surgeons

## SECTION ONE

### 1.1 Background

The Support Scheme for Rural Specialists (SSRS) has been designed to provide continuing professional development opportunities for specialists practising in rural areas of Australia. The SSRS was initiated following a report commissioned in December 2001 by the Office of Rural Health of the Australian Department of Health and Ageing (DHA). The consultant undertook research in order to provide advice to the DHA about the types of strategies that would effectively attract and retain specialists in rural areas, and appropriate ways to deliver this support, to assist in future policy planning.

The research found the following main incentives for rural specialist practice were:

- attractions of a rural lifestyle
- opportunities for professional autonomy and scope of practice
- financial rewards
- opportunities to work as part of a multi-disciplinary team

Key disincentives included:

- negative image of rural lifestyle and practice
- undergraduate selection processes that favoured metropolitan students
- lack of exposure to rural practice in post graduate education
- professional isolation, long hours of work and on call demands
- poor infrastructure support and back up and lack of locum relief
- spouse and family issues
- pessimism about the viability and future of rural practice
- the barriers to re-entry to metropolitan practice
- the problems associated with solo practice
- financial issues such as higher establishment costs and lower remuneration than in metropolitan areas
- the stigma attached to and lack of recognition of rural practice
- the lack of access to continuing medical education activities
- the increasing sub-specialisation of specialist medical practice
- the need for generalist specialist training to meet the demands of rural practice

A number of options for dealing with the disincentives were cited. The development of a critical mass of specialists, at least two specialists of the same discipline in one location, was seen as crucial to sustainability. Critical mass was seen to have the potential to overcome some of the disincentives of professional isolation including lack of locum support and work life balance.

The report also highlighted that telehealth was seen as having the potential to improve the access of rural primary health practitioners to specialist advice. In addition, attracting people with a rural background into specialist training and establishing specialist training posts in rural and regional areas were seen as a useful strategy. The disincentives attached to rural practice could be overcome by including rural experience during training.

Other themes highlighted relating to unmet need of rural specialists included: opportunities for professional development, continuing medical education and up skilling in tertiary teaching hospitals, adequate relief, locum support, and peer support, sufficient funding for trainee and rural specialist positions, family and spouse support and employment and financial support.

Following on from the findings of this report, the DHA funded the Committee of Presidents of Medical Colleges (CPMC) to develop and implement what is now known as the Support Scheme for Rural Specialists. This Scheme was developed to address issues highlighted in the consultancy report including access to professional development, continuing medical education and peer support.

During the first full year of the program in 2003, 22 projects were funded that provided continuing professional development opportunities for rural specialists. Following on from the success of the program in its first year, the Australian Government committed further funds to continue the program

and in 2006 has agreed to fund a sixth round of projects. Table One outlines the number of projects and project funding component of the SSRS from Round One to Round Five.

**Table One: SSRS Projects and Project Funding Rounds One to Five**

Round	Number of Projects	Total Funding
One and Two	22	\$2,326,170
Three	21	\$2,054,000
Four	6	\$568,298
Five	23	\$1,833,000
<b>TOTAL</b>	<b>72</b>	<b>\$6,781,468</b>

## 1.2 Project Objectives

The SSRS aims to increase access to continuing professional development (CPD) for rural specialists and to decrease their sense of professional isolation by providing CPD opportunities. The specific objectives of the SSRS are to:

- a) Provide professional support to medical specialists practising in rural and remote areas of Australia, including through continuing professional development and peer support;
- b) Identify future training and capacity building practices for rural specialist services in rural and remote areas of Australia.

## 1.3 Contractual Arrangements

The Australian Government entered into a funding agreement with the CPMC to coordinate and implement the SSRS. The Australian Government also has funding agreements with each Specialist Medical College for individual projects. The Royal Australasian College of Physicians (RACP) was subcontracted by the CPMC to implement and manage the scheme. Copies of the Contracts for Round Five of the SSRS can be found at *attachments 1, 2 and 3*.

## 1.4 Project Management Committee

The Project Management Committee (PMC) is responsible for the overseeing the operation and implementation of Program Objectives and of the Project Management Unit (PMU), funded by the Scheme. This Committee is also responsible for ensuring contractual compliance and the efficient use of project resources with the objective of achieving valuable professional development outcomes for rural specialists.

The PMC is comprised of the DHA representative, the Chair of the CPMC nominated members, the SSRS Program Director, four CEOs of Specialist Medical Colleges and four specialists with expertise and knowledge in rural and remote practice. The Chair of the CEO sub-group of the CPMC along with the Project Management Unit and representatives from the HIMH are also in attendance at PMC Meetings.

In April 2005, five nominations were received from Specialist Medical Colleges for Fellows to join the PMC. Applicants were considered based on their involvement in rural practice, education and continuing professional development. In January 2006, Professor Michael Cousins was elected Chair of the Committee of Presidents' of Medical Colleges, hence becoming the Chair of the SSRS PMC. The Terms of Reference and membership of the PMC, which were established in 2002 at the commencement of the SSRS, were revised in May 2005. The current PMC Terms of Reference and membership listing can be found at *attachment 4*.

Throughout Round Five, the PMC has met on seven occasions including one face-to-face meeting and six teleconferences. As the model of the Round Five program reflected that of previous years, the need for strategic planning was minimal. The Agendas and Minutes from these meetings are at *attachment 5*. Table Two lists the PMC meetings held during Round Five of the SSRS.

**Table Two: PMC Meetings held during Round Five of the SSRS**

<b>Meeting</b>	<b>Chair</b>	<b>Date</b>
Teleconference	Dr Andrew Child	22 February 2005
Teleconference	Dr Andrew Child	26 April 2005
Teleconference	Dr Andrew Child	21 June 2005
Face to Face	Dr Andrew Child	2 August 2005
Teleconference	Dr Andrew Child	14 November 2005
Teleconference	Professor Michael Cousins	23 January 2006
Teleconference	Professor Michael Cousins	3 April 2006

### **1.5 Project Management Unit**

The Project Management Unit (PMU) was established to coordinate the development, implementation and day-to-day management of the SSRS. Until January 2006, the PMU consisted of the National Program Director and Program Manager. Following a review of the staffing complement required to most effectively support the SSRS and given that the SSRS is in the phase of maintenance rather than growth, several staffing changes were made. This included the appointment of a Senior Project Officer 0.8 FTE. These changes identified some savings within the salary component of the budget.

## SECTION TWO

### 2.1 Communication strategy

A Communication Plan was approved by the Project Management Committee in August 2005. The plan identifies a number of strategies to promote the activities of the SSRS, encourage participation and provide information to specialists to consider their future CPD needs. The Communication Plan has resulted in the publication of a variety of resources as detailed below and the production of a number of promotional materials. The Communication Plan is at *attachment 6*.

### 2.2 Website [www.ruralspecialist.org.au](http://www.ruralspecialist.org.au)

The SSRS website continues to be a valuable source of information for many rural specialists and medical colleges. The website was redesigned early in 2005 and now contains a content management system to assist with promoting the most recent information. Historical project details are now also included.

The menu items featured on the website include:

- |                 |                  |              |
|-----------------|------------------|--------------|
| ▪ Home          | ▪ Events         | ▪ Projects   |
| ▪ Resources     | ▪ About the SSRS | ▪ Contact us |
| ▪ Message Board | ▪ E-Newsletter   | ▪ Link       |

The current web pages are at *attachment 8*.

The website traffic reports indicate the following summary statistics for the Round Five project period.

Average unique people using the website per month	234
Average visits per month	287
Average pages viewed per visit	4
Most popular pages visited	Default (home), projects, events, resources, archive details, e-Newsletter
Most common referral domains	Google, Ninemsn, College websites and the DHA website
Most frequent search terms included	Rural, SSRS and Doctor

Website total hits per month

Jun 2005	Jul 2005	Aug 2005	Sep 2005	Oct 2005	Nov 2005	Dec 2005	Jan 2006	Feb 2006	Mar 2006	Apr 2006
376	260	293	317	267	234	228	257	316	332	274

Percentage of new visitors per month (%)

Jun 2005	Jul 2005	Aug 2005	Sep 2005	Oct 2005	Nov 2005	Dec 2005	Jan 2006	Feb 2006	Mar 2006	Apr 2006
4.76	8.18	11.35	14.29	7.08	11.7	9.0	8.1	10.19	10.14	10.68

Top five page views in Round Five

Page	INDEX	PROJECTS	EVENTS	RESOURCES	E-NEWS
Opens	3044	2056	1105	1099	539

## Top referral URLs for Round Five

<a href="http://www.google.com.au/search">http://www.google.com.au/search</a>	...ntent/ruralhealth-services-msoap.htm
<a href="http://www.google.com/search">http://www.google.com/search</a>	<a href="http://www.ranzcog.edu.au/ssrs/index">http://www.ranzcog.edu.au/ssrs/index</a>
<a href="http://www.racp.edu.au">http://www.racp.edu.au</a>	<a href="http://google.co.nz/search">http://google.co.nz/search</a>
<a href="http://www.ranzcr.edu.au">http://www.ranzcr.edu.au</a>	<a href="http://cpmc.edu.au/ssrs">http://cpmc.edu.au/ssrs</a>
<a href="http://www.ruralspecialist.org.au">http://www.ruralspecialist.org.au</a>	<a href="http://www.google.co.uk">http://www.google.co.uk</a>
<a href="http://www.health.gov.au">http://www.health.gov.au</a>	<a href="http://www.himh.org.au/site/index.cfm">http://www.himh.org.au/site/index.cfm</a>
<a href="http://www.ninemsn.com.au/results.aspx">http://www.ninemsn.com.au/results.aspx</a>	<a href="http://www.ranzco.edu/link/">http://www.ranzco.edu/link/</a>

The CPMC and a number of Specialist Medical College websites contain information and links about the SSRS program. Information about the SSRS program has also been posted on the DHA website [www.health.gov.au/workforce/new/ruralists.htm](http://www.health.gov.au/workforce/new/ruralists.htm).

A monthly breakdown of the monthly website traffic reports for the Round Five SSRS project period are at *attachment 7*.

## 2.3 Newsletters

### **Electronic newsletter**

An electronic newsletter has been developed and includes information about SSRS projects, upcoming CPD activities and useful links to other resources. The newsletter is e-mailed to over 300 people who have registered and include SSRS project managers, college representatives and a large number of rural fellows who have nominated to receive the newsletter. Those involved in SSRS projects and CPD activities are encouraged to provide information to be included in the newsletter. The newsletter is also posted on the SSRS website. *Attachment 9* includes all electronic newsletters published between the periods of May 2005 to April 2006. Table Three outlines SSRS E-Newsletters distributed during Round Five of the SSRS.

**Table Three: E-Newsletters in Round Five**

Subject	Date Sent	# Recipients	% Opened	Links Tracked
SSRS E-News April 2006	4 April 2006	325	40.62 %	38
SSRS E-News January 2006	31 January 2006	319	42.01 %	35
SSRS E-News December 2005	21 December 2005	316	45.25 %	50
SSRS E-News November 2005	8 November 2005	317	44.79 %	0
SSRS E-News September 2005	1 September 2005	322	44.72 %	67
SSRS E-News June 2005	17 June 2005	299	46.15 %	71

### **Printed newsletter**

Following on from a recommendation in 2003, a series of printed newsletters have been developed and distributed during Round Five. Newsletters were distributed to SSRS project staff, College President's and CEO' and they were also distributed at various College Meetings. The three newsletters published during Round Five are at *attachment 10*. Table Four outlines the printed Newsletters distributed during Round Five of the SSRS.

**Table Four: Printed Newsletters in Round Five**

Issue	Month	Featured
Issue 2	April 2005	<ul style="list-style-type: none"> <li>▪ RANZCOG Perinatal Mortality and Morbidity Audit</li> </ul>
Issue 3	July 2005	<ul style="list-style-type: none"> <li>▪ RACS Dealing with Difficult Patients and Work life balance</li> <li>▪ CPD for Rural Surgeons in Northern Queensland</li> <li>▪ RACMA – Improving Management Skills</li> <li>▪ HIMH Program Evaluators</li> </ul>

Issue 4	August 2005	<ul style="list-style-type: none"> <li>▪ Northern Australia Community-Acquired Pneumonia Clinical Practice Improvement Project</li> <li>▪ Rural Organisation of Australian Stroke Teams</li> <li>▪ Update on Treatment Decision Making</li> </ul>
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## 2. 4 Annual Scientific Meetings

Representatives from the SSRS Project Management Unit have had booths at seven College and Faculty Annual Scientific Meetings. The exhibitions serve to provide information to rural Fellows about the SSRS program, activities and programs available and also engaged them in considering their CPD needs for future project development. Most Fellows who visited the stands joined the SSRS mailing list, which ensures they are kept up to date with the latest program information. Representatives from the HIMH were also in attendance and were able to collect information for the external evaluation of the SSRS program. Table Five details the Meetings attended during Round Five.

**Table Five: SSRS representation at College and Faculty Annual Scientific Meetings**

College	Location
Royal Australian and New Zealand College of Psychiatrists	Sydney (May 2005)
Royal Australasian College of Surgeons (Provincial Fellows Meeting)	Shepparton (July 2005)
Royal Australasian College of Medical Administrators	Melbourne (August 2005)
Internal Medicine Society of Australia and New Zealand	Alice Springs (September 2005)
Royal Australian and New Zealand College of Obstetricians and Gynaecologists Provincial Fellows Meeting	Coffs Harbour (April 2006)
The Royal Australasian College of Physicians Annual Scientific Meeting	Cairns (May 2006)

## 2.5 Promotional material

The promotional material outlined in Table Six has been referred to over the course of Round Five of the SSRS.

**Table Six: SSRS Promotional Material**

Promotional Material	Description
<b>SSRS Postcard</b>	A postcard size flyer was produced to promote the SSRS. This postcard was made available to all SSRS project Managers to use at SSRS events, annual scientific meetings and during any written correspondence with rural Fellows. Postcards printed in 2004 continue to be used by the PMU and Colleges to promote the SSRS program. A sample postcard is at <i>attachment 11</i> .
<b>SSRS Promotional Bags</b>	Blue 'environmental' bags have been produced containing the SSRS Logo and website address to assist in the promotion of the program. These bags have been distributed at conferences and to all Colleges for use at SSRS events. They were also provided to participants at the SSRS Forum in March 2006. The bags have been well received and have encouraged a higher number of visits at conference booths. A sample bag is included as <i>attachment 12</i> .
<b>SSRS Sticky Note Pads</b>	SSRS 'sticky note pads' have been produced containing the SSRS Logo and website address to assist in the promotion of the program. These note pads have been distributed at conferences and to all Colleges for use at SSRS events. They were also provided to participants at the SSRS Forum in March 2006. The note pads have been well received and have encouraged a higher number of visits at conference booths. A sample note pad is included as <i>attachment 13</i> .
<b>SSRS Banner</b>	The PMU has several conference posters which promote the SSRS. These posters have been used when the PMU represent the SSRS at College Meetings, and are used at SSRS Forums.

## Newsletters

Previous editions of SSRS Newsletters are used as promotional material for the program. Copies of previous SSRS Newsletters were made available at the SSRS Forum in March and are taken to other College Meetings, to provide Fellows with an opportunity to gain greater insight into the SSRS. See *attachment 10*.

## 2.6 SSRS Forum

On Friday 3 March 2006, the CPMC hosted the SSRS Forum at the Stamford Airport Hotel Sydney; to showcase projects funded under Round five of the SSRS. Associate Professor Jill Sewell, President of the Royal Australasian College of Physicians, both Opened and Closed the Forum as the CPMC nominated representative.

This Forum provided an opportunity to engage participants around the significance of the SSRS as a rural workforce and education strategy and to enable the audience to reflect on the key themes relating to project delivery and sustainability, and issues associated with the delivery of professional development in the context of safety and quality and the specialist rural workforce.

There were over 50 attendees at the forum, including, rural specialists, metropolitan specialists SSRS Project staff, College representatives, the CPMC and DHA representatives.

Four presentations were delivered by specialists, involved in Round Five Projects or working in rural areas. Dr David Browning, provided insight into the RANZCOG Project aimed at improving the capacity of rural obstetricians and gynaecologists to conduct and participate in peer reviews. Dr Graeme Maguire a rural physician based in Broome detailed some of the challenges faced by isolated specialists in Australia, along with some strategies employed by rural specialists to overcome these.

Professor David Watters reported on his experiences in improving the capacity of rural surgeons to conduct and participate in audit peer review and Dr Michele Joseph discussed collaborative learning opportunities, team work and communication for the safe management of a crisis through the use of simulation, from her participation in the ANZCA Train the Trainer project.

Mr Trevor Hazell from the HIMH, the Commonwealth appointed external evaluator for the SSRS, delivered a presentation detailing the broader process used for evaluating the SSRS Program. Many participants reported this was a very useful and interesting session.

Associate Professor Merrilyn Walton from the Office for Teaching and Learning in Medicine and Dr Tim Shaw, Director of the Centre for Innovation in Professional Health Education both delivered presentations at the Forum. Associate Professor Walton effectively engaged specialists and College staff in considering the broader challenges and opportunities associated with creating a competent and responsive clinical workforce, while Dr Shaw's presentation provided forum participants with the opportunity to learn about innovative technical and collaborative models for the delivery of medical education.

Overall the forum received positive feedback from participants who enjoyed the opportunity to network with specialists and college staff, as well as engage in discussions surrounding learning outcomes from current projects and potential future projects. However, some participants stated that they would have preferred the Forum to have been held earlier in the year, to enhance the ability for inter-College collaboration on applications for Round Six of the SSRS. A copy of the Forum Workbook and Program can be found at *attachment 14*.

## 2.7 SSRS Forum Media Release

A media release was released by the CPMC on the morning of the SSRS Forum, providing information on the SSRS and highlighting presentations by Dr Maguire and Dr Joseph. This media release was released to all standard media along with rural radio in the Northern Territory and Northern Western Australia. The release resulted in two follow up calls. On Monday 6 March 2006, a radio interview was also conducted by the SSRS Program Manager with ABC Rural Radio in South

Australia. This provided a positive opportunity to promote the Program and support the provision of education and CPD to rural specialists. A copy of the SSRS Forum Media Release can be found at *attachment 15*.

## SECTION THREE

### 3.1 Round Five Project Assessment Panel

Following the announcement by the DHA to fund a fifth Round of the SSRS, the Chair of the CPMC in December 2004, wrote to all the Presidents and Chief Executive Officers of Specialist Medical Colleges and their Faculties, inviting them to submit applications for funding under Round Five of the Scheme.

The Principles and Guidelines for accessing project funding information and an application form were provided and this information was also made available on the SSRS website. Specialist Medical Colleges were encouraged to contact the PMU should they require assistance or further advice on the SSRS or the application and selection process.

Applications closed on Friday 28 January 2005 and 37 applications were received, which totalled a value of approximately \$3.4 million.

A Project Assessment Panel (PAP) nominated by the PMC, was formed to review and assess applications. The PAP met on 11 February 2005 to assess applications against the published SSRS Principles and Guidelines. In particular, the Panel assessed the proposals for evidence of:

- Demonstrated consultation with rural specialists about their needs;
- Enabled rural Fellows access to CPD/MOPS points;
- Utilised adult learning principles and facilitated practice change;
- Implemented an appropriate evaluation methodology;
- Were within budget guidelines and were cost effective in delivery;
- Where possible involved collaboration of medical colleges or Fellows; and
- Had taken on board recommendations from previous projects.

Following various recommendations including revision of applications, the PAP recommended to the CPMC and DHA, that 23 Projects be funded under Round Five of the SSRS, to a value of \$1.83 million. The Principles and Guidelines and Application Form for Round Five are at *attachment 16*. The Project Assessment Panel Report for Round Five is at *attachment 17*.

### 3.2 Round Five Projects

In Round Five of the SSRS, 23 Projects from were funded from May 2005 to April 2006. Projects have targeted a variety of professional development and educational needs and included activities aimed at providing professional support to medical specialists practising in rural and remote areas of Australia.

The projects funded under the SSRS offered a range of continuing professional development opportunities for rural specialists. These included face-to-face workshops, videoconferences, CD-Rom learning, development of on-line resources and teleconferences. Round Five projects have addressed objectives and clinical and professional topics that have spanned the following themes:

### 3.21 Project Objectives

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#### **Access to CPD**

- Support and improve access to CPD activities for rural medical administrators, rehabilitation physicians and paediatricians
- Support rural dermatologists' and radiologists' access to CPD and clinical meetings at teaching hospitals

#### **Meet CPD requirements and engage in College activities**

- Increase rural psychiatrists' attendance of WA RANZCP presentations
- Provide opportunities for rural psychiatrists and dermatologists to gain CPD points via video conferencing or web based activities
- Provide opportunities for emergency medicine physicians and anaesthetists to maintain procedural skills to meet College CPD requirements

#### **Identify gaps in knowledge and practice**

- Identify current practice gaps in Community Acquired Pneumonia in Northern Australia and in Stroke Unit Care within rural Australia
- Implement and review practice change for Community Acquired Pneumonia and Stroke Care
- Review clinical practice and systems in which influence patient care for obstetricians and gynaecologists

#### **Clinical Audit Peer Review**

- Enable emergency medicine physicians to reflect on and evaluate their response to patient scenarios in their workplace using a patient safety framework
- Provide feedback about positive aspects of clinical practice and areas of vulnerability
- Evaluation of the practice visit process for obstetricians and gynaecologists and the peer review process for surgeons
- Introduce rural psychiatrists to incident analysis surgeons and medical administrators to risk management principles
- Provide support to RANZCO and RACS Fellows to conduct surgical audit and peer review in accordance with CPD requirements

#### **Local Capacity Building**

- Train local rural anaesthetists and other specialists in medium fidelity simulation team training including debriefing and scenario design

- Develop a 'Train the Trainer' surgical audit education package

#### **Enhance networking opportunities and reduction of professional isolation**

- Reduce professional isolation of rural psychiatrists by increasing networking and service integration
- Provide interactive opportunities through simulation training, crisis management workshops, journal clubs and web-based activities to bring together rural specialists and decrease professional isolation
- Provide opportunities for greater communication and collegiality among surgical colleagues within the same region

#### **Enhance Clinical Knowledge and Skills**

- Enhanced medical administrators competence and management skills
- Facilitate the exchange of knowledge, skills and experiences between rural psychiatry professional networks
- Strengthen rural specialists' knowledge and skills in web-based technology
- Strengthen the CPD and learning modes specific for specialists in a rural setting
- Enable rural emergency medicine physicians and their teams to develop their skills in crisis management
- Provide interactive opportunities for clinical updates and peer-review
- Increase knowledge and access to up to date information for occupational and rehabilitation physicians and radiologists
- Encourage practice change by delivering education to support competence and knowledge transfer relating to rural specialists and their interaction with the pharmaceutical industry

#### **Quality Improvement**

- Implement the QI cycle as a result of practice visits for obstetricians and gynaecologists
- Understanding how and what to audit after a perinatal death or near miss
- Improve communication and feedback skills of rural specialists relating to audit
- Develop and distribute resources to support rural specialists in undertaking an audit after an adverse event

**Table Six: Round Five SSRS Projects**

<b>Project Title</b>	<b>College</b>	<b>Project Description</b>	<b>Budget \$)</b>
5.1_Honing Management Skills: Supporting group CPD activities for the rural Fellows and Members of RACMA	RACMA	This project aims to provide support for CPD activities for rural Fellows and Members of RACMA in order to enhance their management skills and knowledge by group learning. Using a variety of modalities to improve access including face-to-face meetings in rural locations and via videoconferencing.	94,000
5.2_Emergency Psychiatry and Consultation Liaison in Rural Settings: ATSI & Drug & Alcohol Streams	RANZCP	This project will provide rural psychiatrists and their selected medical colleagues with an opportunity to discuss clinical issues/situations relating to co-morbidity and Aboriginal mental health in case-based workshops with a sub-specialist panel. Outreach learning modes (video/phone conferencing, asynchronous web forum, consultation liaison) will be used to facilitate discussion and networking	58,000
5.3_Western Australia Rural and Remote Psychiatrist Continued Professional Development Network	RANZCP	This project is targeted at rural and remote psychiatrists in Western Australia and aims to; identify and prioritise rural Western Australian psychiatrists' areas of training need, decrease feelings of professional isolation for rural Western Australian psychiatrists, increase rural Western Australian psychiatrists attendance of WA RANZCAP presentations; and provide opportunities for rural psychiatrists to obtain CPD points via video conferencing	26,000
5.4_Risk Management Workshop Programme	RACS	A series of risk management workshops will take place, aimed at increasing the ability of specialists to manage medico-legal risk, apply risk management principles to improve patient care and reduce the risk of litigation. The program focuses on why patients sue communication strategies to improve patient satisfaction and the consent process.	97,000
5.5_Facilitating Audit and Peer Review for Isolated Procedural Specialists	RACS	In 2003, the RACS, in partnership with the RANZCO, successfully applied for the funding of a project entitled "Facilitating Audit and Peer Review for Isolated Procedural Specialists". The extension of this project in 2004 has allowed workshops to be held in another eight regional centres over the course of the year. This project will continue the work of these two projects; however, the focus will shift to the organisation and attendance of peer review meetings in those centres that participated in this project in 2004, grouped regionally, and to provide training for potential facilitators.	100,000
5.6_A regionally based CPD Program for General Surgeons in North Queensland	RACS	This project involves fortnightly video-linked educational meetings will include General Surgeons in Cairns, Townsville, Mackay, Mount Isa and Atherton. Content will be determined by the participants and will include topic presentations, case discussions, literature reviews, and focused audits. An annual regional surgeons' conference will also be established as a venue for face-to-face interaction.	44,000
5.7_Dealing with Difficult Patients, and Work / Life Balance for Rural Specialists	RACS	This project involves a series of workshops consisting of two modules facilitated by the Cognitive Institute. The first module offers solution-focused approaches to enhancing the effectiveness and ease of dealing with difficult patients and situations. The second module addresses ways to discover a sustainable, healthy and enjoyable professional and personal life. Workshop will be run for rural specialists located in Cairns, Orange, Bunbury, Darwin and Rockhampton.	97,000
5.8_Delivering CPD to Rural Radiologists: Vic	RANZCR	RANZCR's SSRS Victorian Branch Monthly Scientific Meetings program will be delivered by videoconference to Rural Radiologists and other rural medical specialists including	70,000

<b>Project Title</b>	<b>College</b>	<b>Project Description</b>	<b>Budget \$)</b>
Branch Monthly Scientific Meetings		Surgeons, Obstetricians and Gynaecologists, Cardiologists and other specialists. The program of 8 meetings will be extended by an additional joint session with ASUM.	
5.9_Delivering CPD to Rural Radiologists by videoconferencing Case Reviews	RANZCR	This project is a continuation of the Alfred Hospital's Radiology Department's Monthly Case Review Meetings program enables participants to join in via videoconferencing. This project will provide information about current, state of the art and new diagnostic imaging, related treatment techniques in interactive mode, using video-conferencing.	70,000
5.10_Diagnostic problems & clinical solutions: a joint CPD/Case Review	RANZCR & RACS	This joint program of the RANZCR & RACS, to be delivered nationally via videoconferencing, will be available to Rural Radiologists, Surgeons & their medical and colleagues. This joint venture with RACS will match the needs of Rural Radiologists and Rural Surgeons for CPD sessions that foster ongoing contacts at the local level. The program also builds on the findings of RACS's 2004 SSRS-funded program "Facilitating audit & peer review for isolated procedural specialists" & will incorporate methodologies from this project.	70,000
5.11_Practice Visits: reviewing specialist practice to improve the safety and quality of care	RANZCOG	A pilot of practice visits will be conducted in rural NSW in 2005. Practice visits provide collegial peer review of specialists within their work environment. This type of review consists of a preliminary surgical audit, patient satisfaction questionnaire, practice profile survey, observation of major and minor surgery, a peer visit with two outside O&G's, interviews with colleagues, and record review. The outcome of the visit is for the specialist to gain an understanding of their performance/ competencies while gaining frank feedback about areas of risk/ weakness that could be addressed to improve patient care.	110,000
5.12_Perinatal mortality and morbidity: Learning from adverse events to improve care	RANZCOG	This project seeks to improve the audit, investigation and peer review skills of specialists who have been involved in perinatal adverse events ("near misses") that have resulted in a transfer to a neonatal intensive care unit or a perinatal death. By learning from these adverse events, clinicians can improve clinical and organisational practice. Six to eight sites in provincial Queensland and Northern Territory will carry out retrospective audits with external clinicians to facilitate and critique the process.	96,000
5.13_Enabling Rural Dermatologists to Access Teaching Hospital Clinical Meetings Via CD-Rom	ACD	Teaching hospital clinical meetings are a principle method of CPD for metropolitan dermatologists, but have until recently been unavailable to rural Fellows without considerable travel and associated expense. This project allows rural dermatologists to access a number of these meetings at a time of their choosing via CD-Rom recording, with participants interacting via email and associated web forum.	70,000
5.14_Quality Use of Medicines – obtaining and assessing prescribing information for new drugs in Australia.	RACP	This pilot project is designed to promote the critical appraisal skills of Fellows in 2 related areas: interaction with the pharmaceutical industry; and obtaining and assessing prescribing information for drugs new listed on the Pharmaceutical Benefits Scheme. The project is a component the RACP's commitment to orient its educational activities within the framework of the Quality Use of Medicines Strategy, a key component of the National Medicines Policy.	122,000
5.15_Northern Australia Community Acquired Pneumonia Clinical Practice Improvement	RACP	This project seeks to improve the audit, investigation and peer review skills of specialists who have been involved in Community Acquired Pneumonia (CAP) within the northern Australia rural hospitals. By participating in the project clinicians can enhance clinical and organisational practice to improve care and service deliveries.	69,000

Project Title	College	Project Description	Budget \$)
Project			
5.16_ROAST- Stroke Unit Care Practice Change Project	RACP	The Stroke Unit Care Practice Change Project is a joint initiative with The Royal Australasian College of Physicians and The Royal Australian and New Zealand College of Radiologists, utilising a physician network, Australasian Stroke Unit Network to support the initiative. Building on the achievement of the SSRS ROAST project, this project will enable rural specialists to audit current stroke unit care practices and implement changes to improve clinical outcomes. Basing on ROAST methodology, monthly reviews and regular CPD workshops will support audit and practice change activities.	130,000
5.17_Remote paediatric journal club	RACP	This project is a continuation of SSRS Remote Paediatric Journal Club, which ran in 2003 & 2004. The project involves monthly videoconferences linking the 3 above sites for review of journal articles, discussion of complex clinical cases, new therapeutic interventions and wider issues pertinent to remote and rural paediatric practice.	10,000
5.18_FEAT - Further Education and Training for Paediatricians and Advanced Trainees	RACP	This project is designed as an educational program involving rural and remote paediatric centres and provides professional development and ongoing education via videoconferencing technology for Paediatricians who work in rural centres who are unable to attending meetings in person. The project is an interactive workshop format with the opportunity for interaction between rural participants and the panel who present the workshop. It allows rural Paediatricians to learn new information from tertiary specialists and to compare practice styles with each other and metropolitan Paediatricians. The project also acts to inform tertiary referral Paediatricians around the issues confronted by Paediatricians in rural centres.	43,000
5.19_A Project for Enhancing Professional Skills of Rural Physicians using Telemedicine	RACP	This project engages Tele-health in delivering the Victorian Continuing Education Workshop program which runs on a Saturday morning four times a year to remote locations in a number of states. Continuation of this program gives the opportunity for expansion into other states and the opportunity to continuously improve format and delivery as a learning experience.	61,000
5.20_WHAM – Workplace and health assessment modules	AFOM	The interactive web based module WHAM was developed by the Australasian Faculty of Occupational Medicine, after it was recognised that medical practitioners practising in rural and remote areas have fewer opportunities for supervised training in workplace and health assessments and this makes it difficult to ensure competencies in these areas are maintained. This year AFOM aims to develop two further modules on; Asbestos risks to workers, Best Practice Alternative Management of Occupational Soft Tissue Injury where conventional medical management has failed and, refinement of existing Workplace & Health Assessment Modules	94,000
5.21_BEARS – Bringing Educational Activities to Rural/Rehabilitation Specialists	AFRM	This project aims to improve the access of an isolated group of specialists to educational activities. The project has been designed to provide access to mix of educational and support activity combinations including regular Journal Club teleconferences, skills workshops and Practice Quality Reviews, that cater to the particular requirements of rehabilitation physicians who require a broad range of clinical, management and teaching skills.	74,000
5.22_A sustainable program of medium fidelity simulation	ANZCA, ACEM & JFICM	This course combines local instructor training with the delivery of medium-fidelity simulation-based courses for rural specialists at two previously visited sites (Darwin and Launceston). The	116,000

<b>Project Title</b>	<b>College</b>	<b>Project Description</b>	<b>Budget \$)</b>
training for multidisciplinary rural instructors and participants in crisis resource management		program will include pre-course reading and exercises to introduce the concepts of simulation training to novice instructors, a 2-day instructor course using hands-on experience and 3 single-day courses which provide actual training to multidisciplinary teams of rural specialists	
5.23_Emergency Medicine and Crisis Management using Medical Simulation for Rural Practice	ACEM	This project aims to provide rural emergency physicians with cross domain, team-based learning opportunities using medical simulation, incorporating clinical knowledge, procedural skills and Crisis Resource management skills and behaviours.	112,000
<b>Total cost of Round Five Projects</b>			<b>\$1,833,000</b>

### 3.3 Round Five Project Statistics

**Table Seven: Statistics on the type of events, mode of delivery, level of activity and number of participants for each project.**

Project title & College	No. Events	Type of event	Mode of delivery	Level of activity	No. Participants	Total Events/ Participation
5.1_RACMA, Honing Management Skills: Supporting group CPD activities for the rural RACMA Fellows	3	Clinical update presentation	Videoconference	Level 1	29*	Events: 7 OP: 84
	1	Interactive case discussion	Videoconference	Level 2	5*	
	3	Workshop	Metropolitan face to face	Level 2	50*	
5.2_RANZCP, Emergency Psychiatry & Consultation Liaison in Rural Settings: ATSI & Drug & Alcohol Streams	2	Tele Education Session	Teleconference	Level 2	32	Events: 4 OP: 62
	2	Video Education Sessions	Tele & videoconference	Level 2 & 3	30 (T:2)	
5.3_RANZCP, WA Rural and Remote Psychiatrist CPD Network	6	Tutorial	Videoconferencing	Level 1	24 (T:7)	Events: 6 OP: 24
5.4_RACS, Risk Management Workshop Programme	5	Workshop	Rural based face to face workshop	Level 2	40 (T:2, O:4)	Events: 5 OP: 40
5.5_RACS, Facilitating Audit and Peer Review for Isolated Procedural Specialists	1	Train the Trainer course	Face to face Workshop	Level 1 & 2	20	Events: 18 OP: 209
	17	Clinical Audit & Peer Review	Face to face workshops	Level 2	189 (T:44, O:24)	
5.6_RACS, A regionally based CPD Program for General Surgeons in North QLD	23	Educational Session	Videoconference CD-ROM digest of proceedings	Level 2	18 per event (T:13)	Events: 24 P: 88
	1	Regional Surgeons Conference	Rural based face to face conference CD-ROM/DVD	Level 2	35 (T:13)	
5.7_RACS, Dealing with Difficult Patients & Work / Life Balance for Rural Specialists	6	Facilitated Workshop	Face to face workshops	Level 2	40 (T:2, O:3)	Events: 6 P:40
5.8_RANZCR, Delivering CPD to Rural Radiologists: Vic Branch Monthly Scientific Meetings	5	Clinical scientific meetings	CD-ROM/Videoconference	Level 2	Av. 17/Site with 4 people/site*	Events: 5 OP: 340
5.9_RANZCR, Delivering CPD to Rural Radiologists, Case Reviews & videoconferencing from The Alfred Hospital, Melbourne	5	Case club	CD-ROM/Videoconference	Level 2 & 3	Average 17 sites with 4 people/site*	Events:5 OP: 340
5.10_RANZCR, RACS Diagnostic problems & clinical solutions: A joint CPD Case Review	4	CPD Tutorial workshops	Videoconferencing	Level 2	Av. 14 sites/ session. 4 people/site*	Events: 4 OP: 224
5.11_RANZCOG, Practice Visits: reviewing specialist practice to improve the safety and quality of care	1	Sub committee evaluation w/shop	Face to Face & teleconference	Level 3	10	Events: 19 P: 16
	2	Practice Visit face to face	Face to face workshops	Level 2	14	
	16	Workshop, audit, survey, interviews, observation of surgery, feedback and report writing	City based face to face & teleconferencing, paperwork and site/practice visits	Level 2 & 3	72 in Total 12 Visitors and 16 receiving visits*	
5.12_RANZCOG, Perinatal mortality and morbidity: Learning from adverse events to improve care	1	Workshop	City based face to face	Level 2	14	Events: 10 OP: 55
	9	Retrospective record audit interviews, feedback and report writing	Workplace visits and audits	Level 2 & 3	55 (T:7, O:27)	
5.13_ACD, Enabling Rural Dermatologists to Access Teaching Hospital Clinical Meetings Via CD-Rom	5	Virtual meeting / Case Discussion	CD-ROM	Level 1	25*	Events: 5 OP: 25
5.14_RACP, Quality Use of Medicines: obtaining and assessing prescribing information for new drugs in Australia	2	Interactive Workshop	Rural based Face to face workshops	Level 2	20*	Events: 2 OP: 20
5.15_RACP, Northern Australia Community Acquired Pneumonia Clinical	1	Discussion workshop	Rural based face to face	Level 1	7 Hospitals	Events: 14 OP: 70
	4	Virtual meetings	Teleconferencing	Level 1	40 (O:35)	
	9	Hospital based education	Workshop (all participants	Level 2	70 (O:35)	

Project title & College	No. Events	Type of event	Mode of delivery	Level of activity	No. Participants	Total Events/ Participation
Practice Improvement Project		workshops	/site)			
<b>5.16_RACP</b> , ROAST- Stroke Unit Care Practice Change Project	1	Participative workshop	Face to face workshop	Level 2	42 (O:27)	Events: 13 P: 42
	Monthly	Meetings	Teleconferencing	Level 1	site based	
	Monthly	Case discussions	Teleconferencing	Level 2	site based	
	6	Site Education Workshops	Rural based face to face workshop/ teleconference	Level 2	16 Sites	
	6	Rural Based Clinical Audit	As above	Level 3	20	
<b>5.17_RACP</b> , Remote paediatric journal club	1	Workshop	Face to face	Level 1	9*	Events: 6 OP: 54
	5	Case discussions	Videoconference	Level 1	45*	
<b>5.18_RACP</b> , FEAT: Further Education and Training for Paediatricians and Advanced Trainees	6	Case Discussion/virtual meeting	Videoconference 22.02.2006	Level 1 & 2	Av. 25 sites/ session. 2-5/ site*	Events: 6 OP: 450
<b>5.19_RACP</b> , A Project for Enhancing Professional Skills of Rural Physicians using Telemedicine	4	Case Discussion/ virtual meeting	Videoconference	Level 1 & 2	Av. 25 sites with 1-5/site*	Events :4 OP: 450
<b>5.20_AFOM</b> , WHAM – Workplace and health assessment modules	2	Module Launch, Tutorials and Virtual Meetings	Online resources and videoconferencing	Level 2	311 (T:46, O:215, OS: 50)	Events: 2 OP: 261
<b>5.21_AFRM</b> , BEARS - Bringing Educational Activities to Rural/ Rehabilitation Specialists	6	Practice Quality Reviews	Face to face reviews 2/site	Level 3	18 (O:6)	Events: 20 OP: 211
	5	Journal club/grand rounds	Teleconferencing	Level 2	50 (O:24)	
	8	In-service skills	Videoconferences	Level 2	211*	
	1	Residential workshop	Face to face	Level 2	39 (T:10)	
<b>5.22_ANZCA, JFICM, ACEM</b> A sustainable program of medium fidelity simulation training for multi-disciplinary rural instructors and participants in crisis resource management	2	2 Day Instructor Course	Train the Trainer Course	Level 3	8	Events: 4 OP: 64
	2	Clinical Skills Training	Rural Based Workshop	Level 3	56 (O:13)	
<b>5.23_ACEM</b> , Emergency Medicine and Crisis Management using Medical Simulation for Rural Practice	5	Emergency Medicine & CRM interactive workshop	Rural based face to face workshop	Level 3	84 (O:59)	Events: 5 OP 84

#### KEY

<b>P</b>	Total Participants Known (non-recurring participation rates)
<b>OP</b>	Occurrences of Participation Known (i.e. does not take into account recurring participation rates)
<b>T</b>	Trainee Participation
<b>O</b>	Other Health Workforce Participation
<b>*</b>	Breakdown of Trainees or health workforce other than specialists not provided

### 3.4 Round Five Project Results

In total, approximately 200 educational events were held with roughly 1,200 occurrences of participation by rural specialists. In addition, many SSRS events involved participation of other rural health workforce. By including participation of overseas trained doctors, trainees and other health workforce, this increased the total number of participant occurrences over the course of Round Five projects to approximately 3,300. Projects were able to include these additional groups where the cost of their involvement did not impede on the budget, or where their costs were absorbed by external funding agencies.

In the current round of funding, the SSRS fostered strong collaborative partnerships with external organisations such as Health Workforce Queensland, the Centre for Rural and Remote Health, James Cook University and the NSW Rural Institute of Clinical Services and Teaching.

### 3.4.1 Project Activities against the Leap Framework

Project events were classed according to the Leap Framework, a tool used to assist in understanding and describing the diverse roles and the wide range of skills, knowledge, attitudes and attributes that are now considered to be part of being a medical professional today. The Leap Framework is outlined in Table Eight.

**Table Eight: Leap Framework**

Level of Activity	Description	% of Round Five Events
<b>Level One</b>	Provides the participant with information to improve their practice such as passive activities including lectures, journal reading and grand rounds	<b>15%</b>
<b>Level Two</b>	Ensure the participant can demonstrate maintenance of best practice or demonstrate implementation that facilitates changes in practice (eg. preparation for and taking part in practice review, clinical audits, incident monitoring, and participative workshops)	<b>66%</b>
<b>Level Three</b>	Participant evaluates the impact of an activity or intervention (eg. Trying out a new approach and evaluating the outcomes, implementing outcomes of peer reviews and audits)	<b>19%</b>

### 3.4.2 Project Resources Produced

Ten educational resources were developed within the context of Round Five Projects. These resources are listed in Table Nine:

**Table Nine: Project Resources developed during Round Five**

Project	Resource
5.2	MulgaBoard Web based discussion forum for rural psychiatrists
5.5	RACS Surgical Audit and Peer Review Guide and Train the Trainer Education Package
5.6	CD Rom compilation of selected presentations from video-linked education sessions and DVD compilation of highlights from Regional Surgeons' Conference
5.11	Practice Visits Newsletters and Practice Visit Guidelines and Evaluation Tools
5.12	Perinatal Mortality and Morbidity Audit facilitator handbook
5.13	Interactive CD Rom of Hospital Clinical Meetings for Dermatologists
5.14	QUM website to engage clinicians with project resources provide them with updated information regarding the Quality Use of Medicines
5.15	Local Community Acquired Pneumonia management guidelines and data collection tools (based on the Australian Therapeutic Guidelines)
5.16	'Teleform' ROAST acute and sub acute data collection and data evaluation tools
5.20	4 Workplace health Assessment Modules

### 3.4.3 Projects Outcomes

In most instances, projects met their objectives in full or in part. Some of measurements that were in place to assess the extent to which the objectives were achieved were not completed due to time constraints or the datasets were too small to conduct statistical analysis. The individual achievements for each project are outlined in the project abstracts at *attachment 18*.

#### **Specific outcomes associated with Round Five Projects include:**

1\_Specialists were supported to identify service and practice gaps and implement evidence based practice and compliance with national performance indicators in their workplace (5.12, 5.15, 5.16)

- 2\_** Specialists were able to participate in scenario based learning activities in a safe and supportive environment (5.22, 5.23)
- 3\_** Specialists were provided with opportunities to self evaluate skills and response to clinical situations (5.22, 5.23)
- 4\_** Specialists were supported to become education leaders within their own fields (5.02, 5.08, 5.09, 5.10, 5.11)
- 5\_** Clinical leaders were given the opportunity to showcase project outcomes and education models at the SSRS Forum (5.05, 5.11, 5.15, 5.22)
- 6\_** Specialist Medical Colleges were able to identify future leaders and champions of clinical education and CPD (5.06, 5.11, 5.12)
- 7\_** Specialists were able to plan and lead clinically relevant CPD activities to meet local need (5.02, 5.03, 5.05, 5.06, 5.11, 5.12, 5.15, 5.17, 5.22)
- 8\_** Sustainable networks supported rural specialists to consult with their colleagues regarding clinical practice, after SSRS project activities had ceased (5.03, 5.13, 5.17, 5.21)
- 9\_** Professional isolation of was reduced through increased networking and service integration (5.02, 5.03, 5.06, 5.11, 5.21)
- 10\_** Projects promoted greater communication and collegiality among colleagues in the same region (5.03, 5.04, 5.06, 5.07)
- 11\_** Project resources including data collection and evaluation tools were developed, disseminated and evaluated to be refined for future use (5.02, 5.05, 5.11, 5.12, 5.15, 5.16, 5.20, 5.22)
- 12\_** Experience gained through projects has assisted to develop medical education resources which can be adopted by Specialist Medical Colleges (5.06, 5.11)
- 13\_** Specialists were able to increase attendance at CPD activities and increase CPD points (5.01, 5.03, 5.04, 5.07, 5.08, 5.09, 5.10, 5.13, 5.17, 5.18, 5.19, 5.20)
- 14\_** Specialists were able to access interactive CPD and learning activities, often at no cost which would otherwise not have been available to them (5.1, 5.13, 5.20, 5.21)
- 15\_** Pre and post project evaluation was undertaken to strengthen CPD education models and identify CPD need, to inform future SSRS projects for rural specialists (5.02, 5.05, 5.11)
- 16\_** Technology and 'virtual' outreach learning modes, brought together multidisciplinary rural specialists participate in interactive case based education activities and exchange knowledge, skills and experiences, despite their dispersed locations (5.02, 5.20, 5.23)
- 17\_** Participation in projects strengthened participants' knowledge, skills and confidence in the use of web based technology and other outreach learning modes (5.12)
- 18\_** Specialist Medical Colleges collaborated productively to deliver CPD to rural Fellows (5.22)
- 19\_** Promotion of the SSRS to Hospital Executive and staff, to support project infrastructure at a site level, and encourage the process of delivering education and CPD to rural specialists (5.15, 5.16)
- 20\_** Development of local capacity to work along side rural specialists in the implementation of SSRS project objectives (5.15, 5.16)
- 21\_** Trainees and International Medical Graduates were able to be interact with Specialist Medical Colleges and rural specialists in locality based clinically relevant CPD activities (5.03, 5.04, 5.06, 5.07, 5.20)
- 22\_** Colleges were assisted to implement their education strategies and CPD curriculum activities in

rural areas (5.01, 5.03, 5.04, 5.05, 5.13)

**23**\_Projects promoted a culture of audit, peer review, clinical practice improvement and quality assurance and increased the confidence of specialists to participate in processes such as practice review and peer audit (5.05, 5.11, 5.12, 5.15, 5.16)

**24**\_Specialists were provided with tools and techniques for understanding what to audit and how to conduct clinical audits and practice reviews and how to evaluate and communicate results (5.05, 5.11, 5.12)

**25**\_Specialists learnt how to systematically discuss adverse events with a range of stakeholders (5.11, 5.12, 5.15, 5.16, 5.22, 5.23)

**26**\_The SSRS provided the opportunity to identify and test cost effective education based learning modules for rural specialists (5.02, 5.03, 5.20, 5.23)

**27**\_enhancement of critical appraisal skills of specialists in their engagement with the pharmaceutical industry (5.14)

**28**\_Increase in the capacity of Specialist Medical Colleges to educate rural specialists and staff about specific medical conditions and topics (All)

### **3.5 Round Five Project Limitations and Constraints**

There were some constraints and limitations identified by projects, which had the capacity to limit the extent to which SSRS project objectives could be achieved. These limitations also impacted on projects by contributing to lower than anticipated participation rates and reducing the extent to which project evaluation could be conducted. The individual limitations and constraints for each project are outlined in the project abstracts at *attachment 18*.

#### **Constraints identified by Round Five Projects include:**

##### **1\_CPD: Preferences, participation concurrent CPD activities**

**1.1**\_ Specialists had varying preferences for the type of event they attended i.e. a preference for attending activities in person or a preference in topic and scope of activities (5.1 & 5.13)

**1.2**\_ RANZCOG stated that innovative CPD activities usually draw the same crowd of 'early adaptor'. Projects such as Practice Visits predominantly attract Fellows who are unthreatened by peer review and willing to open their practices to colleagues. This is possibly in contrast to the wider Fellowship (5.11)

**1.3**\_Concurrent provision of CPD activities, which are perceived to be similar, can potentially impact on project participation, result in the challenges of distinguishing the difference between projects, and also question the effectiveness of resource use (5.4, 5.12)

**1.4**\_Attendance figures can be adversely affected by waning interest over time and CPD meeting burnout, particularly when the number of potential attendees is relatively small (5.6)

##### **2\_Technological support**

**2.1**\_ Despite increasing user skill and confidence, and pre-trialling of technology, technical difficulties still occur, often requiring resolution from service providers. Technical support is difficult to access after hours, when many SSRS activities are conducted. Some sites also lacked technical facilities to support SSRS activities and some participants were described as 'technology resistant'. Overall, repeated unresolved technical difficulties or insufficient technical skill or confidence can lead to a decrease in participation (5.2, 5.3 5.6 5.13 & 5.16)

##### **3\_External constraints**

**3.1**\_The event of Cyclone Larry meant that 5 Queensland rural psychiatrists were unable to

participate in one video-conference education session and the Bali Bombings in October 2005 impacted on the ability of several specialists to participate in the Darwin train the trainer course. In the Kimberley, travel to remote project sites within the NACAPP was hindered by the wet season when roads and airstrips are often cut due to flooding (5.2, 5.15, 5.22)

#### **4 Project timeframes**

**4.1** Limited project timeframes were cited by several projects as barriers to the implementation of project objectives. Delays in the funding for projects had flow on effects extending to delays in recruitment of project staff and scheduling and advertising of events (5.3, 5.4, 5.7, 5.15)

**4.2** The 12 month funding cycle of SSRS projects limits the outcomes, achievements and sustainability of project. In particular, innovative professional networks take time to develop and expand and implementing clinical practice and system change (and evaluating this) is difficult within the parameters of project timeframes (5.02, 5.15, 5.16)

#### **5 Time constraints of rural specialists**

**5.1** Most projects stated that the competing work commitments and on-call duties of rural specialists impacted adversely on their ability to participate in project activities. Specialists were also often unable to find locum relief to participate in activities (5.3, 5.4, 5.5, 5.7, 5.11 5.12, 5.13 & 5.21)

**5.2** Participants in rural areas such as Alice Springs and the Kimberley have extensive and varied responsibilities are required to travel great distances in order to provide services throughout dispersed geographical areas. Participation in SSRS projects added to these extensive responsibilities (5.15)

**5.3** Travel time for specialists involved in practice visits across rural NSW or audits across regional Queensland were a time intensive exercise. Activities were often scheduled into weekends to reduce the specialists' time away from their own clinical responsibilities (5.11 & 5.12)

#### **6 Difficulty contacting participants and changes in project staff**

**6.1** Several projects experienced problems in contacting participants in specific areas to partake in SSRS activities, for reasons such as practice relocation or leave and changing employment responsibilities. In some areas this was compounded by the low number of specialists working in that location (5.3, 5.5, 5.8 & 5.9)

#### **7 Clinical leadership and audit champions**

**7.1** Most projects stated that a clinical champion was often beneficial in driving the Project. When clinical champions/audit champions and project staff in general were unable to follow through with their commitment to project activities due to competing workload responsibilities, this generally had a negative effect on project delivery (5.5, 5.8, 5.9 & 5.10)

#### **8 Project support**

**8.1** Without, dedicated project staff, several site based projects reported that it was difficult to implement and maintain data collection, reporting processes and project compliance. The regionally based CPD program where participants were widely dispersed stated that they required funded administrative support in order to deliver project objectives (5.06)

**8.2** Shortage of human resources and the ability to engage hospital-based staff at project sites was an impediment to the implementation of project objectives for ROAST and in NACAPP (5.15 & 5.16)

**8.3** Limited College resources have meant that project information such as pre reading, pre-test of knowledge were unable to be placed on the RANZCR website prior to each Monthly Scientific Meeting and Case Club (5.08, 5.09, 5.10)

#### **9 Project funding**

**9.1** Projects stated that the low remuneration for clinical leaders were compounded by the fact that

many specialists must travel away from their practices to participate in or lead SSRS activities, often at the expense of their private income. Reliance on pro bono work is not always feasible or sustainable for the future of SSRS projects (5.11)

### **10\_Legal and Ethical Issues**

**10.1**\_RANZCOG was required to gain Qualified Privilege to manage the risk to the College and Fellows participating in this project. This was a major barrier in progressing the project as it took until October 2005 to be granted. Until this time, while some participants completed preparatory work for the Practice Visits, Fellows were reluctant to provide audit information to the College (5.11)

**10.2**\_As the NACAPP was being run in WA and NT and the majority of participants were Aboriginal Australians, ethics approval needed to be granted from; the Western Australian Aboriginal Health Information and Ethics Committee, the University of Western Australia Human Research Ethics Committee, and the Central Australian Human Research Ethics Committee. This caused significant delay in the delivery of the Project (5.15)

### **11\_Low evaluation responses**

**11.1**\_Low evaluation responses were problematic for many projects. Response to pre and post activity surveys and tests was marginal and along with low participation rates, this has impacted on the ability to comprehensively evaluate SSRS project activities (5.18, 5.23 & 5.13)

Many of these constraints could be managed or minimised through a number of strategies. Some management strategies need to occur at a local and project level, while other initiatives could be incorporated in to the larger context of program administration. A comprehensive needs assessment and effective project planning are essential in assisting Colleges to anticipate possible project limitations.

## **3.6 Round Five Project Recommendations**

It was a requirement for Round Five projects to have developed an evaluation methodology to evaluate outcomes of their SSRS project. Based on project evaluation and project outcomes, the following recommendations have been made. The individual recommendations made for each project are outlined in the project abstracts at *attachment 18*.

### **Recommendations from Round Five Projects include:**

#### **1\_ Scheduling CPD**

**1.1**\_Consider scheduling SSRS activities during working hours (5.2)

**1.2**\_Consider the feasibility of coinciding SSRS events with other College activities or meetings to promote the project and provide opportunity for team building between college staff and rural specialists (5.15)

**1.3**\_Review similar CPD activities being conducted at a specific time/location to avoid duplication, or lower participation rates (5.4)

**1.4**\_Provide incentives to encourage participation in activities such as awarding CPD points, convenient scheduling of sessions, personalised invitations or democratic means of setting the agenda (5.6)

**1.5**\_Provide a variety of CPD activities such as an annual face-to-face conference as an adjunct to the ongoing videoconference-based CPD program (5.6, 5.21)

#### **2\_Funding**

**2.1**\_Request CPMC review the lack of ongoing CPD provided to RACMA members as rural Fellows have few opportunities to partake in specifically tailored CPD activities at no cost to participants (5.1)

**2.2**\_Provide remuneration to compensate for time away from private practice and to encourage a critical mass of Fellows to become practice visitors. RANZCOG to explore future funding models which may involve seeking a financial contribution from individuals receiving a visit, hospitals or medical defence organisations (5.11)

**2.3**\_Seek funding where appropriate from local health jurisdictions, specialist colleges and industry, to support program administration and infrastructure for a regionally based CPD program (5.6)

**2.4**\_SSRS to consider setting up grants to cover the costs of travel and locum cover for rehabilitation physicians in regional, rural and remote areas attending conferences and courses (5.21)

**2.5**\_Increase economies of scale by delivering fewer, better planned and delivered project activities (5.18)

**2.6**\_Revise project budgets based on experiences from previous rounds of funding (5.6)

### **3 Technology**

**3.1**\_Strengthen project resources such as the interface of MulgaBoard (web discussion forum) to enable it to be more intuitive and less complex for users (5.2)

**3.2**\_Support participants to use project technology more extensively eg. register to use the web, make a posting, retrieve information and respond to comments or participate in debates (5.2, 5.21)

**3.3**\_Support specialists to develop their technical skills to enhance distance management of rural and remote clients and communities, increase their clinical leadership skills and competence and share their clinical expertise through interactive (virtual) networks of geographically dispersed professionals (5.2)

**3.4**\_Progress the development of electronic resources such as an e-bulletin and on-line library (5.21)

### **4 Evaluation**

**4.1**\_Follow up with sites to look at the sustainability of practice change in the longer term (5.11, 5.12)

**4.2**\_Provide feedback on evaluation of projects to Qld Health and the Council of Maternal and Perinatal Mortality, so that they can understand project findings and act on the recommendations (5.12)

**4.3**\_Revise the evaluation methodology to reduce number of questions asked and address the issue of non-completion of evaluation forms, i.e. make completion of evaluation forms a compulsory component required for certification of participation in this CPD activity (5.5)

**4.4**\_Ongoing evaluation of CPD programs should continue to focus on defining the unmet education needs of rural and regional specialists (5.6, 5.21)

**4.5**\_Evaluate and refine audit tools to improve effectiveness, user acceptability and increase uptake of surgical audit (5.5)

### **5 Invest in project infrastructure**

**5.1**\_Invest time and resources in project infrastructure such as the support and education of local hospital staff to aid in project implementation (5.15, 5.16)

### **6 Involve trainees, overseas trained doctors and other health workforce**

**6.1**\_Involve trainees and OTDs in SSRS project activities maximise the critical mass for discussion and to enhance the learning environment. This is particularly important for trainees who may be encouraged to undertake regional or rural practice in the future (5.6)

**6.2**\_Act on evaluation data which supports the provision of inter-professional learning experiences in a team environment such as emergency department (5.23)

## **7\_College and Organisational Collaboration**

**7.1\_** Consideration coordination or collaboration with organisations such as the Australasian Stroke Unit Network in leading data collection and feedback or the Great Metropolitan Clinical Taskforce and the Clinical Excellence Commissions' Towards a Safer Culture Program in encouraging the continuation of Stroke teams in Rural Australia (5.16)

**7.2\_** Coordination and collaboration with other organisations for resources, management and clinical expertise (5.18)

**7.3\_** Facilitate interaction between metropolitan and rural rehabilitation physicians and develop trainee mentoring programs for specialist trainees in rural areas (5.21)

**7.4\_** Invite SSRS participants interested in education and training to present to remote general practitioners and rural Queensland doctors at future Health Workforce Queensland workshops (5.23)

## **8\_Transfer and share effective models of education**

**8.1\_** Expand the Practice Visits Program to an effective regional basis and consider expanding nationally in 2007 (5.11)

**8.2\_** Develop a national sustainable network based on the Western Australian network, (rather than one off or periodic initiatives) for psychiatrists to reduce isolation and provide a forum for rural psychiatrists to share skills and experiences of rural and remote practice with their colleagues (5.2 & 5.3)

**8.3\_** Continue to use models such as simulated scenarios and reflective exercises such as debrief in a safe environment to improve clinical practice and the treatment of a critically ill patient (5.23)

**8.4\_** Share trialled and evaluated project methodology and evaluation tools within and across Colleges (5.3)

**8.5\_** Consider the provision of generic web based education models, based on adult learning principles for all rural specialists (5.20)

**8.6\_** Use SSRS project resources to promote audit and peer review to rural and remote procedural specialists and develop benchmarks and guidelines for identifying surgical outliers developed (5.5)

## **9\_Promote work-life balance**

**9.1\_** Recognise impediments to workload and stress management and deliver projects through the SSRS to address this issue and decrease the likelihood of burnout for rural specialists (5.7)

## **10\_Clinician champions**

**10.1\_** Ensure better use of paediatricians in recruiting Fellows to act as facilitators: in future there will be greater efforts to recruit and train paediatricians as facilitators to ensure true peer review can take place, rather than obstetricians making judgements on the work of paediatricians (5.12)

Colleges are required to take project findings and recommendations into consideration when developing future project application proposals. The PMU and HIMH will also review all project outcomes, limitations and recommendations in considering the future direction and scope of the SSRS.

## **3.8 Project Extensions**

During Round Five, the Royal Australasian College of Physicians and the Royal Australasian College of Medical Administrators applied to the Department of Health and Ageing for extensions to complete project activities. These projects were:

- 5.1 Honing Management Skills: Supporting group CPD activities for the rural Fellows and Members of RACMA
- 5.14 Quality Use of Medicines – obtaining and assessing prescribing information for new drugs in Australia

Both projects were required to submit interim reports to the PMU by 30 April 2006 and they will submit final project reports, along with audited financial statements to the PMU and DHA in July and August 2006 respectively.

## SECTION FOUR

### 4.1 Program Results

**Objective A:** Provide professional support to medical specialists practising in rural and remote areas of Australia, including through continuing professional development and peer support

Rounds Five of the SSRS funded 23 new or continuation projects that aimed to meet the continuing professional development needs of specialist practising in rural and remote areas of Australia. In many instances rural specialists have approached College staff with project concepts based around the professional education and support which they and their peers require. In Round Five, Colleges, along with the Project Management Unit assisted rural Fellows develop project applications based on their professional need, and which address the SSRS Principles and Funding Guidelines.

During Round Five, professional support was provided to medical specialists through clinician led workshops and activities on specific clinical topics such as perinatal mortality and morbidity, events for specialists on professional competence such as risk management and honing management skills or projects focusing on the development of sub-specialist professional support networks.

In total, approximately 200 educational events were held with roughly 1,200 occurrences of participation by rural specialists. In addition, many SSRS events involved participation of other rural health workforce. By including participation of overseas trained doctors, trainees and other health workforce, this increased the total number of participant occurrences over the course of Round Five projects to approximately 3,300. Projects were able to include these additional groups where the cost of their involvement did not impede on the budget, or where their costs were absorbed by external funding agencies.

Professional support was also provided to medical specialists and Colleges through the development of ten project resources (See Table Nine). These resources were able to strengthen the implementation of College continuing professional development objectives and support the provision of continuing professional development to rural specialists.

To assist in achieving this objective the PMU actively promoted SSRS activities and other relevant continuing professional development activities through an electronic newsletter, hard copy newsletters, SSRS promotional material, at SSRS events and at College Annual Scientific Meetings. The PMU have also maintained up to date information on the SSRS website.

As a result of SSRS projects, specialists and project staff have raised the profile of continuing professional development for rural specialists in rural and regional hospitals. This has enabled the provision of ongoing education and professional support for rural specialists, to become a more common aspect of professional duties.

**Objective B:** Identify future approaches to the provision of continuing professional development and capacity building for medical specialists practising in rural and remote areas of Australia

There are substantial learning's in terms of outcomes, limitations and recommendations to be taken from Round Five SSRS Projects. The SSRS has proved to be an innovative Program to assist rural Fellows to meet College continuing professional development requirements. The SSRS has also supported specialists and Specialist Medical Colleges to develop, trial, evaluate and promote new resources and modes for the provision of continuing professional development.

The SSRS has provided an opportunity for Specialist Medical Colleges to pilot and participate in education-based programs, which may not have been able to be delivered within existing College resources. As a result of Round Five Projects, the following themes have been identified in terms of future approaches to the provision of continuing professional development:

- Multidisciplinary team based learning in the specialists environment

- Simulated and scenario based training to enhance reflective analysis
- 'Virtual' professional specialty and sub-specialty networks
- Web-based interactive learning modules
- CDP activities involving peer audit and peer review

The SSRS Program has also provided information on possible limitations and constraints, which need to be examined in the identification of future approaches to continuing professional development. These include higher than anticipated drop out rate at face to face meetings, recruitment of clinical champions to lead projects, investment in site infrastructure for projects delivered in a hospital environment, legal and ethical issues associated with continuing professional development approaches and issues associated with technology based models.

On review of Round Five Reports, the PMU is planning to conduct consultation with Specialist Medical Colleges to discuss continuing professional development approaches and project models, which are best able to deliver suitable continuing professional development activities to rural specialists. Furthermore, it is expected that the external evaluators will also be able to provide information that will assist in identifying future approaches to the provision of continuing professional development.

Based on the experiences of the SSRS, CPMC will continue to be informed of project outcomes and possible future approaches to the provision of continuing professional development and capacity building for medical specialists practising in rural and remote areas of Australia.

**Objective C:** Identify continuing professional development activities suitable for medical specialists practising in rural and remote areas of Australia

Projects were recommended for Round Five funding on the basis that they could demonstrate the need for the type of activity they were conducting and the suitability of the mode of delivery. Applications are often informed by College surveys, consultation with rural specialists and reviews of relevant literature.

Specialists involved in SSRS projects have again proved to be a valuable resource in developing and testing education models and continuing professional development activities, which are most suitable for specialists practicing in rural and remote areas of Australia.

In some instances, projects piloted through the SSRS have been recommended to Colleges to adopt as part of their continuing professional development program, for example the Audit and Peer Review Guidelines (RACS), the Workplace Health Assessment Modules (AFOM) and the Practice Visit Program (RANZCOG). It is anticipated that as specialists continue to be involved in developing and piloting these projects, that this will lead to the identification of further need based activities for the future projects.

On review of Round Five Reports, the PMU is planning to conduct consultation with the HIMH to discuss project models which are best able to deliver suitable continuing professional development activities to rural specialists. The PMU will also meet with Colleges to identify any issues involved in delivering these activities, in preparation for possible future rounds of funding.

Based on the experiences of the SSRS, CPMC will continue to be informed of project outcomes and continuing professional development suitable for medical specialists practising in rural and remote areas of Australia.

**Objective D:** Assist in building inter-college capacity to deliver these activities and provide professional support to medical specialists practising in rural and remote areas of Australia

Inter-College capacity is an important objective of the SSRS, as in rural areas, sub-specialist 'critical mass' is low, and specialists often rely on cross-College professional networking for professional support. Since its inception, the SSRS has provided a significant forum for Specialist Medical Colleges and their Fellows to collaborate on needs based projects and bring about sustainable outcomes for specialists working in rural and remote Australia.

Specialist Medical Colleges are encouraged to collaborate in the delivery of projects and the development of education models, project methodology and evaluation frameworks. The principles and guidelines for funding for round five also offered larger amounts of funding to applications submitted by more than one Specialist Medical College. This resulted in two collaborative projects. In addition to this, 10 projects offered CPD opportunities to more than one speciality group.

The annual SSRS Forum, held in March 2006, has provided an opportunity for rural specialists and SSRS project and College staff to learn about SSRS projects being conducted by different Colleges, and consider how learning outcomes or practice change can be implemented in their own setting. At the Forum, several participants commented that they saw the forum as a significant opportunity to collaborate with staff from other Colleges, to plan professional support activities for Fellows of multiple Colleges

SSRS collaboration has provided an extensive network of key stakeholders who share a common vision on the education outcomes for education and training. Strategically, the SSRS program has facilitated the communication networks not only between Specialist Medical Colleges, but between all levels of health professionals and health industry organisations, such as:

- Health Workforce Queensland/Medical Education Solutions
- The Centre for Rural and Remote Mental Health
- James Cook University
- The NSW Rural Institute of Clinical Services and Teaching
- The Royal College of Nursing Australia
- Divisions of General Practice
- Rural Workforce Agencies; and
- The Australian College of Rural and Remote Medicine.

**Objective E:** Assist in building the capacity of Specialist Medical Colleges in planning, delivering and evaluating professional development support projects.

At the announcement of each round of SSRS funding, Specialist Medical Colleges have been offered support in the development of comprehensive needs based project proposals, which meet the SSRS application criteria. Colleges are also required to submit a Progress Report and a Final Report on their project.

To build the capacity of Colleges in the planning, delivery and evaluation of professional development support projects, Colleges are provided with application and reporting proforma's which detail the scope of information required in planning or reporting on a SSRS Project. This ensures that Colleges have considered the following:

<b><i>Project Applications</i></b>	<b><i>Project Reports</i></b>
<ul style="list-style-type: none"> <li>▪ Target group(s) &amp; expected participation</li> <li>▪ Budget and external funding</li> <li>▪ Needs assessment</li> <li>▪ Project Aim</li> <li>▪ Project Objectives and strategies to achieve these</li> <li>▪ Evaluation Methodology</li> <li>▪ Project Schedule</li> <li>▪ Project Communication</li> <li>▪ Risks and Risk Management</li> <li>▪ CPD value for College</li> </ul>	<ul style="list-style-type: none"> <li>▪ Background and Project Description</li> <li>▪ Project Objectives</li> <li>▪ Description of Methodology</li> <li>▪ Methodology Rationale</li> <li>▪ Evaluation methodology</li> <li>▪ Results including qualitative or statistical analysis</li> <li>▪ Discussion of Project outcomes</li> <li>▪ Achievement against objectives</li> <li>▪ Constraints and Limitations</li> <li>▪ Recommendations</li> </ul>

The PMU continues to liaise frequently with College project managers during the course of the SSRS to assist in building their capacity to deliver projects. The PMU also ensures that Colleges share information and strategies with other Colleges to assist in delivering successful projects. In most instances, Colleges have taken feedback on board relating to Applications, Progress and Final Reports and as a result, the capacity to deliver a sound and cost effective project has increased. The Communication Plan has also assists colleges in supporting rural specialists through mediums including newsletters, website information and conference attendance.

Some project resources are shared amongst colleges to support in the planning, delivery or evaluation of SSRS Projects. These resources, also increases the capacity of colleges to delivery and evaluate professional development projects. Several shared resources include:

- Project Proformas
- SSRS Website
- Leap Framework
- Media Guidelines including how to write a newsletter article
- RACS Surgical Audit and Peer Review Guide and Train the Trainer Education Package (with RANZCO)
- Perinatal Mortality and Morbidity Audit facilitator handbook (Obstetricians and Paediatricians)
- Workplace Health Assessment Modules (Occupational Physicians, Rehabilitation Physicians, Rheumatologists and Psychiatrists)

In many instances, the delivery of SSRS projects has also identified education needs or gaps in clinical practice, which need to be addressed. The capacity of Colleges to deliver professional development projects will only increase as Colleges become more experienced in the delivery of projects which meet the needs of specialists working in rural and remote Australia.

## 4.2 Recommendations

The Support Scheme for Rural Specialists has been funded by the DHA since November 2002. It is recognised that the implementation of future continuing professional development opportunities for rural specialists should be considered in light of the evidence gained from the conduct of individual projects and the results of the external evaluation. The recommendations listed below are the result of a meta-analysis conducted on the recommendations made by individual projects and the analysis of qualitative data collected by the SSRS Project Management Unit throughout the Round Five project period. In many instances, the following section reflects previous recommendations which have been made for this Program.

### **1. Review of the Support Scheme for Rural Specialists Program**

An extensive consultation should be undertaken to review the way in which opportunities for continuing professional development should be delivered to rural specialists as funded by the SSRS. This consultation should include a meta-analysis of project outcomes, limitations, recommendations, effective education models and other relevant information from the five completed rounds of the SSRS to date. The consultation would assist to:

- Identify specific needs of rural Fellows
- Identify the role that the SSRS has filled in delivering CPD activities
- Determine the types of programs, education models and project methodology that should be supported
- Determine the future approach to the provision of continuing professional development for rural specialists in Australia and understand the preferred methods for the delivery of programs
- Implement sustainable and cost effective continuing professional development programs for rural specialists
- Recommend any changes to the current *Principles and Guidelines for Accessing Project Funding* and the scope and implementation of potential future rounds of the SSRS
- Communicate the purpose and outcomes of the SSRS to a wider audience of clinicians, academics, management and policy makers.

This PMU will manage this process and consultation will be conducted with all Specialist Medical Colleges; in particular Council Members, CPD/Education Units, Rural Interest Group, Fellows involved in developing and participating in continuing professional development programs and College support staff. In implementing this recommendation, the PMU will consult with the HIMH to identify suitable methods for consultation (i.e. focus groups or a facilitated workshop). The HIMH have also offered Program evaluation information to date, to assist with this process.

## **2. Commitment to Funding**

The SSRS has historically been funded on a year by year basis. Consequently, the announcement of funding for a future Round of projects has led to minimal timeframes for the PMU and PMC to publicise the availability of Program funds and coordinate the Scheme including the application and assessment process. This has also resulted in reduced timeframes to allow Colleges to prepare project applications. Colleges have cited that this lack of lead-time has impeded inter-College collaboration on SSRS applications. It is recommended that six months is an optimum lead-time to allow sufficient preparation and review of existing processes.

## **3. Project Timeframes**

The delivery of a comprehensive Program that meets the continuing professional development needs of rural specialists is difficult to achieve in a twelve month program. This is especially apparent for program involving clinical practice improvement, the implementation of best practice guidelines, or in the development of a sustainable professional network. This timeframe is also less conducive to the measurement of knowledge transfer and sustainable outcomes as a result of project activities.

In addition, the formulation of new contractual arrangements each year between the DHA, the CPMC, the PMU and individual Specialist Medical Colleges, further impact on the Program period. The majority of individual projects conducted under the SSRS program have highlighted that the short timeframes have a negative impact on the achievements against objectives that were initially planned for each project. Lengthier timeframes for the implementation of the SSRS Program would assist to:

- Improve outcomes that projects could achieve by enabling a longer period to implement and evaluate projects
- Determine the longer term impacts of the implementation of such projects
- Revise project tools as required during the course of the project
- Build aspects of sustainability into individual projects.

The HIMH have also reported this issue in their evaluation of Rounds 3 and 4 of the SSRS. They reported the following as a specific finding of the evaluation:

***An area identified as a major problem was the timeframes involved. It was suggested that they could be lengthened and that longer-term planning would improve the success and sustainability of the Program.***

In light of this recommendation, the PMC recommends consideration of a future project driven program to be planned in a two tiered approach:

- a) Encourage the establishment of program based projects that extend over two years that incorporate higher models of learning such as demonstrated maintenance of best practice standards, implementation of practice changes, and evaluation of the impact of an activity or intervention.
- b) Encourage the piloting over 12-18 months of new innovative projects or activities that with a successful evaluation would progress into program based projects as indicated in point a) above.

All future projects funded would need to consider building in sustainability for such programs.

## **4. Communication Strategy**

In 2005 the PMU and PMC implemented the SSRS Communication Strategy. This strategy was developed to enhance the understanding of the objectives and outcomes of the Scheme by relevant individuals and organisations and to increase access to and participation by rural specialists in SSRS project activities. It is recommended that this Strategy be further developed to include the areas listed below areas:

#### **a) CPD within Colleges**

The delivery of CPD programs and associated activities should be considered within the broader CPD/Education strategies of Colleges. The types of programs and associated activities that will be supported would need to reflect the College CPD Curriculum and / or Education Strategy. This would increase the potential for the sustainability and maintenance of the education model after SSRS funding has ceased.

#### **b) Previously Funded Activities**

Colleges have reported participant satisfaction and successful outcomes in relation to many SSRS projects funded to date. However, the Communication Strategy will reaffirm the message that the scope of this program, is to assist Specialist Medical Colleges in consultation with their rural Fellows, to develop, pilot, refine and evaluate education projects. Based on this process, Colleges should consider the incorporation of successful project models into their College CDP Curriculum or Education Program.

#### **c) Site Visits**

The process of Site Visits will be used in Round Six to strengthen the communication between the PMU, PMC and Project teams. By gaining a greater understanding of SSRS projects at an operational level, the PMU and PMC will increase their ability develop a target communication strategy and further refine program resources and scope. Site Visits will also provide a means for the PMU and PMC to assess and cross communicate the transfer of learning outcomes, project resources and implementation strategies across individual projects.

The PMU will also continue to use the SSRS Communication Strategy to raise the profile of the role of the CPMC and Specialist Medical Colleges in the provision of CPD activities for rural specialists.

### **5. Overseas Trained Doctors and Specialist Trainees**

In Round Five as in previous rounds of the SSRS, projects have benefited from the involvement of Overseas Trained Specialists and Specialist Trainees in project events and activities. Trainees and OTSs can increase the critical mass of professional networks and contribute to the transfer of clinical and non clinical skills, knowledge and professional support. This is particularly important as it has been widely reported that the experiences of trainees undertaking rural placements may influence their decision to undertake regional or rural practice in the future. It is recommended that closer liaison with the Overseas Trained Doctors Taskforce of the Department of Health and Ageing along with College Training Departments would assist to achieve the following:

- Determine the location of overseas trained specialists and trainees working in rural areas
- Identify any specific needs these group has in relation to CPD and professional support
- Promote the programs and associated activities of the SSRS program and actively encouraged their participation

The PMU will continue to liaise with Colleges; SSRS project staff, the Department of Health and Ageing, the PMC and the CPMC to support the delivery of the SSRS and achievement of Program objectives.

### **4.3. Future Direction of the SSRS**

In 2005, the Productivity Commission Report identified 'a strong focus on regionally based education and training' as a specific targeted initiative which can potentially improve health workforce services in rural and remote areas. However, professional isolation, along with access to CPD, education and training opportunities remain a significant inhibitor to recruitment and retention of health care professionals and workforce availability in rural areas (Curran, Fleet, & Kirby, 2006, 2005 Productivity Commission Report). While the HIMH are currently completing their Round Five SSRS Evaluation Report, the Round 3 and 4 Report stated that access to CPD for rural specialists was still seen as inequitable, but that the SSRS was supported as a Program which has gone some way in redressing this issue. The existence, objectives and function of the SSRS is as relevant in 2006 as it was at the

Programs inception. This Program plays a significant role in improving access to CPD for rural specialists and in reducing professional isolation of specialists practicing in rural and remote areas of Australia.

## SECTION FIVE

### 5.1 Project Expenditure

Table Ten indicates the individual project funding and expenditure at the close of the project period. Individual Project Audited Financial Statements can be found at *attachment 19*.

Project	Budget (\$)	Expenditure (\$)	Surplus/(Deficit) (\$) (Inc. interest) from Project Budget
5.1 RACMA – Management Skills	94,000.00	80,000.00*	14,000.00*
5.2 RANZCP - Tutorial	58,000.00	62,463.00	0.00
5.3 RANZCP – WA Network	26,000.00	25,799.00	201.00
5.4 RACS – Risk Management	97,000.00	63,937.00	33,063.00
5.5 RACS Audit & Peer Review	100,000.00	86,541.00	13,459.00
5.6 RACS – North QLD CPD	44,000.00	39,600.00	4,400.00
5.7 RACS – DWDP/WLB	97,000.00	77,692.00	19,308.00
5.8 RANZCR – Vic Branch CPD	70,000.00	215,246.87	0.00
5.9 RANZCR – The Alfred Melbourne CPD	70,000.00		
5.10 RANZCR, RACS – Joint CPD	70,000.00		
5.11 RANZCOG – Practice Visits	110,000.00	118,822.14	0.00
5.12 RANZCOG - Perinatal	96,000.00	112,289.93	0.00
5.13 ACD – CD ROM	70,000.00	60,766.04	9,453.96
5.14 RACP – QUM	122,000.00	89,763.36	20,036.64
5.15 RACP – NACAPP	69,000.00	69,474.27	0.00
5.16 RACP – ROAST	130,000.00	121,595.79	8,404.21
5.17 RACP – Journal Club	10,000.00	10,000.00	0.00
5.18 RACP – FEAT	43,000.00	43,300.00	0.00
5.19 RACP – CPD	61,000.00	59,703.92	1,296.08
5.20 AFOM – WHAM	74,000.00	65,316.40	8,683.60
5.21 AFRM - BEARS	94,000.00	76016.15	17,983.85
5.22 ANZCA, JFICM & ACEM – Instructor	116,000.00	101,366.32	14,633.68
5.23 ACEM – Crisis Mgmt Workshops	112,000.00	135,000.00	0.00
<b>TOTAL</b>	<b>1,833,000.00</b>		<b>\$164,923.02</b>

\*Project 5.1 has been granted an extension until mid-July. Expenditure and Surplus are based on estimates for the extended project period, from a RACMA financial report printed 9 May 2006.

All projects funded in Round Five have received 90 per cent of their project budget. Now that Final Reports and Audited Financial Statements have been received, the Project Management Unit will liaise with the CPMC who will:

- Request Colleges invoice the CPMC for up to the Final 10 per cent payment where required; or
- Invoice Colleges where surplus project funds have been identified.

### 5.2 Project Management Unit Expenditure

The Project Management Unit has received 90 per cent of the total budget to date. Table Eleven indicates the budget and expenditure for the Project Management Unit at the close of the project period. The Audited Financial Statement for the Project Management Unit can be found at *attachment 20*. This audited financial statement and the Table below, indicate that;

- The PMU Expenditure is \$347,085.31

- The final 10% payment of \$44,880 from CPMC is not required
- The CPMC will invoice the PMU for a surplus (based on the 90 per cent of funds received) of \$63,831.80 including interest.

**Table Eleven: Project Management Unit Budget and Expenditure**

<b>Item</b>	<b>Budget (\$)</b>	<b>Expenditure (\$)</b>
<b>Total PMU</b>	303,800.00	247,124.57
<b>Website</b>	5,000.00	3,112.50
<b>Workshop</b>	30,000.00	13,789.82
<b>Communication</b>	30,000.00	23,058.42
<b>Contingency Funds</b>	20,000.00	0.00
<b>RACP management fee</b>	60,000.00	60,000.00
<b>TOTAL</b>	<b>448,800.00</b>	<b>347,085.31</b>
<b>Interest accumulated</b>	<b>6,997.11</b>	
<b>GRAND TOTAL</b>	<b>455,797.11</b>	

## References

1. Productivity Commission 2005, *Australia's Health Workforce*, Research Report, Canberra, 203 and 210.
2. Curran, VR., Fleet, L. and Kirby, F. 2006, Factors influencing rural health care professionals' access to continuing professional education, *Australian Journal of Rural Health*, 14(2), 51-55. (in Final Report 5.2)
3. SSRS Round Five Individual Project Reports 5.1 – 5.23.