

# Support Scheme for Rural Specialists

## Round SIX Program Final Report

May 2006 to 30 May 2007



### Committee of Presidents of Medical Colleges

---



Australian Government  
Department of Health and Ageing

**Support Scheme for Rural Specialists  
Project Management Unit**

145 Macquarie Street  
Sydney NSW 2000

Ph: (02) 9256 9615 Fax: (02) 9256 9610

Email: [info@ruralspecialist.org.au](mailto:info@ruralspecialist.org.au)

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

## 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 [Electronic Newsletters](#)
- 2.4 [Annual Scientific Meetings](#)
- 2.5 [Promotional Material](#)
- 2.6 [SSRS Forum](#)

### Section THREE

- 3.1 [Round Six Project Assessment Panel](#)
- 3.2 [Round Six Projects](#)
- 3.3 [Project Objectives](#)
- 3.4 [Round Six Project Statistics](#)
- 3.5 [SSRS Communication and Marketing of Projects](#)
- 3.6 [Round Six Project Outcomes and Results](#)
- 3.7 [SSRS Resources Developed](#)
- 3.8 [Round Six Project Limitations and Constraints](#)
- 3.9 [Round Six Project Recommendations](#)
- 3.10 [SSRS Transferability of Education and Project Models](#)
- 3.11 [SSRS Feedback to Specialist Medical Colleges](#)
- 3.12 [Dissemination of SSRS Project outcomes and information](#)
- 3.13 [Variations to Funding Agreements](#)

### Section FOUR

- 4.1 [Program Results](#)
- 4.2 [Site Visits](#)
- 4.3 [Program Limitations and Recommendations](#)
- 4.4 [Future directions of the Scheme](#)

### Section FIVE

- 5.1 [Project Management Unit Budget and Expenditure](#)
- 5.2 [Project Budget and Expenditure](#)

## TABLES

<b>Table One</b>	SSRS Projects and Project Funding Rounds One to Six
<b>Table Two</b>	PMC Meetings held during Round Six
<b>Table Three</b>	E-Newsletters in Round Six
<b>Table Four</b>	SSRS representation at College Annual Scientific Meetings and Conferences
<b>Table Five</b>	SSRS Promotional Material
<b>Table Six</b>	SSRS Round Six Projects
<b>Table Seven</b>	Statistics on SSRS Project Activities
<b>Table Eight</b>	Project Resources developed during Round Six
<b>Table Nine</b>	SSRS Projects – self reported transferability of education models
<b>Table Ten</b>	SSRS Round Six Site Visits
<b>Table Eleven</b>	Round Six - Project Management Unit: Budget and Expenditure
<b>Table Twelve</b>	Round Six - Projects: Budget and Expenditure

## ATTACHMENTS

1. Project Management Committee Membership and Terms of Reference
2. Agenda and Minutes of Project Management Committee Meetings
3. Rural Specialist Website Traffic Reports
4. SSRS Electronic Newsletters
5. SSRS Promotional Materials
6. SSRS Forum Workbook
7. Principles and Guidelines for Accessing Project Funding and Application Form
8. Round Six Project Assessment Panel Report
9. Requests for extensions to funding or project period (6.03, 6.04, 6.05, 6.13)
10. SSRS Site Visit Proforma
11. Project Management Unit Financial Statement
12. Project Financial Statements
13. Round Six Project Final Reports

## ACRONYMS

CPD	Continuing Professional Development
CPMC	Committee of Presidents of Medical Colleges
DOHA	Australian Government Department of Health and Ageing
PMC	Project Management Committee
PMU	Project Management Unit
SSRS	Support Scheme for Rural Specialists
OTS	Overseas Trained Specialist

### 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 (CPD) opportunities for specialists practising in rural areas of Australia. The Program is a joint initiative of the Committee of Presidents of Medical Colleges (CPMC) and Department of Health and Ageing and is funded by the Australian Government. This Scheme was developed to address issues highlighted in the initial consultancy report including access to professional development, continuing medical education and peer support.

Since 2002, Program funds have supported the implementation of over 80 CPD and education projects based on the learning and professional support needs of rural specialists. In 2006, 13 projects have been supported to the value of \$1,207,000. Two projects received additional funding to support the implementation of the project to a wider target audience; this took the total investment in Round Six Projects to \$1,266,460.

Table One outlines the number of projects and project funding component of the SSRS from Round One to Round Six.

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

Round	Number of Projects	Total Funding
One and Two	22	\$2,326,170
Three	21	\$2,054,000
Four	6	\$568,298
Five	23	\$1,833,300
Six	13	1,266,460
<b>TOTAL</b>	<b>85</b>	<b>\$8,048,228</b>

### 1.2 Project Objectives

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

1. Provide professional support to medical specialists practising in rural and remote areas of Australia, including through continuing professional development and peer support;
2. 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 Specialist Medical College for each individual project. The Royal Australasian College of Physicians (RACP) has been subcontracted by the CPMC to implement and manage the Scheme.

### 1.4 Project Management Committee

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

The PMC is comprised of the DoHA 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 Committee also includes the Chair of the CEO sub-group of the CPMC, the Chair of the CPMC Education sub-committee along with the Project Management Unit.

Professor Michael Cousins, Chair of the Committee of Presidents' of Medical Colleges, is the Chair of the SSRS PMC. The current PMC Terms of Reference and membership listing can be found at *attachment 1*.

During Round Six, the PMC met on seven occasions including two face-to-face meeting and five teleconferences. The Agendas and Minutes from these meetings are at *attachment 2*. Table Two lists the PMC meetings held during Round Six of the SSRS.

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

Meeting	Chair	Date
Project Assessment Panel Face to Face Meeting	Professor Michael Cousins	24 March 2006
Teleconference	Professor Michael Cousins	3 April 2006
Teleconference	Professor Michael Cousins	22 May 2006
Teleconference	Professor Michael Cousins	10 August 2006
Teleconference	Professor Michael Cousins	13 November 2006
Teleconference	Professor Michael Cousins	19 February 2007
SSRS Round Six Forum Face to Face Meeting	Mr Gary Disher	23 March 2007

### 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. During Round Six, the SSRS PMU has also assisted Colleges in with the following:

- Development of Project Applications which meet the SSRS Application and Funding Guidelines
- Communication and Promotion of Projects to rural specialists
- Project and Planning
- Feedback from Site Visits to Project staff and Colleges.

The Project Management Unit consists of the following staff:

Position	FTE	Incumbent
National Program Director	0.1	Mr Gary Disher
Program Manager	0.2	Ms Lauren Dalton
Senior Project Officer	0.8	Ms Belinda Pond

## SECTION TWO

### 2.1 *Communication strategy*

There are many strategies employed by the PMU and PMC aimed at promoting both the Scheme and individual projects. Such strategies are designed to maximise awareness of the Scheme, encourage participation in projects, and support rural specialists in meeting their ongoing CPD needs. The following tools are all central to the communication of the Scheme:

- Rural Specialist Website
- SSRS Forum
- Presentations and networking at Conferences
- E-Newsletters
- Media Releases
- Consultation with Specialist Medical College staff and Committee of Medical College Educators
- Consultation via CPMC CEOs / Presidents' Forums
- Project promotional flyers
- Program hard copy flyers, pens, bags

### 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 contains a content management system to assist with promoting the most recent information. Historical project details are also included.

The menu items featured on the website include:

- *Home*
- *Resources*
- *Message Board*
- *E-Newsletter*
- *Events*
- *About the SSRS*
- *Projects*
- *Contact us*

The website traffic reports indicate the following statistics for Round Six of the Scheme.

Average pages viewed per visit	3.1	
Most common referral domains	Google, Ninemsn, College websites and the DoHA website	
Top referral URLs	<a href="http://www.google.com/search">http://www.google.com/search</a> <a href="http://www.racp.edu.au">http://www.racp.edu.au</a> <a href="http://www.google.com.au/search">http://www.google.com.au/search</a> <a href="http://cpmc.edu.au/ssrs">http://cpmc.edu.au/ssrs</a> <a href="http://www.google.co/uk">http://www.google.co/uk</a>	
Most frequent search terms included	Rural, SSRS, Doctor and Specialist	
Top page view (Page and Opens)	Index 2283 Events 958	Projects 2089 Resources 919

Website statistics per month for Round Six are reported below:

	May 2006	Jun 2006	Jul 2006	Aug 2006	Sep 2006	Oct 2006	Nov 2006	Dec 2006	Jan 2007	Feb 2007	Mar 2007	April 2007	Average / month
Website hits	197	229	229	215	238	228	139	280	184	232	213	231	218
Percent new visitors	12.9	9.2	6.1	11.7	8.00	10.1	10.8	10.4	10.9	9.5	8.5	3.9	9.33

The DoHA, CPMC and a number of Specialist Medical College websites contain information about the SSRS and links to the rural specialist website. Monthly website traffic reports for the Round Six project period can be found at *attachment 3*.

### 2.3 Electronic Newsletters

An electronic newsletter has been developed and includes information about SSRS projects, upcoming CPD activities and links to other resources. The newsletter is e-mailed to over 300 registered recipients, including; 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 4* includes electronic newsletters distributed during Round Six of the Scheme.

**Table Three: Round Six E-Newsletters**

Date Sent	Campaign Content	# Recipients	% Opened	Links Tracked
16 Jun 2006	<ul style="list-style-type: none"> <li>▪ Round Six SSRS Projects</li> <li>▪ Round Five SSRS Final Project Reports</li> <li>▪ 9<sup>th</sup> National Rural Health Conference</li> <li>▪ Anti-Poverty Week 2006</li> </ul>	329	37.08%	65%
7 Sep 2006	<ul style="list-style-type: none"> <li>▪ Improving outcomes in Acute Paediatric Emergencies: Simulation Training</li> <li>▪ The Northern Australia Surgeons' Conference</li> <li>▪ Round Five SSRS External Evaluation</li> <li>▪ 7<sup>th</sup> Wonca Rural Health Conference</li> <li>▪ Paediatric advanced life support: Australian Resuscitation Council Guidelines 2006</li> </ul>	324	43%	45%
5 Dec 2007	<ul style="list-style-type: none"> <li>▪ SSRS Round Seven Forum, 23 March 2007</li> <li>▪ RACP Congress May 2007 (Abstracts)</li> <li>▪ Specialist Obstetrician Locum Scheme (SOLS)</li> </ul>	381	47%	8%
23 Mar 2007	<ul style="list-style-type: none"> <li>▪ SSRS Round Seven Forum</li> </ul>	372	50%	20%
26 Apr 2007	<ul style="list-style-type: none"> <li>▪ SSRS Round Six Forum March 2007</li> <li>▪ Future directions for the SSRS (Potential Round Seven)</li> <li>▪ 9<sup>th</sup> National Rural Health Conference, March 2007 (Recommendations)</li> <li>▪ Paulson Rural Medical Research Fellowship</li> </ul>	371	36%	9%

### 2.4 College Annual Scientific Meetings and Conferences

Conferences and College Meetings provide the SSRS PMU with an opportunity to network with rural specialists regarding the SSRS, CPD needs of rural specialists and barriers to participation in SSRS activities. The table below details College conferences attended, along with other opportunities where the SSRS PMC and PMU have been able to promote the Scheme.

**Table Four: SSRS representation at College Meetings and Conferences**

College	Location and Date
The Royal Australasian College of Physicians Congress	Cairns May 2006
The Royal Australasian College of Medical Administrators Congress	Hobart August 2006
Chair SSRS PMC, SSRS National Director meeting with CPMC CEOs Forum	Melbourne August 2006
The Australian College for Rural and Remote Medicine Conference	Adelaide November 2006
Chair SSRS PMC meeting with the Hon Tony Abbott	November 2006
Chair SSRS PMC meeting with Editor, Medical Journal of Australia	November 2006
Australian Commission for Safety and Quality in Health Care	Sydney, November 2006
Committee of Medical College Educators	Melbourne, November 2006
Australasian College of Dermatology National Rural Conference (SSRS 6.01)	Queenscliff, March 2007
9 <sup>th</sup> National Rural Health Conference (Poster Presentation)	Albury, March 2007

## 2.5 Promotional material

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

**Table Five: SSRS Promotional Material**

Promotional Material	Description
<b>SSRS Postcard</b>	A postcard size flyer, Promotional Bag, Sticky Note Pads and Pens have all been produced to assist in promoting the Scheme.
<b>SSRS Promotional Bags</b>	These resources are made available to all SSRS projects to use at SSRS events and activities. The PMU also use these items when promoting the Scheme at annual scientific meetings and conferences.
<b>SSRS Note Pads</b>	In many instances, offering pens, sticky note pads or bags, this is a means to engage specialists around the issues associated with access to education in rural areas.
<b>SSRS Pens</b>	The promotional material all contain the rural specialist website address to direct recipients to further information on the Scheme. A sample of the material can be found at <i>attachment 5</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. In July 2006, the PMU purchased a professional exhibition banner to promote the SSRS at College and CPMC functions. A printed copy of the banner can be found at <i>attachment 5</i> .

In 2007, the PMU drafted an editorial on the Scheme for the Medical Journal of Australia. This descriptive publication highlights key outcomes of the implementation of the Scheme from Round One to Round Six. An editorial sub-committee has been appointed to support the PMU in this publication.

## 2.6 SSRS Forum

The Support Scheme for Rural Specialists Annual Forum was held in at the Melbourne Airport Hilton Hotel on Friday, 23 March 2007. This Forum incorporated key sessions addressing; CPD and Quality and Safety for Rural Specialists; Supporting Overseas Trained Specialists working in Rural and Remote Australia and; The future of CPD for specialists working in Rural and Remote Australia.

Three Round Six Projects presented on their experiences through the implementation of their CPD and peer support projects; **6.04** CPD for Australian Rural Psychiatrists; **6.05** Laparoscopy in gynaecology and surgery; audit of errors to improve safety; and **6.13** Improving clinical quality by enhancing organisational collaboration and skill development.

Specific informative feedback captured in the evaluation of the Forum indicated that participants rated some of the most valuable aspects of the day as the opportunity to:

- Hear about the diversity and experiences of projects funded under the Scheme
- Feel that CPD is recognised by Colleges and the DoHA as a crucial aspect of sustaining rural practice
- Network and discuss common issues with colleagues and colleges

Participants completing evaluations for the day, were also queried as to what they believe are the three key priority areas in supporting the recruitment and retention of medical specialists in rural and remote Australia. Overwhelmingly, responses included the themes of: professional networking opportunities; providing incentives for rural medical practice, and supporting infrastructure and facilities for rural medical practice. A copy of the Forum Workbook and Media Release can be found at *attachment 6*.

## SECTION THREE

### 3.1 Round Six Project Assessment Panel

Following the announcement by the DoHA to fund a sixth Round of the SSRS, the Chair of the CPMC, wrote to all College Presidents and Chief Executive Officers, inviting them to submit applications for funding under Round Six 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. Assistance was provided by the PMU to Colleges in the development of applications. Applications closed on Thursday 9 March 2006 and 36 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 24 March 2006 to assess applications against the published application criteria. In particular the PAP looked for evidence of the following;

- 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 several recommendations and changes to project applications, the PAP recommended to the CPMC and DoHA, that 13 Projects be funded, to a value of \$1.2 million. The Principles and Guidelines for accessing SSRS funding can be found at *attachment 7* and a copy of the Project Assessment Panel Report can be found at *attachment 8*.

### 3.2 Round Six Projects

**Table Six: Round Six SSRS Projects**

No.	College	Project Description	Budget (\$)
6.01	ACD	Rural Dermatology Conference	\$65,000
6.02	RACS	A regionally-based interdisciplinary CPD program for Surgeons in Northern Australia	\$64,000
6.03	RACP, JFICM ANZCA, ACEM	Achieving better integrated team – based care and use of clinical guidelines in acute rural paediatric practice	\$143,000
6.04	RANZCP	CPD for Australian Rural Psychiatrists	\$77,000
6.05	RANZCOG ANZCA, RACS	Laparoscopy in gynaecology and surgery: practice review using audit of errors for improving safety	\$115,000
6.06	RANZCOG (RACP)	Peri-natal mortality and morbidity: Learning from adverse events to improve care	\$101,000
6.07	RANZCP	Managing the pressures of rural psychiatry. Clinical leadership	\$73,000
6.08	JFICM	Basic Assessment and Support in Intensive Care: Rural Specialists	\$28,000
6.09	AFRM	Improving the Care for Stroke Patients in Rural & Regional Areas: Rural Organisation of Stroke Teams 3	\$100,000
6.10	RANZCR	Emerging Techniques in Radiology	\$70,000
6.11	RACS	Rural Craft Group – from Audit to performance Monitoring	\$111,000
6.12	ACEM	Scenario-Based Clinical Teaching Skills for Acute Care Medicine	\$125,000
6.13	RACP, RACS, RACMA	Improving clinical quality by enhancing organisational collaboration and skill development	\$135,000
		<b>TOTAL</b>	<b>\$1,207,000</b>

### **3.3 Project Objectives**

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

---

#### **Access to CPD**

- Assist rural specialists meet College CPD requirements through rural specific activities such as up-skilling and clinical audit (6.1, 6.2, 6.4)
- Assist rural specialists meet professional registration requirements in relation to CPD (6.4)
- Facilitate peer and professional networks for rural specialists to decrease professional isolation and increase communication and collegiality among rural specialists (6.1, 6.2, 6.4, 6.7, 6.10)
- Identify and prioritise education and training needs for rural specialists (6.4)
- Support the increasing use of video-conference and communication technology as a resource to support learning and access to CPD (6.1, 6.2)
- Create interactive and supportive learning environment for rural specialists (6.7, 6.9).

#### **Clinical skills development**

- Support rural specialists gain hands-on practice with a range of infrequently encountered emergency conditions (6.3, 6.8)
- Improve the clinical teams' preparedness, communication and integration to respond appropriately to an acute patient episode (6.3, 6.8)
- Improve clinical skills and knowledge (6.2, 6.7, 6.10)

#### **Improve the development of educational programs and learning objectives**

- Development an understanding of the educational principles of scenario based learning for rural specialists educators (6.12)
- Develop education programs based on best practice guidelines, to improve the site based management of specific patient conditions (6.3, 6.09, 6.12)
- Develop the capacity of rural specialists to facilitate performance review and provide constructive feedback following peer reviews or simulated clinical activities (6.3, 6.6, 6.12)
- Development of practical skills in setting and communicating learning objectives (6.3, 6.12)
- Develop, evaluate and revise clinical and educational resources to support rural CPD programs (6.6, 6.7, 6.11)
- Measuring sustainability of educational activities through participant follow up post project (6.6, 6.13).

#### **Safety and Quality**

- Enhance understanding of quality improvement rationale and methodology, through collaborative participation in local QI projects (6.13)
- To improve complex decision-making relevant to acute conditions (6.3)
- Raise awareness of risk management as a tool to improve quality and safety of care (6.3)
- Implement risk management strategies such as audit and peer review to identify and address gaps in skills and clinical practice (6.3, 6.6, 6.5)
- Raise awareness of the benefits of implementation of clinical guidelines for clinicians and their teams (6.3)
- Promote continuity of care and improve health outcomes for patients and their carers (6.9)
- Implement continuous quality improvement processes through analysis and benchmarking of performance based on data collected in audits (6.5, 6.9, 6.11)
- Identify barriers to implementing best practice care to patients in rural and regional areas and design methods to overcome these barriers (6.5)
- Understand how and what to audit after an adverse event or near miss (6.6).

#### **Promote research and dissemination of effective models for service improvement**

- Provide educational events to highlight the prevalence of specific clinical issues (6.3, 6.5)
- Promote a culture of clinical research in regional centres (6.2)
- Disseminate project results and findings to relevant agencies through publications or conference presentations (6.5, 6.7, 6.9, 6.11)
- Undertake pilot and demonstration projects around complex clinical issues and communicate evaluated educational strategies and project experiences (6.7)

#### **Clinical leadership**

- Support rural specialists to act as clinical leaders and implement clinical guidelines in their own hospital or practices to improve the quality of care provided by teams in their workplaces (6.3)
  - Work with participants interactively to identify clinical leadership and teamwork issues (6.7)
  - Enhance clinician leadership of quality improvement activities within rural hospitals and practices (6.13).
-



No.	Date of event	Type of event <sup>1</sup>	Mode of Delivery <sup>2</sup>	No. Participant (& sites if videoconf)	Total Events/ Participation
		peer review visits	Paper based resources		
6.07	22.09.06 06.10.06 30.10.06 27.11.06 06.02.07 26.03.07	Expert panel meeting Expert panel meeting Workshop (virtual) Workshop (virtual) Participant Meeting Expert panel meeting	Teleconference Teleconference Videoconference Videoconference Teleconference Teleconference	8 (6 sites) 7 (5 sites) 7 (6 sites) 5 (4 sites) 4 (4 sites) 4 (4 sites)	6 Events 14 Fellows
6.08	29-31.08.06 2-3.11.06 2-4.02.07 3-5.04.07	Skills workshop Skills workshop Skills workshop Skills workshop	Interactive face to face Interactive face to face Interactive face to face Interactive face to face	24 (1 Rural Fellow) 29 (0 Rural Fellow) 8 (0 Rural Fellow) 17 (0 Rural Fellow)	4 Events 1 Fellow
6.09	09.06 30.11.06 Ongoing 11.06 03.07 12-13.03.07 Ongoing 04.07	Hard-copy edu resource Learning Session On line tutorials Hard-copy edu resource Learning Session Audit Report consult Audit Report Consult	CD-Rom/paper based Face to Face workshop Web based CD-Rom/paper based Face to Face workshop Email Discussion Email Discussion	100 93 Not recorded 100 76 21 sites 21 sites	7 Events, 55 Participants
6.10	21.04.06 18.05.06 16.06.06 21.07.06 27.11.06 10.02.07	Education Update Education Update Education Update Education Update Education Update Education Update	Video-conference Video-conference Video-conference Video-conference Video-conference Video-conference	80 (14 sites) 60 (9 sites) 70 (11 sites) 15 (5) 15 (5) 10	6 Events Approx 80
6.11	01.09.06- 15.03.07	Electronic Audit	Audit	82 (11 Sites)	1 Events 82 Participants
6.12	21-23.09.06 19-21.10.06 30.11-2.12.06	Skills Workshop Skills Workshop Skills Workshop	Interactive face to face Interactive face to face Interactive face to face	8 (5 Fellows) 10 (5 Fellows) 9 (5 Fellows)	3 Events 15 Participants
6.13	11.08.06 08.09.06 06.10.06 20.10.06 08.02.07 26.04.07	Education Workshop Education Workshop Education Workshop Education Workshop Education Workshop Follow up Workshop	Interactive face to face Interactive face to face Interactive face to face Interactive face to face Interactive face to face Interactive face to face	19 19 12 13 13 4	7 Events 76 participants
<b>Total Events: Approx 100; Total Participants (approximate): 750</b>					

### \*Reoccurring Participation Rate

In Projects such as video-conference series, recurring participation is frequent. While Project coordinators are asked to collect participant information on all individual attendees (not just the number of sites connecting) it is difficult to ascertain exact recurring participation rates. For this reason, only approximate unique participants can be provided.

### 3.5 Communication and Marketing of Projects

The following communication and marketing strategies have been employed by Colleges and SSRS project coordinators, to attract participants and promote SSRS activities:

- Promote activities through existing clinical networks developed in previous rounds of the SSRS
- College and project hard copy and e-newsletters
- Specialty specific hard copy or electronic mail outs to all rural College Fellows / target audience
- Presentations about the project at Provincial Fellows meetings or Rural Special Interest Group meetings
- Presentations or booths at College Conferences
- Network with potential clinical leaders who can champion the project at relevant targeted locations
- Site based promotion (Hospital departments)
- Promote project via local College or organisational website (i.e. Health Workforce QLD)
- SSRS Website and SSRS e-Newsletter
- Telephone contact with individuals previously involved in similar projects
- Telephone contact to follow up those who did not respond to hard copy or electronic mail outs
- Project resources distributed to State College branches
- Event details promoted on Global Telehealth website
- Word of mouth and specialists asked to recruit colleagues

### 3.6 Round Six Project results and outcomes

During Round Six, approximately 100 educational events were held involving roughly 750 participating specialists. In addition, many SSRS events have involved participation of other rural health practitioners where their participation has been cost neutral, or supported through external funding arrangements.

The following section highlights key outcomes and evaluation results as reported by each Round Six Project. Specific information on key outcomes and results from individual project reports can be found in *attachment 13*.

#### Outcomes and results Round Six Projects include:

<b>Collaboration</b>	<ul style="list-style-type: none"> <li>- Colleges and project staff fostering collaborative partnerships with: Health Workforce QLD, Bendigo Health Service, the Sydney Medical Simulation Centre, James Cook University the Centre for Rural and Remote Mental Health and the QLD Skills Development Centre.</li> <li>- Networking with non-medical workers in rural areas such as financial councillors and drought support workers to raise awareness about a community approach to clinical service provision and patient care.</li> <li>- Collaboration between overseas trained doctors, specialist trainees and other medical staff in building professional critical mass in rural and regional areas to enhance peer support.</li> <li>- Implementation of four collaborative College projects and seven multidisciplinary projects.</li> <li>- Hospital medical administration supporting the implementation of site based quality assurance CPD activities and involvement of specialist's colleagues in these projects.</li> <li>- Collegial audit from clinicians working in similar circumstances created a supportive environment for opened and frank discussion, enabling areas of risk to be identified.</li> </ul>
<b>Participation</b>	<ul style="list-style-type: none"> <li>- Higher than anticipated participation in several projects by speciality groups and location, due to effective needs based planning and appropriate methods for the delivery of CPD.</li> <li>- Lower than anticipated participation of specialists in some projects, potentially resulting from insufficient needs assessment being conducted prior to program implementation or ineffective marketing and communication strategies.</li> <li>- AON, GP proceduralist's and specialists working in rural areas or providing outreach services in rural areas identified and supported to participate in specialist CPD projects.</li> </ul>
<b>Clinical and Professional Skills</b>	<ul style="list-style-type: none"> <li>- Reported acquisition of new or improved skill or knowledge in relation to specific clinical or professional areas.</li> <li>- Compliance with national guidelines or national priority areas in relation to clinical and professional skills and processes.</li> <li>- Reported increase in skill, knowledge and confidence in conducting audits and peer reviews and providing feedback to colleagues.</li> <li>- Benchmark and aggregate datasets provided to participants for specific clinical procedures and guidelines for planning to improve individual competence or clinical systems against the aggregate.</li> <li>- Understanding of the processes of organisational change to enable integration of needs based education and CPD activities in a site based context.</li> <li>- Reported changes to the way in which participants will work with patient groups or communities in the future.</li> <li>- Increases in clinical and professional outcomes based on pre and post evaluation of knowledge and attitudes in relation to specific topics.</li> </ul>
<b>Project Funding</b>	<ul style="list-style-type: none"> <li>- The granting of additional funding by the DoHA to maximise project reach and participation.</li> <li>- Partnerships with external organisations to obtaining funding to support implementation and sustainability of projects.</li> <li>- Ongoing investigation in to the financial and technical sustainability of the CPD activities post SSRS funding.</li> <li>- Concern expressed by participants by the non-ongoing nature of the SSRS or support for rural specialists.</li> </ul>
<b>Project Resources</b>	<ul style="list-style-type: none"> <li>- Development of seven project resources to support the delivery of CPD to rural specialists.</li> <li>- Commitment by specialists' hospitals for future use of education models.</li> <li>- Project participants' now effective teachers or facilitators of simulation or scenario based education programs in contexts of varying resource capacity and organisational structure.</li> </ul>

<b>Reduction in professional isolation</b>	<ul style="list-style-type: none"> <li>- Nationwide projects establishing effective networks with key stakeholders.</li> <li>- Participation in rural activities reducing professional isolation and strengthening collegiality.</li> <li>- In situ delivery of CPD used to support local collegiality and collaborative approaches to clinical and professional issues.</li> <li>- Participants in CPD activities agreed that their participation assisted them to build better relationships with colleagues and reduced their sense of professional isolation.</li> </ul>
<b>College Education Programs</b>	<ul style="list-style-type: none"> <li>- Project curriculum designed to enhance inter-organisational collaboration around specific clinical content for future application and consistency.</li> <li>- Allocation of College CPD and MOPS points.</li> </ul>
<b>Evaluation and data collection</b>	<ul style="list-style-type: none"> <li>- Incomplete evaluation components of projects limiting the ability to evaluate the program reach, impact, or benefit to specialists involved along with decreasing the capacity to learn from program implementation and plan effective strategies for the delivery of CPD in the future.</li> <li>- Incomplete participation records for project activities due to technical difficulties or non-compliance with reporting guidelines, inhibiting the ability to determine the effectiveness of the activity in terms of engagement of rural specialists and evaluation of their participation.</li> <li>- Achievement of a range of evaluation activities such as pre and post testing on knowledge or attitude, focus groups, interviews, mail out surveys and ongoing web-based progress tracking.</li> <li>- Qualitative evaluation of most events demonstrating that specialists value the opportunity to participant in peer support and CDP programs which may otherwise not be available.</li> </ul>
<b>Lessons learned</b>	<ul style="list-style-type: none"> <li>- Feedback from site visits and initial project activities has informed the planning and implementation of future activities.</li> <li>- Feedback from participants on preferred models for the delivery of CPD and peer support.</li> <li>- Lessons learned in relation to engaging specialists in audit based CPD or developing and implementing collaborative CPD activities.</li> <li>- SSRS activities contributing to understanding and confidence in the use of models within specific geographical and clinical context.</li> <li>- Identification of barriers to specific education models or methods for teaching and learning.</li> </ul>

### 3.7 Resources Developed under Round Six Projects

**Table Eight: Project Resources developed during Round Six**

Project	Resource
6.03	Simulation course providers' materials including Training Manual for Simulation based Workshop and Quality Assurance and Risk Management Tool Kit.
6.05	Rural Laparoscopy Audit Tool for Anaesthetists, Surgeons and Gynaecologists and tools including templates for action planning, implementing change and completing the quality cycle and patient information and consent materials.
6.06	Peri-natal Mortality and Morbidity Resource Manual with sample audit tools; what investigations should be sought, information about handling the event, communicating with colleagues or parents.
6.07	Web based interactive Project forum created on (Mulga Net) <a href="http://www.mulganet.net.au">www.mulganet.net.au</a>
6.09	Spasticity Learning Module, "Stoke: Life Long Spasticity Management" published and circulated to all participating organisations.
6.12	Didactic education materials for scenario based learning on website <a href="http://www.sbl.net.au">www.sbl.net.au</a> Includes: templates for project plans (to be completed prior to course attendance).
6.13	Participant's Manual with tools to assist with planning and implementing site based quality projects.

### 3.8 Round Six Project Limitations and Constraints

There have been several constraints and limitations identified by Round Six projects, which have limited the extent to which SSRS project objectives have been achieved. Colleges have been advised that in some instances, projects may not be able to meet specific project components or project objectives. However, projects must reflect and report on reasons for this, to support mitigation of these risks in future projects designed to support rural specialists. Specific information from individual reports can be found in *attachment 13*.

### 3.8.a) Constraints and limitations identified by Round Six Projects include:

#### Timeframes

- Sub-contracting arrangements place further pressure on already limited timeframes.
- Ambitious learning objectives difficult to achieve and evaluate within existing timeframe.
- Reduced time to complete scheduling of activities with specialists, follow-up and evaluation activities.
- Delays for granting of qualified privilege or ethics approval delay other project activities.
- Inability to revise project tools as desired, within existing timeframe.

#### Recruitment

- Difficulty in locating visiting medical officers and overseas trained specialists for projects.
- In some instances, low responses to project recruitment strategies.
- Projects based on national recommendations / guidelines or priority area of academics, do not always guarantee recruitment of target audience.
- Insufficient needs assessment leading to poor recruitment of target audience

#### Technical

- Managing the diversity of video-conference equipment across remote sites. The mode of dissemination needs to be compatible with various types of equipment to provide high-quality audio and simultaneous visuals and sound for all participants.
- Problems with technical providers meaning that evaluation statistics were unavailable. This affected the ability to disseminate further project information and evaluation information to some participants.

#### Capacity to deliver

- Staff turnover to administer the project affects the engagement of clinicians in rural areas.
- Constraints caused by completing all activities with a larger than anticipated project audience.
- Projects based on the good will of clinical leaders create difficulty in sustainability planning.
- Staff turn-over within project (site based activities).

#### Scheduling and time constraints of participants

- Timing and location of project activities to maximise attendance and cost efficiency.
- Time zone differences cause difficulties in scheduling national wide video-conference series.
- Project requiring participants to travel can mean that specialists are away from practices up to 3 days.
- Project Coordinators and leaders required to spend time away from their practices.

#### Budget

- Budgetary constraints resulting in negotiations with pharmaceutical companies and external agencies to supplement SSRS activities.
- Small group based learning activities including scenario-based learning and simulation models require a higher ratio of facilitators to participants so it is more difficult to demonstrate cost effectiveness.
- Delivering workshops in'situ means that there is a higher costs for facilitators to travel to sites.

#### College Processes (inter College Projects)

- Differences in College 'rural' classification.
- Variation in preferred methods for accessing specialists and distributing promotional material.
- Variations in application for and awarding of MOPS points per project.

#### Evaluation and Impact

- Difficulty of demonstrating intangible outcomes or project impact such as enhanced institutional collaboration or practice change. Longitudinal follow would be required for an extensive period of implementation for these outcomes to be evaluated.
- Audit based projects require longer timeframes and larger sample sizes to often produce statistically significant results.

#### Participant commitment to evaluation activities

- Participant compliance with evaluation activities.
- Voluntary evaluation feedback lower than expected.
- Evaluation activities neglected by both project coordinators and participants when time is limited.

The PMU also identified additional limitations which have potentially impacted on the achievement of project objectives.

### 3.8.b) Broad constraints and limitations and issues identified by the PMU

#### Target Audience and pre determined 'need' for Projects

- Project 6.08 (JFICM) was awarded \$28,000 to implement a project to support rural specialists access clinical and professional up-skilling in intensive care medicine. This Project had previously been delivered internationally with positive participation and feedback. Of 78 participants, only one was a rural specialist.
- The PMU continued to work with JFICM over the course of the project to plan marketing strategies and discuss potential methods to support the Project meet objectives as specified in the funding agreement held with the DoHA.
- No funds were expended and the full amount will be returned to the DoHA. The PMU believe the following factors contributed to the inability of this project to meet its objectives:
  - Insufficient needs assessment conducted prior to project implementation
  - Insufficient marketing and communication strategies for the project.
  - No funding component dedicated to project support (project or admin support)
- Other Projects also experienced lower than anticipated participation rates of the target audience, in relation to original estimates. These included; 6.07, 6.09 and 6.12.

<b>SSRS supporting health workers / academics / training facilitators outside the SSRS rural specialist target audience</b>	<ul style="list-style-type: none"> <li>- Projects including 6.03, 6.07, 6.09 and 6.12, while delivering sound educational activities, involved a large proportion of non-rural specialist participants.</li> <li>- Specialists in rural areas often benefit from supportive and highly competent medical and allied health teams. <i>I.e. to achieve full benefit from participation in a stroke project, the complete stroke team needs to be involved.</i> Similarly, training future project clinical leaders in metropolitan, regional and rural areas to deliver rural based CPD and peer support activities through scenario and team based learning or simulation based education models, have longer term benefits than can be realised within the timeframes of a Round of SSRS funding.</li> <li>- Where the participation of non-rural specialists in SSRS activities is cost neutral this is supported. However, it is assumed that in some instances, SSRS support has subsidised the up-skilling of non-specialists working in regional, rural and remote Australia, or metropolitan Fellows. It is recommended that the SSRS PMC and DoHA communicate a more direct position regarding indirect methods for supporting the CPD needs of rural specialists.</li> </ul>
<b>Compliance with project reporting</b>	<ul style="list-style-type: none"> <li>- Projects are aware of the short timeframes for implementing and reporting on projects and apply for SSRS funding within this context. However, at least half of Round Six projects raised the feasibility of an extension with the PMU, many with the expectation that this would be granted. In general, College and Project compliance with reporting deadlines and financial audit information is not strong. While there are no doubt a range of factors leading to this, it is difficult for the PMU and CPMC to report on the implementation of the Program as a whole, or reconcile financial and reporting information for the Commonwealth.</li> </ul>
<b>Project Evaluation</b>	<ul style="list-style-type: none"> <li>- Evaluation is a core component of the delivery of any education program. Staffing and project budgets are also reflective of the time and resource requirements in evaluating a project. However, in some instances and perhaps as a result of the current Program timeframes, this component of the project may be neglected or rushed. The PMU continues to emphasise the importance of Project evaluation and the need for project coordinators and clinical leaders to present and report back to College Executives on project results.</li> </ul>
<b>Intellectual property for sub-contracted projects</b>	<ul style="list-style-type: none"> <li>- An aim of the SSRS is to increase the capacity of Colleges in the planning, implementation and evaluation of CPD projects. Projects 6.03, 6.07, 6.08, 6.09 and 6.12 all had either all or some components of the project which were developed or administered externally to the College. This raises the following issues in relation to subcontracted projects: <ul style="list-style-type: none"> <li>- Sustainability of project resources developed for rural specialists (i.e. who will update project web resources post SSRS funding).</li> <li>- While the DoHA has ownership of content developed under each Project, intellectual property and access to resources post SSRS funding has not yet been tested.</li> <li>- Due to the differences in priorities between Colleges and external education providers, consideration should be given to how these organisation can best deliver 'rural specific' resources and education models in addition to competing business priorities.</li> </ul> </li> </ul>

### 3.9 Round Six Project Recommendations

Round Six Projects have experienced both benefits and constraints associated with the delivery of their rural specific CPD activities. The following table contains key recommendations in relation to each Project. Further information on recommendations from individual project reports can be found in *attachment 13*.

Project	Key Recommendations
6.01	<ul style="list-style-type: none"> <li>▪ Present all outcomes of this Project to the broader College membership at the ASM.</li> <li>▪ Develop a Rural Dermatology Strategy for the ACD and investigate the feasibility of a biennial Rural Dermatology Workforce and CPD conference to support rural dermatology practice.</li> </ul>
6.02	<ul style="list-style-type: none"> <li>▪ Ongoing support for international medical graduates and specialist trainees to access CPD.</li> <li>▪ Recruitment of a core of local 'champions' to form a regional Steering Committee for a CPD Network in northern Australia, to support project promotion and implementation.</li> <li>▪ Provide incentives for individuals to lead CPD activities such as administrative and financial support or professional recognition.</li> </ul>

---

**Project Key Recommendations**


---

	<ul style="list-style-type: none"> <li>▪ Consolidation of regional CPD networks through inter-institutional professional visits, or supporting activities such as institutional audits, peer review meetings and interactive web-based resources.</li> </ul>
<b>6.03</b>	<ul style="list-style-type: none"> <li>▪ <i>Final Report Pending, extension granted until 30.07.2007 - No interim recommendations provided</i></li> </ul>
<b>6.04</b>	<ul style="list-style-type: none"> <li>▪ Continue to support rural psychiatrists through appropriate and accessible CPD activities.</li> <li>▪ Continue to invest in CPD activities, which are potentially sustainable post SSRS funding.</li> <li>▪ Review of evaluation activities associated with the implementation of this program including both activities provided through Global Tele-health and College evaluation activities. For example, videotape an education session for use in training for future events.</li> </ul>
<b>6.05</b>	<ul style="list-style-type: none"> <li>▪ Follow-up evaluation to be undertaken 6-12 months post project to identify project impact and practice change as a result of the project.</li> <li>▪ Further analysis of causative factors for error in laparoscopy in gynaecology and surgery within the current aggregate dataset, to observe patterns between practice and outcomes.</li> <li>▪ Broader distribution of Project resources and process, including to metropolitan specialists.</li> <li>▪ Future audit comparing rural and metropolitan data to explore differences and similarities in care and to determine setting (i.e. rural / regional) specific patient safety initiatives.</li> <li>▪ SSRS develop protocols and guidelines for video-conferencing of educational activities including information on regional gateways, participation and evaluation techniques.</li> </ul>
<b>6.06</b>	<ul style="list-style-type: none"> <li>▪ Ongoing perinatal audits and continued multidisciplinary collaboration of paediatricians and obstetricians for perinatal audits to allow greater case analysis of contributing factors of antenatal, intrapartum and postnatal issues and initiation of rural specific solutions to improving practice.</li> <li>▪ NSW Health provide in-service to regional hospitals on the PSANZ guidelines to improve their uptake, understanding and implementation.</li> <li>▪ Follow-up of sites visited be undertaken to assess uptake of recommendations and project impact.</li> <li>▪ Project resources refined for adaptation within other clinical or geographical contexts.</li> <li>▪ Funding and resourcing to support pathologists to up-skill in perinatal autopsy skills.</li> </ul>
<b>6.07</b>	<ul style="list-style-type: none"> <li>▪ Continued use of CPD programs to support the reforms of mental health practice in rural areas.</li> <li>▪ Replication of the process for modelling of inter-professional practice with health and non-health workers within other speciality disciplines or geographical settings.</li> <li>▪ Ongoing use of a problem based learning approach combined with other educational methods can be broadly adapted in a variety of settings.</li> <li>▪ Development tools evaluate inter-professional networking and collaboration to improve services.</li> </ul>
<b>6.08</b>	<ul style="list-style-type: none"> <li>▪ Greater investment in a needs assessment and marketing strategies for future projects.</li> </ul>
<b>6.09</b>	<ul style="list-style-type: none"> <li>▪ Ongoing use of combined methods for education programs to rural practitioners including both face-to-face learning supported by peer networks, hands on participant learning and resources.</li> <li>▪ Clinical leadership for the projects to continue to come from locally based specialists.</li> <li>▪ Program broadly applied to junior medical staff in rural, regional and metropolitan sites.</li> <li>▪ Continued acknowledging and resourcing of team based education for specialists practicing in rural and remote areas. (The importance of a strong, cohesive, well educated care team for to support the specialist crucial to rural practice).</li> </ul>
<b>6.10</b>	<ul style="list-style-type: none"> <li>▪ Ongoing support for rural radiologists to access the latest imaging and treatment techniques and relevant case conferences through videoconferencing technology.</li> <li>▪ Greater leadership for rural radiology within RANZCR (clinical champions for CPD and technology)</li> </ul>
<b>6.11</b>	<ul style="list-style-type: none"> <li>▪ Other College consider the adaptability of this model for auditing and benchmark of procedures.</li> <li>▪ Consider application to external agencies for ongoing project support.</li> <li>▪ Revision of the cost and time requirements of clinical leaders for CPD activities, and how they can be reimbursed or supported for this in the future.</li> <li>▪ Continuation of the project to support the quality cycle of audit, analysis, reflection, dissemination and education. Also recognising that changes in practice will difficult to measure within the project.</li> </ul>
<b>6.12</b>	<ul style="list-style-type: none"> <li>▪ Recognition that ongoing use of workshops and activities that enhance clinical educator skills are of significant benefit for longer term outcomes supporting regional and rural self-sufficiency.</li> </ul>

---

**Project Key Recommendations**

- Greater focus on identification of target audience, both as participants and change champions.
  - Participants require a project focus to add authenticity and relevance to more generic skills being taught and facilitators require skills in both process and content to support participants.
  - Workshops are most suitable for institutions with 'critical mass', i.e. who can support a small group of motivated educators, rather than very rural locations or regional areas who have just procured simulation or scenario based learning equipment, without any provision for effective utilisation.
- 6.13** ▪ Bringing clinicians and managers together to talk about improving patient care is both critical and viable. Ongoing multidisciplinary and collaborative CPD and quality initiatives need to be supported by Colleges to strengthen the implementation and evaluation of this type of activity.

Most frequently reported recommendations were in relation to:

- 1) Current Project timeframes and the limitations they impose on planning, implementation and evaluating clinical practice improvement based CPD programs or developing sustainable professional networks;
- 2) Recruitment of site based clinical champions and remuneration of clinical leaders for CPD and education based Programs to ensure sustainability and provide recognition for the contribution to rural practice; and
- 3) Consideration of broader adaptation or transferability of project and education models, often those which combine multiple strategies to support the CPD needs of specialists practicing in rural and remote Australia.

### 3.10 Transferability of Education and Project Models

Sharing of project resources and information on limitations and outcomes associated with education models is strongly supported by the CPMC and the SSRS PMC. Several Projects have indicated that the education models may be transferable for another clinical area. The following Projects have indicated their education model could be used in other settings.

**Table Nine: Self reported transferability of project education models**

Project No.	Education / Project Model
<b>Regional or Professional Education Network</b> 6.02 RACS 6.04 RANZCP	<p><b>Model:</b> Regional CPD clusters, utilising video-conferencing and / or occasional meetings.</p> <p><b>Transferability:</b> Peer support and education network could be readily implemented in other clinical or geographical settings. Video-conference is an effective and accessible training mode for the delivery of education to rural health practitioners.</p> <p>As technology enables live interaction it can also be utilised for case discussions, peer review and as a forum for meetings, involving both rural and metropolitan practitioners. Some technology providers are also able to assist with basic evaluation activities and monitoring of project participants.</p> <p><b>Recommendation/ Requirements:</b> Include a critical mass of participants along with site champions (or a steering committee of clinical leaders) for projects. Administrative support and professional recognition would support clinical leaders engage in this model.</p>
<b>Peer Audit / Clinical Practice Improvement Model</b> 6.05 RANZCOG 6.06 RANZCOG 6.11 RACS	<p><b>Model:</b> CPD programs involving quality cycles to audit and benchmark a clinical system or procedure, and then make recommendations to improve systems and processes. Feedback is provided to participants and practice change is encouraged (and measured pending time).</p> <p><b>Transferability:</b> Models applicable across all geographical settings or discipline areas. Resources have been developed for gap analysis, data collection, feedback and future CPD planning.</p> <p>The transferability of models to a broader geographical setting (within a same clinical discipline) may provide further insight regarding the procedure being benchmarked, and the transferability of the project resources to a different clinical discipline may further test the value of project resources and mechanisms of clinical benchmarking, analysis and feedback.</p> <p>Collection of KPI data and regular reporting of performance is an effective method for encouraging clinicians to achieve best practice standards of care. It is advantageous to have reports that the team can discuss and plan together to make and measure improvements.</p> <p><b>Recommendations/ Requirements:</b> Review national or state based data to understand</p>

Project No.	Education / Project Model
	what and why to audit and consider what results may mean. Clinical leaders and site based champions along with local data or project coordinators are crucial to the implementation of this type of a CPD project. Projects are often difficult to implement and evaluate in current timeframes. Colleges must recognise that these projects are resource intense and require substantial planning prior to commencement under SSRS funding.
<b>Scenario based teaching and Simulation learning models.</b>  6.03 RACP 6.12 ACEM	<p><b>Model:</b> Using problem-based learning such as real life case study's or scenario based education models to enhance reflective learning, clinical skills teaching, communication and teamwork approaches to clinical care within the context of rural organisational framework, service integration and resource availability.</p> <p><b>Transferability:</b> Models for learning and educational resources to support reflective analysis, debrief and feedback within varying clinical or resource contexts, could support education and learning for a range of specialist disciplines. Learning models could also support Colleges implement education programs addressing areas of professional competencies.</p> <p><b>Recommendations / Requirements:</b> A component of such team-based projects is emphasis on collaborative learning and the need to either deliver the projects in-situ or involve a specialists clinical team.</p> <p>Online web resources, hard-copy material and participant support during the project and post project is beneficial. Difficulties arise in the ability to demonstrate project reach, or tangible clinical practice improvement outcomes within current project timeframes.</p>

### 3.11 Feedback to Colleges

The PMC is dedicated to ensuring that Colleges are informed of SSRS project objectives and outcomes. Colleges are encouraged to design projects which support College education programs and objectives, to maximise the sustainability of education models and the ongoing use of resources, which are developed within the Scheme. The following strategies have been employed to keep Colleges informed of SSRS project implementation and outcomes:

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>▪ Project steering committee including College representation</li> <li>▪ Feedback to College CEO and Board of Directors</li> <li>▪ Progress and Final Reports submitted to the College</li> <li>▪ Progress reports publicised through College magazine</li> <li>▪ Reporting to Director of Education</li> <li>▪ Periodic reporting to Professional Standards Board</li> </ul> | <ul style="list-style-type: none"> <li>▪ Updates on progress on College websites</li> <li>▪ Periodic reporting to the College Rural Special Interest Group/ Provincial Fellows Committee</li> <li>▪ Periodic reporting to College CPD Committee</li> <li>▪ Site visit participants (PMC) fed back project information to Colleges</li> <li>▪ Periodic updates to College State and Territory Branch Committees</li> <li>▪ Written and verbal feedback to participating Colleges</li> </ul> |
|--|--|

### 3.12 Dissemination of Project Models and Outcomes

In previous Rounds of the Scheme, some projects have published or presented on results of project outcomes and implementation of education models. During Round Six, the following projects have been the subject of a presentation, or intend to publish project results:

- 6.02: North Australian CPD Program
- 6.04: CPD for Australian Rural Psychiatrists
- 6.05: Laparoscopy Audit Project
- 6.06: Perinatal Mortality and Morbidity Audit
- 6.07: Clinical Leadership Project for rural psychiatrists
- 6.09: Rural Organisation of Stroke Teams
- 6.10: Emerging Techniques in Radiology
- 6.11: Rural Craft Group Audit
- 6.13: Improving clinical quality by enhancing organisational collaboration and skill development

### 3.13 Variations to Funding Agreements

During Round Six, two Colleges requested increased funding, to support expansion of the project to a larger target audience and two projects requested to extend the project period, to be able to achieve objectives specified in Funding Agreements. Applications for additional funding or an extension to the project period followed the following process:

- Initial discussions with the PMU regarding the need for an extension, and potential alternate strategies to support the achievement of project objectives;
- Formal correspondence submitted to the Chair of the PMC requesting an extension;
- Request for extension circulated to the PMC for endorsement or comment; and
- Formal recommendation made to the DoHA as to whether the PMC support the request.

Request for additional funds or extended timeframes can be found at *attachment 9*.

Project	Application and Change	Outcome
6.03_ Achieving better-integrated team-based care in acute rural paediatric practice	Request for additional time to meet project objectives due to; delays in signing original contract, scheduling difficulties for participants and faculty; and attempts facilitate course timing with other professional conferences or meetings.	Application made to the PMC in Nov 2006. Supported by the PMC and DoHA. (Final Project Report now due 30 July 2007, no additional funding requested).
6.04_CPD for Australian Rural Psychiatrists	Increase budget from \$77,000 to \$102,460 to support operational costs associated with increased target audience.	Application made to the PMC in Oct 2006 and supported by the PMC and DoHA. (Funding from CPMC surplus funds)
6.05_Laparoscopy in gynaecology and surgery audit	Increase budget from \$115,000 to \$149,000 to support operational costs associated with increased target audience.	Application made to the PMC in July 2006 and supported by the PMC and DoHA. (Funding from CPMC surplus funds)
6.13_Improving clinical quality by enhancing organisational collaboration and skill development	Request for additional time to meet project objectives due to; desire to be able to support participants through the quality cycle with individual site based projects and to allow sufficient time for follow up and evaluation activities.	Application made to the PMC in March 2007 and supported by the PMC and DoHA (Final Project Report now due 30 May 2007, no additional funding requested).

## 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

Thirteen projects were implemented to provide CPD and peer support to medical specialists practicing in rural and remote areas of Australia. More than 100 CPD events have been held which have involved up to 750 rural specialists as either participants or clinical leaders.

In addition, many SSRS events involved participation of other rural health workforce including overseas trained doctors or Area of Need practitioners, specialist trainees, allied health workers, general practitioners and nursing staff. The inclusion of a broader core of health workers (when their participation is cost neutral to the project), allows for an increase in professional support and networking opportunities. Broader participation strengthens the critical mass of professional skills and support in rural areas, and in some instances enables significant collaboration regarding specific health issues within the context of a particular rural community. For example; the multidisciplinary care of cancer in northern Australia (6.02).

There were a variety of types of CPD being used including peer review, audit, quality assurance activities, clinical education and up-skilling sessions and rural conferences. Models for CPD and preferences for ongoing learning have largely been determined by rural specialists in consultation with their College, via provincial Fellows meetings or Rural Special Interest Groups. In most instances, CPD models have effectively engaged rural specialists. For example, the laparoscopy audit project (6.05) alone attracted 260 rural specialists.

The PMU have continued to actively promote the SSRS and rural specific CPD activities through an electronic newsletter, Program website, promotional materials and formal and informal networking opportunities such as College Annual Scientific Meetings.

**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

External evaluations, program management and Colleges through individual project reports, have identified and made recommendations for effective and future models for the delivery of CPD and peer support for specialists practicing in rural and remote Australia. These include:

- Multidisciplinary team based learning in the specialists environment
- Simulation and scenario based training to enhance reflective analysis
- CPD activities involving audit and peer review to build capacity and reflect on measures of safety and quality with in a rural context
- CPD programs where both need and intent of specialists to participate are assured
- Virtual' professional specialty and sub-specialty networks to support workforce retention in rural areas
- Web-based interactive learning modules to enhance technological access and skill
- CPD activities engaging employers and hospital administration to support project implementation, facilitate practice change support the sustainability of quality assurance activities

The SSRS has also provided information on limitations and constraints associated with the delivery of CPD to rural specialists (Section 3.8a and 3.8b). The impact of limitations include; lower than anticipated participation, difficulties recruiting clinical leaders to projects, technological issues, delays in project activities, issues associated with project infrastructure inability to evaluate reach, benefit or impact of project including achievement of project objectives, and various legal and ethical issues associated with CPD approaches. Constraints should be taken into consideration for the implementation of future strategies to support rural specialists.

The Program *Application and Funding Guidelines* have been revised for Round Seven of the Scheme, in order to either prevent constraints which were identified within the Round Six Program or at least ensure that potential issues are transparent at the time of projects being considered for funding. These include:

- Needs assessments to determine intention of specialists to participate in project activities.
- SSRS funding subsidising non 'rural specialist' health workforce to access CPD and peer support.
- Compliance with project reporting and timeframes.
- Intellectual property for sub-contracted projects
- Compliance with Project activities as per funding agreement.

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

It is imperative to recognise that 'need' or 'interest' to participate in a specific CPD or educational activity alone, does not translate into actual participation. Barriers to accessing CPD have been widely reported and often relate to time constraints, clinical, workplace and family commitments, inability to arrange locum cover, complexity of intervention or perceived need to participate in intervention. Consequently, consultation with rural specialists must incorporate the suitability of activities by which to deliver CPD.

Projects were recommended for Round Six 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 College 'rural' committees, and reviews of relevant literature.

The Site Visit process has highlighted several CPD activities, which despite being based on sound education models, have not achieved original estimates of rural specialist participants. Significant learnings can still be taken from the implementation of these projects and a recommendation relating to both the needs assessment process and targeted project communication and marketing strategies have been made. It is anticipated that this will improve the suitability of CPD programs and methods to support rural specialists.

In the past, some suitable SSRS projects have been recommended to Colleges to adopt as part of their broad CPD programs. For example, the Audit and Peer Review Project (RACS) and the FEAT Video-conference Education Program (RACP). Often, these project models reflect activities, which are perceived by rural specialists, as suitable to engage in. During Round Six, projects such as the Northern Australian Rural CPD Network (6.02), the CPD Network for Australian Rural Psychiatrists (6.04) and the collaborative quality assurance project delivered by RACP, RACMA and RACS (6.13), provided examples of appropriate CPD activities for rural specialists. They are also projects, which have the capacity to be sustained by Colleges and utilised as a platform to meet College education objectives in the future.

The SSRS Forum in March 2007 along with ongoing promotion of Round Six Projects has provided an opportunity for Colleges to observe CPD and education models being implemented by other Colleges, and determine how they could be applied with Fellows of their own College.

**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 building 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 also offered larger amounts of funding to applications submitted by more than one Specialist Medical College. This has resulted in four **collaborative** projects. In addition to this, seven of the thirteen projects offer CPD opportunities to more than one speciality group (**multidisciplinary**).

Project	Multidisciplinary / collaborative
6.02_ regionally-based interdisciplinary CPD program for Surgeons in Northern Australia (RACS)	- Multidisciplinary
6.03_ Achieving better integrated team – based care and use of clinical guidelines in acute rural paediatric practice ( <b>RACP</b> , JFICM ANZCA, ACEM)	- Multidisciplinary - Collaborative
6.05_ Laparoscopy in gynaecology and surgery: practice review using audit of errors for improving safety ( <b>RANZCOG</b> ANZCA, RACS)	- Multidisciplinary - Collaborative
6.06_ Peri-natal mortality and morbidity: Learning from adverse events to improve care ( <b>RANZCOG</b> , RACP)	- Multidisciplinary - Collaborative
6.08_ Basic Assessment and Support in Intensive Care: Rural Specialists (JFICM)	- Multidisciplinary
6.12_ Scenario-Based Clinical Teaching Skills for Acute Care Medicine (ACEM)	- Multidisciplinary
6.13_ Improving clinical quality by enhancing organisational collaboration and skill development ( <b>RACP</b> , RACS, RACMA)	- Multidisciplinary - Collaborative

The annual SSRS Forum, also 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.

The Site Visit process provided an opportunity for the PMC and College education staff to gain a greater understanding of the projects funded under the scheme and experiences of participants of these activities. Those conducting site visits were also able to consider the implementation of projects against the original application objectives, along with other issues relating to program management. This will no doubt contribute to supporting inter-College collaboration through the facilitation of inter-College or inter-disciplinary specialists collaborating around the assessment and observation of education models.

As an activity of the CPMC, the SSRS has in many instances filtered through and strengthened existing inter-college networks and provided a platform for Colleges to collaborate around specific 'common' objectives, in this instance being the provision of professional support and CPD to rural specialists. The SSRS has been an agenda item for discussion and collaboration at the following forums;

- *Committee of Medical College Educators*
- *CPMC Presidents Forum*
- *CPMC CEO's Forum*
- *College CPD / Mops Committee*

The SSRS has also demonstrated an effective method for the DoHA to collaborate with all Colleges via the CPMC, to address issues of relevance to all Specialist Medical Colleges.

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

Implementation of SSRS activities has assisted Colleges in the planning of CPD activities to support rural specialists. An example of this has been via supporting Colleges to identify

potential topic for CPD. Several projects have identified gaps in current practice, which could be addressed via the Scheme or alternate strategies. For example, The Perinatal Mortality and Morbidity Project Report (6.06) stated that a recommendation based on the implementation of their project, is the need for CPD for pathologists conducting perinatal autopsy in rural areas. Similarly, implementation of the Rural Organisation of Acute Stroke Care Project (6.09), has identified that junior medical officers working in emergency departments in rural and regional areas, could potentially improve their skills in relation to stroke identification and management.

Colleges are supported in the implementation of well-targeted CPD activities from application development through to implementation, reporting and evaluation. Program tools and resources are provided to guidance Colleges in terms of what to consider throughout the project period and for the purposes of understanding the impact and outcomes of their project in relation to original project objectives. Reporting proformas detail the scope of information required in planning or reporting on a SSRS Project. They include the following information:

<b>Project Applications</b>	<b>Project Reports</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 implementation strategies</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>

Proformas and one on one support in the implementation of projects, assists Colleges and project staff, with individual project management skills, which can assist them in the delivery of future SSRS or non-SSRS projects.

Over the course of Projects, Colleges have continued to support each other and collaborate around the use and application of educational resources and recent Project reports have highlighted how project models and resources could be transferred for use by other Colleges. The sharing of resources also increases the capacity of Colleges to deliver and evaluate CPD projects, and make recommendations against the future application of specific tools to support the delivery of CPD to rural specialists.

SSRS collaboration has provided an extensive network of key stakeholders who share a common vision regarding the need to strengthen education and support for rural specialists. Strategically, the SSRS program has facilitated communication networks not only between Specialist Medical Colleges, but also between multiple levels of health professionals and agencies. During Round Six, the following originations collaborated with Colleges to implement CPD and education Projects funded under the Scheme;

- *Health Workforce Queensland*
- *Bendigo Health Care*
- *James Cook University*
- *Medical Education Solutions*
- *The Sydney Medical Simulation Centre*
- *The Centre for Rural and Remote Mental Health Orange, NSW*
- *Queensland Skills Development Centre*

Six Rounds of SSRS funding and Program implementation to date, have built on the capacity of Colleges and collaborating organisations to deliver CPD projects will only increase as Colleges become more experienced in the delivery of rural specific education and CPD projects.

## 4.2 Site Visits

During Round Six, the SSRS PMC with support from College education staff, conducted site visits on SSRS Projects. This process involves participating in project activities and meeting with project coordinators to discuss education models, project marketing, implementation and evaluation and transferability of learning outcomes.

Site visits provided an opportunity for education staff from Colleges to view projects of other Colleges with the aim of increasing the knowledge about specific education models and strategies to support rural specialists.

While positive aspects of projects have been identified through this process, project constraints and potential limitations have also been identified. In these instances, the PMU has provided feedback to project coordinators and the respective College and discussed strategies to address these issues. A copy of the site visit proforma can be found at *attachment 10*.

**Table Ten: SSRS Site Visits Round Six**

Project	Site Visit and Outcomes
6.01	Observe and participate in Rural Dermatology Conference, 16-18.03.06, VIC. Valuable opportunity to observe CPD event, and to contribute to potential CPD and peer support strategies by sharing what other Colleges are doing to support rural specialists.
6.02	No visit conducted due to scheduling of activities. Phone contact with project coordinator and report submitted on the outcomes of the Rural Surgical Conference in August 2006.
6.03	Observe simulation based course and meet with project coordinators, 15.11.06, Sydney. Very useful opportunity to observe education model which is transferable across a number of specialty areas. Better opportunity to observe how funding is distributed across the operating components of the projects. Discussed with project coordinator non-specialist participants and rural specific nature of education content. Project coordinators willing to work with the PMU on potential Round Seven proposals. Conducting the Site Visit, prior to the request for additional funding for this project made it easier to see why it was required and how this was required.
6.04	Observe video-conference education 06.09.06. Feedback to project coordinators 09.06.06. Made recommendations in relation to technical and content related aspects of education delivery via videoconference. Observed that this activity was very well received by participants. Discussed evaluation components of the project and how some videoconference providers can assist with pre and post testing as part of their services.
6.05	Observed video-conference: Introduction to the laparoscopy audit tool 29.08.06. Meeting with project coordinators 10.10.06. Very professional delivery of content and context for the project including justification for specific topic and collaborative implementation. Recognition by the PMU of the restrictions current SSRS timeframes have on such a project and the ability to use findings which are statistically significant. Observed how the audit tool and project framework in general could be readily adapted to another clinical or geographical setting. Very high participant interest and clinical leadership to support the Project. Conducting the Site Visit, prior to the request for additional funding for this project, made it easier to see why it was required and how this would be spent.
6.06	Observe audit facilitators workshop, 15.09.06, Sydney. Meeting with project coordinator 10.10.06. Able to observe potential concerns specialists had in participating in this project (qualified privilege and confidentiality) and how these issues had been considered and addressed by the project leaders. Very beneficial to have someone who had previously participated in the project (in a different location) as the clinical leader for this project. Participants appeared more at ease with project requirements and components knowing that it had been previously undertaken. The event provided very practical education, feedback, etc for reviewing practices and included substantial on 'rural specific' issues. PMU were also informed that this 'model' has been taken up

Project	Site Visit and Outcomes
	<p>by RCPA, ANZCA and RANZCR.</p> <p>Discussed strategies with project coordinators for potential inclusion of a larger proportion of paediatricians in the future and also queried how RANZCOG have used the information from the past project 'de-identified' report findings.</p>
6.07	<p>Observe video-conference education 30.10.06. Teleconference with project coordinators 06.11.06</p> <p>Able to observe education model based on problem based learning (with a patient centred focus). Good overview of current situational analysis for patients accessing services. However, evident that 'patient' focused approach to delivering education to rural specialists meant that there was lower than anticipated participation rates. There was a high ratio of facilitators to participants, decreasing the cost effectiveness of the project. As a result of observing this first event, the PMU provided ongoing support to the project, regarding marketing, communication of the project, technical issues and resource support for the project. Feedback was well received by participants and largely implemented.</p>
6.08	<p>Attend BASIC Course 29.08.06, Brisbane. Meeting with project coordinators 09.06 and 17.10.06. Several issues were raised as a result of this site visit and ongoing follow up with project coordinators in relation to the fact that the project was not attracting rural specialist participants. While this was not resolved over the course of the project, the site visit process at least provided an opportunity for the Faculty and the PMU to discuss and implement strategies which would potentially redress this from an early point in the project.</p>
6.09	<p>No visit conducted due to scheduling of activities (conducted via phone). Due to the fact that this Project had been successfully implemented in previous Rounds of the Scheme, the PMU were fairly confident with the implementation of the project.</p>
6.10	<p>The PMU contacted the project coordinator on many occasions to establish an opportunity to meet the project clinical leaders however, this did not eventuate. The project coordinator also ceased with RANZCR mid way through the project. This also made it difficult to arrange a site visit.</p>
6.11	<p>The nature of this project involved collecting data from participating hospitals. Project coordinators felt that an 'in person' site visit would not be appropriate for the project. The PMU kept in close contact with the project coordinator to discuss potential issues with project implementation.</p>
6.12	<p>Attend Scenario Based Learning Course, 30.11-01.12.06, Toowoomba Hospital. Meeting with project coordinators 01.12.06.</p> <p>Very useful opportunity to observe the education model of scenario based teaching and assisted in seeing why a high facilitator to participant ration was required. Very positive to see how the project is adapted different organisational and resource contexts and how it teaches participants to be able to teach clinical skills in a variety of settings. Provided to opportunity to query project coordinators regarding the sustainability of resources developed within the project and also how best to demonstrate project impact of a train the trainer approach.</p>
6.13	<p>Attend Improving clinical quality workshop 20.10.06, Rockhampton. Teleconference with project coordinators in 2007.</p> <p>Workshop delivered as per original application. Feedback from participants at the event was positive and the site visit provided a valuable opportunity to observe the inter-College approach to improving clinical quality in specific settings. Project has capacity to be expanded and continued to support medical administrators and hospital based specialists to collaborate and improve safety and quality in rural and regional facilities.</p>

### 4.3 Program Limitations and Recommendations

In response to recommendations made by the Hunter Institute for Mental Health (HIMH), individual Colleges and the PMC and PMU, during 2006, a revised SSRS Program Framework was developed. Consultation on this revised framework was conducted with some Round Six Project coordinators, the PMC, the CPMC and the Committee of Medical College Educators. The revised framework has been developed to:

- Be reflective of the diversities in capacity of medical colleges to support CPD initiatives, along with the learning preferences of rural specialists.
- Be more pragmatic in terms of project expectations given the budget and timeframes parameters and their impact on project evaluation and sustainability planning.
- Draw on recommendations from the HIMH, Program Evaluation, along with other literature on both CPD and access to education for rural practitioners.

Program recommendations regarding refinements for the Round Seven Program were forwarded to the DoHA in December 2006 and January 2007.

As a result of implementation of Round Six of the Scheme, the following limitations and recommendations have been reported. As in previous reports by both the PMU and the HIMH, a primary recommendation relates to the current timeframe for project development, implementation and evaluation, and the difficulties in demonstrating clinical practice improvement within a 12 month timeframe. Other major Round Six project limitations were reported in Section 3.8, and as a result the following recommendations are made to address these:

- Strengthen the needs assessment requirements (and assessment of this) in project proposals;
- Review the DoHA, CPMC or SSRS PMC position on the involvement of non-rural specialist participants in SSRS activities;
- Continue to work with Colleges and Program participants regarding compliance with Project funding agreements including reporting, timeframes and financial management;
- Increase the emphasis on project evaluation and feedback of project results to College executive committees; and
- Strengthen guidelines for sub-contracted projects to support project sustainability and issues associated with intellectual property.

The PMU have revised the application and funding guidelines for Round Seven. This has taken place to incorporate the above recommendations with the aim to prevent or at least ensure transparency in relation to limitations or constraints which were experienced in the Round Six Program.

#### **4.4 Future Direction of the SSRS**

While Australian rural specialists report that access to CPD contributes to their decision to commence or continue practice in a rural location, appropriate CPD opportunities are still inequitable.<sup>1</sup> The SSRS has played an important role in redressing the disparity experienced by rural specialists in accessing CPD and feedback provided to both the HIMH and the SSRS Program Management Committee, has asserted the value of the Scheme in its contribution to the appeal of rural practice,<sup>2,3</sup> and in its capacity to provide opportunities for specialists to access CPD activities that would have been otherwise unavailable.<sup>4</sup>

It is anticipated that the learnings and outcomes from the implementation of this Scheme be used to inform future policy initiatives to both support rural specialists and strengthen medical capacity and the sustainability of specialist medical services for people residing in rural and remote Australia.

---

<sup>1</sup>Support Scheme for Rural Specialists Program Evaluation (Round 5); Report to the Australian Government Department of Health and Ageing *Hunter Institute of Mental Health* 2006.

<sup>2</sup>Support Scheme for Rural Specialists Program Evaluation (Round 5); Report to the Australian Government Department of Health and Ageing *Hunter Institute of Mental Health* 2006.

<sup>3</sup>McLean R. Continuing professional development for rural physicians: an oxymoron or just non-existent? *Intern Med J* 2006; 36: 661-664.

<sup>4</sup>Support Scheme for Rural Specialists Program Evaluation (Round 3 and Round 4); Report to the Australian Government Department of Health and Ageing *Hunter Institute of Mental Health* 2005.

## SECTION FIVE

### 5.1 Project Management Unit Expenditure

The total PMU expenditure is **\$172,438.45**, leaving a PMU surplus of \$57,561.55. A summary of expenditure for the PMU is detailed below in Table Eleven. A surplus was recorded for 'Travel and Site Visits' due to the fact that several site visits were conducted over the phone or via videoconference. A surplus was also recorded for 'Website'. The PMU originally intended to upgrade and expand the website facilities, given the uncertainty for ongoing Program support, it was felt that this was not an appropriate use of funds. Full expenditure is detailed in *attachment 11*.

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

Item	Budget (\$)	Expenditure (\$)	Funds Available (\$)
PMU Administration and Salary	91,000.00	92,308.45	-1,308.45
Travel and Site Visits	40,000.00	12,746.73	27,253.27
Website	20,000.00	2,962.50	17,037.50
Workshop	30,000.00	18,873.61	11,126.39
Communication	25,000.00	21,547.16	3,452.84
RACP Management Fee	24,000.00	24,000.00	0.00
<b>SUB-TOTAL</b>	<b>230,000.00</b>	<b>172,438.45</b>	<b>57,561.55</b>

### 5.2 Project Expenditure

Round Six Projects with the exception of project 6.08 have received 90 per cent of their budget to date. As Final Reports have now been received, up to a further 10 per cent of funds will be paid to Projects, where an independent audit demonstrates that this is required. As of 30 May 2007, the total Project expenditure came to **\$1,071,601.15** leaving a surplus of \$155,917.38. However, projects 6.03 and 6.13 have been awarded extensions to 30 July and 30 May respectively. As a result, total program expenditure and surplus amounts will be modified and an amended financial table will be forwarded to the DoHA in August 2007.

**Table Twelve: SSRS Projects Budget and Expenditure**

Project No	College	Budget (\$)	Expenditure (\$)	Surplus (\$)
6.01	ACD	65,000.00	67,610.28	0.00
6.02	RACS	64,000.00	37,818.00	26,182.00
6.03	<b>RACP (ANZCA, JFICM, ACEM)</b>	<b>143,000.00</b>	<b>86,827.70*</b>	<b>0.00*</b>
6.04	RANZCP	102,460.00	107,826.97	0.00
6.05	<b>RANZCOG (ANZCA, RACS)</b>	<b>149,000.00</b>	<b>142,652.00</b>	<b>6,348.00</b>
6.06	<b>RANZCOG (RACP)</b>	<b>101,000.00</b>	<b>101,741.00</b>	<b>0.00</b>
6.07	RANZCP	73,000.00	73,881.81	0.00
6.08	JFICM	28,000.00	0.00	28,000.00
6.09	AFRM	100,000.00	101,476.13	0.00
6.10	RANZCR	70,000.00	72,241.22	0.00
6.11	RACS	111,000.00	79,623.00	30,377.00
6.12	ACEM	125,000.00	129,913.42	0.00
6.13	<b>RACP (RACMA, RACS)</b>	<b>135,000.00</b>	<b>69,989.62*</b>	<b>65,010.38*</b>
	<b>SUB-TOTAL</b>	<b>1,266,460.00</b>	<b>1,071,601.15*</b>	<b>155,917.38*</b>

\*See 3.9 Variations to Funding Agreements