PROCEEDINGS

of the

Rural Remote Institute of Palliative Medicine

[RRIPM project]

ROUND TABLE WORKSHOP

28th February 2024, 10am – 3pm
EAST Hotel, Canberra

Introduction

Senior clinical and managerial representatives from organisations across Australia with an interest in rural palliative care were invited to participate in a reference group round table discussion held in Canberra on February 28th. Twenty-four individuals attended in person and fourteen others joined virtually [Participant list - Appendix A]. The purpose of the meeting was to inform the development of the Rural and Remote Institute for Palliative Medicine.

Summary of Recommendations

The following key recommendations were proposed. RRIPM should:

RECOMMENDATION 1: Maintain independence, with clearly defined roles and expectations when working in partnership across participating organisations

RECOMMENDATION 2: Advocate for the establishment of a tri-partite group [RACP, RACGP and ACRRM] to strengthen training alignment.

RECOMMENDATION 3: Launch a trial network across training ready locations

RECOMMENDATION 4: Consider proposed actions relating to education and training, leadership and governance, capacity building and relationships for implementation in Year 1 to Year 3

RECOMMENDATION 5: Seek guidance from the Office of the National Rural Health Commissioner, and other jurisdictional representatives to identify future funding sources.

Background

Palliative medicine is an important component of a broader palliative care eco-system, where collaboration and multi-disciplinary teamwork are important elements to delivering quality health outcomes in rural communities. Streamlining and coordinating rural palliative medicine training will be essential to driving needed workforce growth in the national palliative medicine landscape.

The RRIPM project aims to develop and support an integrated Rural and Remote Specialist Palliative Medicine training network in Australia-

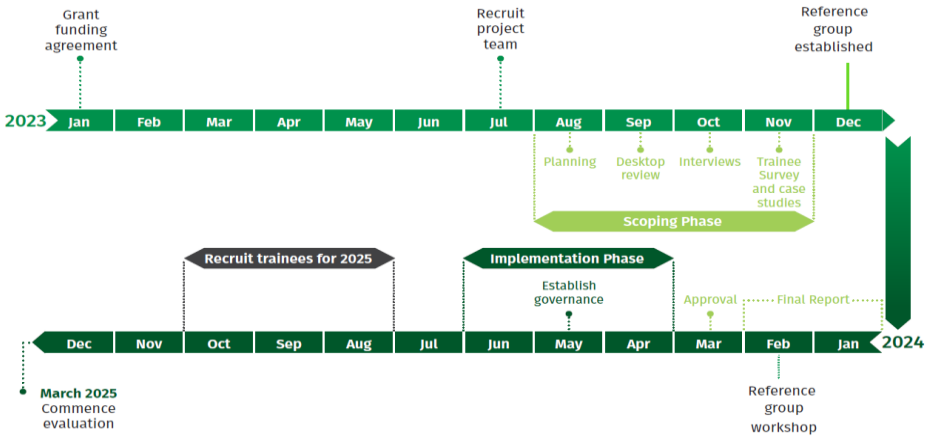
- based on RACP competency-based training curriculum
- offering a full range of high-quality training experiences in predominately rural locations
- ensuring positive and supported rural and remote training experiences.

A two-phase approach has been adopted:

Scoping Phase
During the scoping phase, a rapid assessment of palliative medicine training across the country has mapped barriers to and opportunities for rural palliative medicine training.
The scoping phase commenced in July 2023 and is nearing completion. The scoping review draft report is available here.

Implementation Phase
During the implementation phase, training ready providers in rural services will coordinate to form training networks and rural training pathways. Round table discussions will contribute to the design of the implementation phase.

Project Timeline



The RRIPM project is funded through a Flexible Approach to Training in Expanded Settings (FATES) grant from the Department of Health and Aged Care. This grant is being administered by the Royal Australasian College of Physicians (RACP) and supports project activities through until June 2025.

Activities on the Day

Delegates were invited to participate in discussion with the purpose of

- Determining a **collective vision** for rural palliative care.
- Specifying the **steps required to establish** a Rural and Remote Institute of Palliative Medicine within that vision (**a roadmap**)
- Identifying **partnership potential** and **opportunities to align** endeavours – including in recruitment, education, training, funding.
- Harnessing existing rural coalitions and allies to **advocate** for the Institute as it evolves.

The following information summarises output from the day.

Proceedings

Setting the Scene

The morning session included presentations that provided a snapshot into the difficult realities of receiving and providing palliative medical care in rural Australia. Speakers outlined the challenges and opportunities of their lived experience – underpinning the need for change and setting the scene for meaningful discussion.

> *Jodie Clarkson delivered a poignant reflection on her lived experience after a brain cancer diagnosis in 2017, shedding light on the profound impact of access to quality palliative care in rural communities. She underscored the necessity of cultural understanding and intercultural competence when caring for First Nations peoples.*

Delegates are invited to consider making a donation to Jodie's brain cancer research fundraiser here.

> *Lesley Reilly, a NT resident of 51 years, shared firsthand accounts of supporting people dying in Central Australia in the 1970s, 80s and 90s, contrasting their experience with the transformative impact of the opening of a respite home in 2016 and a 10-bed Palliative Care facility in Alice Springs in 2018. Lesley stressed that palliative care in a rural or remote setting cannot be a one size fits all approach.*

A recorded presentation by Associate Professor Mat Coleman at the Greater Southern Specialist Centre in Western Australia offered insights into a successful and innovative approach to rural and remote medical specialist training in psychiatry. **Due to technical difficulties during the session, delegates have been given online access to this presentation.*

Vision Building

Dr. Christine Sanderson, RRIPM's Clinical Lead, articulated the core vision and principles of rural palliative care.

The session examined policy alignment, the pathways for entry into Advanced Specialist Training in palliative medicine and explored the potential benefits of having palliative medicine specialist training embedded in rural services. As a specialist training pathway, policy alignment with the Royal Australasian College of Physicians is important. The graphic maps RACP and RRIPM policy principles which were agreed to be well aligned.

RACP Regional, Rural and Remote Physician Strategy, 2023

Principles

- Grow your own "connected to" place
- Select trainees invested in rural practice
- Ground training in community need
- Rural immersion – not exposure
- Optimise and invest in general medicine
- Include service and academic learning components
- Join up the steps in rural training
- Plan sustainable specialist roles

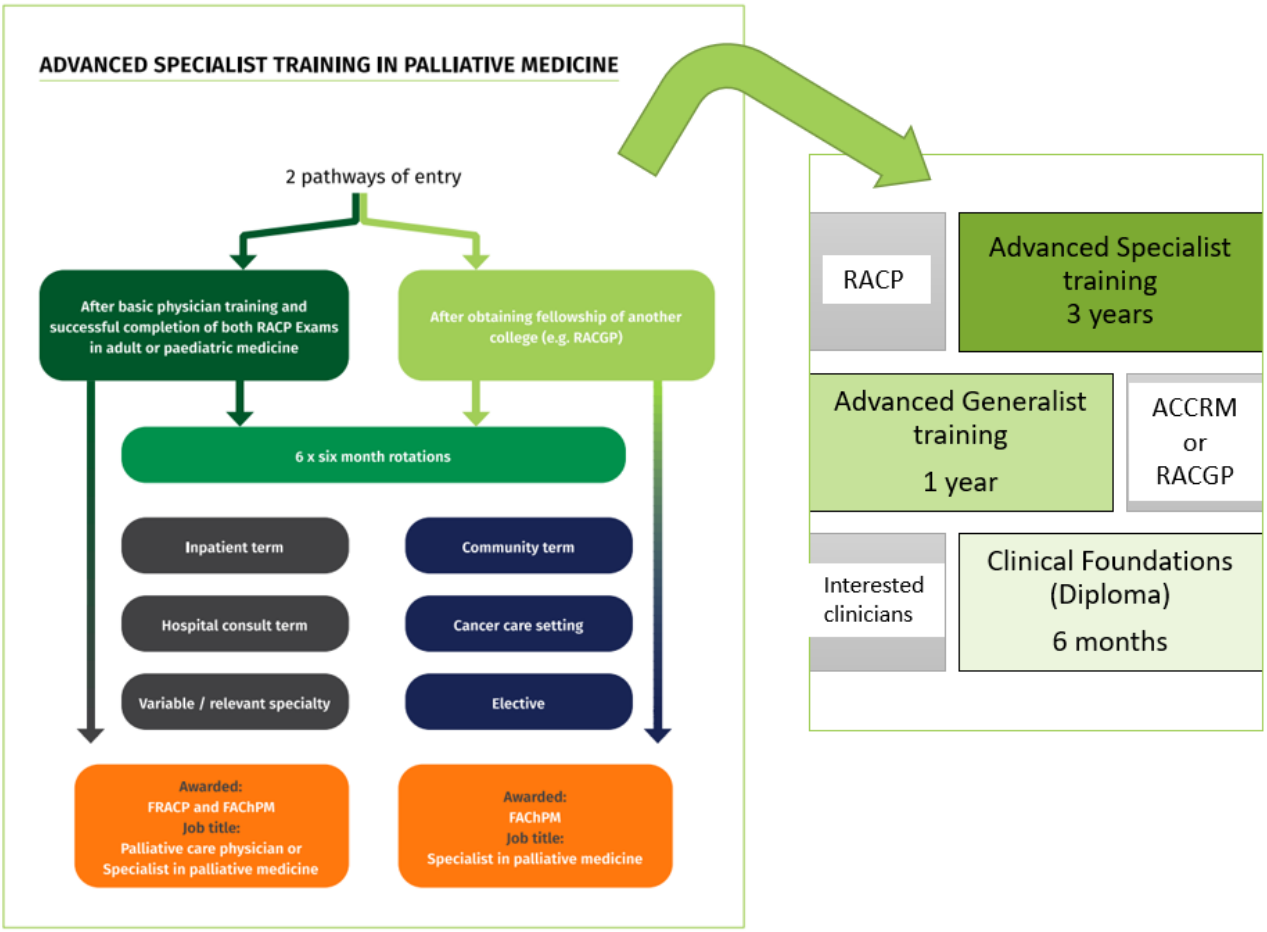
RRIPM Project 2023

Key Principles

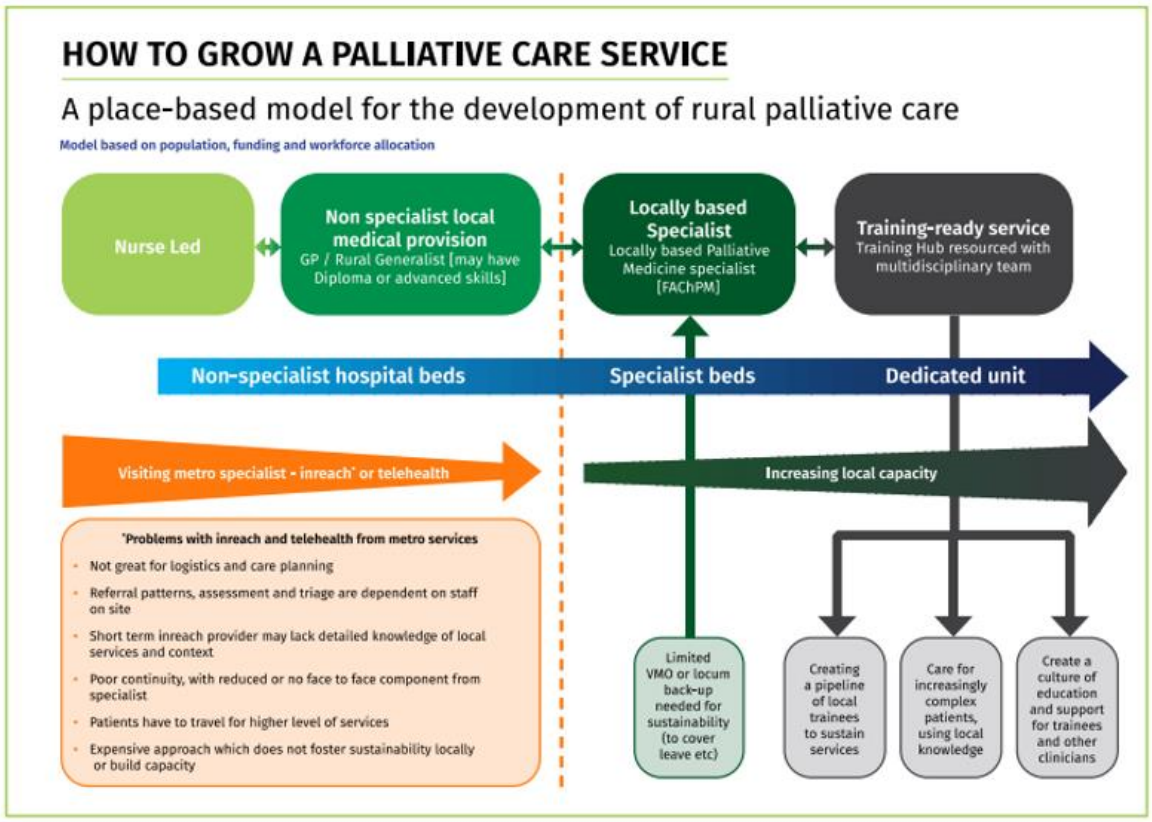
- The priority is rurality
- Rural training to happen in the right place
- There must be a national / cross-jurisdictional approach to training
- Capacity-building is required for sustainability of rural services as well as individual clinicians

Palliative care is provided by many disciplines with many people contributing to the wellbeing of the individual in care. The palliative medicine specialist is only one of these contributors – so while acknowledging the important role played by all within the palliative care eco-system the RRIPM project is primarily focused on training palliative medicine specialists.

The steps required to achieve palliative medicine specialist training were presented and then further mapped to demonstrate the interrelationship between generalist and specialist training pathways. Though the RRIPM project is specifically focused on specialist medical training, it was noted that current training pathways across all three colleges [RACP, ACRRM and RACGP] are not standardised, using different curricula, different accreditation standards and differing supervision requirements. There is limited / no recognition of prior learning for those who choose to extend their palliative medicine specialist learning. There is opportunity to collaborate.



The final provocation was the 'how to grow a palliative care service' as a framework to describe the evolution of workforce resourcing in the development of a service over time, including the challenges and barriers presented by lack of local specialist services.



Modifications to this framework have been suggested to show the interrelationship that exists between providers. In closing this session, the vision for RRIPM was described for consideration.

The proposed RRIPM model

Delegates received background reading which included a proposed model for further discussion. The model outlined what a RRIPM might do. It was proposed that:

> *RRIPM will be an independent, not for profit legal entity, led by a council of rural palliative care stakeholders supported by a modest staff allocation. Rural palliative care services will be offered membership.*
>
> *The central function of this entity will be to virtually link interested **rural services** across the country with each other to create a training network. The goal is for palliative medicine specialist training to be able to be done either predominantly or completely within a rural setting. RRIPM will provide 'backbone' support for networked rural specialist training across Australia. This will include:*
>
> • *supporting rural palliative care services to gain accreditation for training*
> • *being the information source and entry point for candidates seeking rural specialist palliative medicine training*
> • *developing shared recruitment and supervision processes to support rural palliative care services and their trainees, and*
> • *networking RRIPM services to share educational and research opportunities.*
>
> *An important secondary role will include the ability to advocate for system improvements addressing relevant rural concerns.*

Round Table Discussion One

After the morning *scene setting* sessions, participants entered small group discussions to answer three questions:

- *Does this RRIPM vision make a **distinctive** case and is it **feasible** and **implementable**?*
- *What are our most **ambitious ideas** for RRIPM? Are there any missing elements?*
- *What **value-add** would a RRIPM offer the palliative medicine ecosystem?*

There was recognition and agreement about the significant issues facing rural people when needing to access quality palliative care. Resourcing was seen as not sufficient and workforce challenges were noted to create additional pressure. In general, there was support and acknowledgement that a RRIPM was a useful and feasible undertaking.

Discussion was predominately focussed on rural **models of care** rather than models of specialist training. One strong message in this context was that the role of rural generalists with advanced skills training in palliative medicine should be considered as an important component of the rural palliative medicine eco-system. The emerging idea then was how do specialist palliative medicine training and GP advance skills training align to support models of care in rural communities? It was determined that this would be an opportunity to work through collectively involving all three colleges [ACRRM, RACGP and RACP] in the design with a tripartite approach. Feasibility for this approach was further discussed by citing the precedent set with the Joint Consultative Committee on Anaesthesia (JCCA).

Other points raised included:

- A suggestion to change the name to The Institute of Rural and Remote Palliative Medicine
- Drawing parallels with successful models in Anaesthetics and Psychiatry. *"What can we learn from them about implementation and the path for maturity?"*
- Consider the possibility of peer accreditation for training sites.
- Identifying the need to address housing and childcare concerns.
- Looking for solutions/collaborations in the Defence and Police sectors where placements are fully supported.
  "*Can Defence (Commonwealth Govt) and Police (State Govt) share their resources and infrastructure to make the experience of rural doctors more positive?"*
- Exploring potential partnerships with local government.
- Clarifying that while RRIPM has specific responsibilities such as mentoring, supervision, recruitment, advertising, and collaborating across Colleges, it is not accountable for all rural health infrastructure issues.
- Specialists don't operate or train in isolation - *"We're all in it together…"*

When considering the potential value-add of a RRIPM network, supporting inclusive networks for peer support creates opportunity for other professionally isolated rural practitioners to engage. It was suggested that over time, the RRIPM approach could extend to include tailored development of multidisciplinary team members through knowledge sharing, and upskilling and local training for Nurse Practitioners, Allied Health, and rural Pharmacists. The key message was the value of collaboration.

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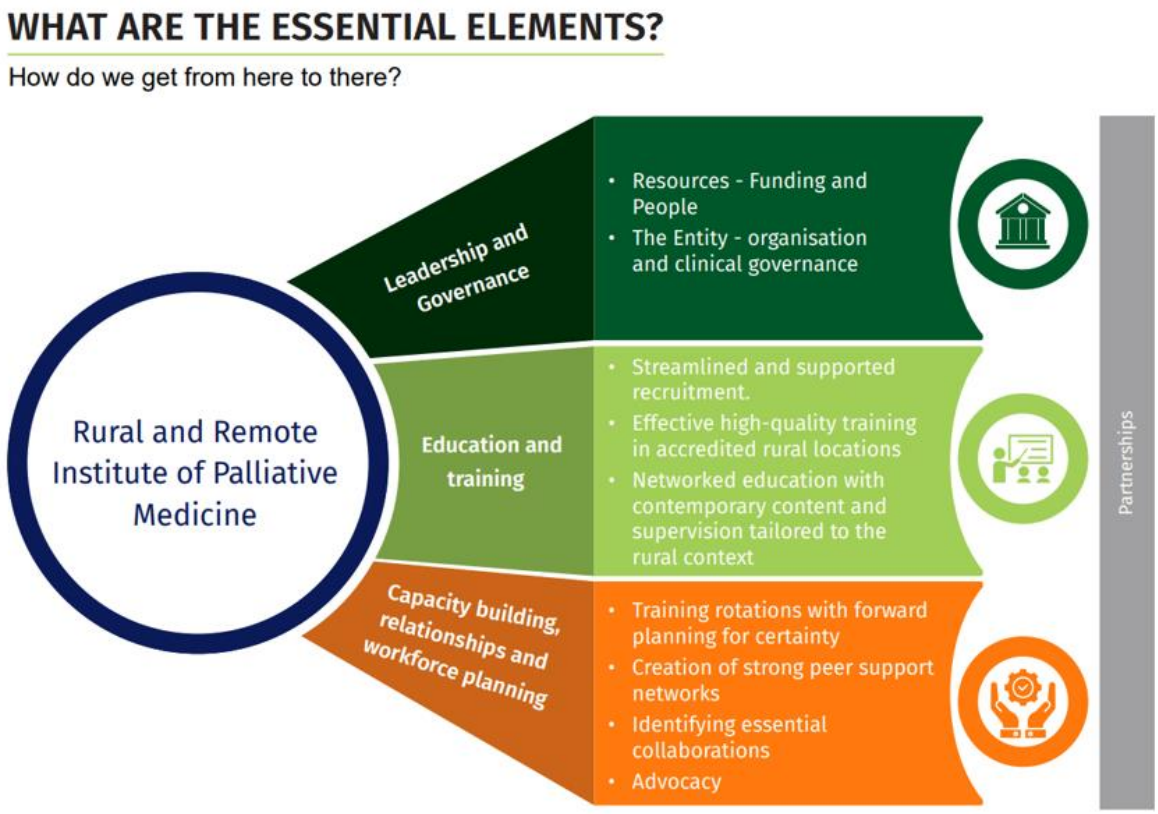
RECOMMENDATION 2: Advocate for the establishment of a tri-partite group [RACP, RACGP and ACRRM] to strengthen training alignment.

Round Table Discussion Two

Building on the consensus achieved in the morning session, the afternoon discussion focused more specifically on the 'how' a RRIPM could progress inviting suggested next steps for consideration.

Participants were asked to consider and discuss the essential elements in the establishment of a RRIPM. For guidance, essential elements were framed around leadership and governance; education and training; and capacity building, relationships, and workforce planning.



Within these three essential elements, questions posed to the groups were:

- *How should any change/s be implemented?*
- *What support and collaborations are needed from across the palliative care ecosystem?*
- *What would you prioritise in Year 1? In Year 3?*

This was a challenging undertaking in the time available.

Regarding **leadership and governance**, consensus was not achieved. Where the entity of RRIPM is best situated was variously proposed to sit within a single college, a collaboration of colleges, under the auspice of a university, one or more peak bodies or as an independent entity.

Determining the best fit has resource implications and future funding sources were mooted. It was suggested that the Office of the National Rural Health Commissioner would be an important advocate for identifying

Department of Health and Aged Care funding beyond the grant period. So too, jurisdictional funding sources were proposed.

Regarding **education and training**, some discussion focused on complexities and challenges requiring advocacy and change - for example achieving changes to RACP site accreditation, term approval and supervision requirements.

The concept of initiating a pilot or trial to demonstrate the RRIPM concept was a recurrent and strongly supported theme. This was thought to create opportunity for establishing rural competency benchmarking, exploring cross border collaboration, and building capacity via early integration with other specialties like oncology.

Regarding **capacity building, relationships, and workforce planning,** emphasising inclusivity, consumer input, and the prioritisation of Aboriginal and Torres Strait Islander people's needs in the development of the RRIPM entity was advised. Prioritising the training needs of Aboriginal and Torres Strait Islander practitioners should be explicit.

By aggregating comments and suggestions, the following activities have been distilled to include:

Year 1

- Refine the options and establish an entity with appropriate governance and membership arrangements
- Establish training pathways, considering rural and metropolitan contexts.
- Launch pilot programs to support trainees and bring supervisors together.
- RRIPM will advocate for the establishment of a tri-partite group with RACP,RACGP and ACRRM to streamline and harmonise the rural palliative medicine training pipeline
- Develop a business case for future steps
- Secure funding for sustainability

Year 3

- Establish mentoring and peer support systems including the broader palliative care workforce
- Aim for consensus on metrics.
- Develop pathways connecting multidisciplinary teams, particularly nurse practitioners.
- Advocate for a broad suite of changes – for example, enhance consistency in Recognition of Prior Learning (RPL) procedures.

RECOMMENDATION 3: Launch a trial network across training ready locations

RECOMMENDATION 4: Consider proposed actions relating to education and training, leadership and governance, capacity building and relationships for implementation in Year 1 to Year 3

RECOMMENDATION 5: Seek guidance from the Office of the National Rural Health Commissioner, and other jurisdictional representatives to identify future funding sources.

In Summary

There were some common themes or 'takeout' messages from all speakers:

- the need for and benefits of access to rurally based specialist palliative care was well demonstrated and universally supported
- there was solid agreement about the value of 'growing your own' by training and supporting specialist palliative doctors in-place, and the additional value that flows from fully embedded rural palliative medical specialists such as the role they can play as catalysts for other service developments
- there is a care continuum and a spectrum of needs that go beyond medical care. Specialist palliative care needs to be nested in a clinical ecosystem as well as wider system that addresses other determinants of access such as patient assisted travel arrangements
- specialist palliative care delivery needs to mirror the hallmarks of best practice care delivery in all fields of medicine: team-based delivery
- specialist palliative care training should be both formal, including training in interprofessional collaborative practice, and informal, inclusive of opportunities for learning and the reinforcement of such mentorship
- A whole-of-person approach is essential following the standard of partnering with consumers
- Consideration of families and carers is important: "carers want the opportunity to care, not necessarily to be the carer"
- There are many structural and systemic barriers which a RRIPM would solve, and which can be overcome with the right leadership, mobilisation, and harmonisation of effort.

Recommendations for further consideration:

RECOMMENDATION 1: Maintain independence, with clearly defined roles and expectations when working in partnership across participating organisations

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Next Steps

RRIPM steering group members will further consider the advice and recommendations arising, enriched by participation in this forum. A RRIPM Roadmap 2025-2030 will be finalised to inform future actions. The workshop concluded with a commitment to keep the communication channels open as RRIPM implementation proceeds.

To receive regular updates on project progress please register your interest with the project team via email rripmproject@anzspm.org.au

Thank you.

Appendix A: List of Participants

Title	First Name	Last Name	Title	Organisation
Dr	Alaa Al	Abdullah	Palliative Medicine Specialist Western NSW/General Practitioner	RACGP / SW Sydney LHD
Professor	Kirsten	Auret	Clinical Director Palliative Care	Rural Clinical School Western Australia
Mr	Ian	Bell	Statewide Manager, Palliative and End of Life Care	Dept of Health Tasmania
Dr	Laura	Booth	Program Coordinator	Victorian Palliative Medicine Training Pathway (VPMTP)
Professor	Mark	Boughey	Director Palliative Medicine	St Vincent's, Melbourne
Mr	Gareth	Boylan	Manager, Recruitment Strategy	NSW Health
Emeritus Professor	Will	Cairns	Emeritus Prof FAChPM	Editor ANZSPM/Expert
Dr	Louis	Christie	Senior Medical Officer, Palliative Care	Western NSW LHD
Ms	Jodie	Clarkson	Palliative Care Consumer	PCA Consumer Rep, NT
Ms	Raylene	Cox	Director, Policy	Cancer Australia
Dr	Lea	Currie	Physician Staff Specialist	ACT Health
Ms	Margaret	Deerain	Director	National Rural Health Alliance
Mr	Josh	Fear	National Policy Director	Palliative Care Australia
Ms	Janeen	Foffani	Coordinator	PEPA / SIPM
Dr	Graham	Grove	Medical Director	SPaRTa
Dr	Susan	Haynes	Rural Support Service	Adelaide
Mr	Joe	Hooper	Chief Executive Officer	ANZSPM
Dr	Karin	Jodlowski-Tan	National Clinical Head of Rural Pathways	RACGP
Ms	Jenny	Johnson	Senior Policy and Development Officer	ACRRM
Dr	Sophia	Lam	Palliative Medicine Physician	Queensland Health
Dr	Chi	Li	Palliative Medicine Physician	Albury Wodonga Health (East Hume Pall Care Service)
Mr	Blake	Macdonald	Manager, STP / FATES	Dept of Health and Aged Care
Ms	Ann	Mawhinney	Consumer Representative	Palliative Care Consumer
Ms	Penny	Petinos	FATES Manager	RACP FATES
Ms	Theresa	Pot	Nurse Practitioner	Australian College of Nurse Practitioners
Ms	Bronwyn	Raatz	Nurse Practitioner	Australian College of Nurse Practitioners
Dr	Suzanne	Rainsford	Palliative Care Specialist	Private Practice
Ms	Lesley	Reilly	Consumer Representative	Bosom Buddies NT
Ms	Camilla	Rowland	Chief Executive Officer	Palliative Care Australia

Dr	Christine	Sanderson	RRIPM Clinical Lead	NT Palliative Care Central Australia
Ms	Zoe	Schofield	Head of Programs and Translational Research	Royal Flying Doctor Service
Dr	Odette	Spruijt	Medical Director Launceston Specialist PC Service	Tasmania North Specialist Palliative Care Service
Dr	Penny	Stewart	Consultant at Alice Springs Hospital ICU	NT Palliative Care Central Australia
Dr	Ruth	Stewart	Rural Health Commissioner	Office of Rural Health Commissioner
Ms	Zoe	Tassicker	Policy Officer STP Funding	Dept of Health and Aged Care
Ms	Susanne	Tegen	Chief Executive	National Rural Health Alliance
Professor	Martin	Veysey	Senior Staff Specialist, Professor Rural Medicine	NT Health/ Flinders/RACP
Ms	Leanne	Wells	Workshop Facilitator	Leanne Wells Consulting
Ms	Nicole	Willico	Training Manager	RACP
Professor	Paul	Worley	Executive Director Clinical Innovation	Riverland Academy of Clinical Excellence, Riverland Mallee Coorong LHN
Ms	Karen	Motyka	Project Officer	ANZSPM / RRIPM
Dr	Jo	Risk	Project Manager	ANZSPM / RRIPM