Rural Research Capacity Building Program Review

Dr Tim Smyth
Guyra Ardee Pty Ltd
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GUYRA ARDEE PTY LTD ABN 46 095 832 778

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What is this Report?

The Health Education and Training Institute (**HETI**) commissioned Dr Tim Smyth to review the Rural Research Capacity Building Program (RRCBP). The program has been running for 7 years. It is targeted at "research novices" - rural clinicians who have not had substantive experience in research.

The program seeks to:

- increase the number of rural clinicians in NSW able to undertake and contribute to research;
- encourage participants to continue their training in research in the higher education sector;
- build a critical mass to strengthen rural health research; and
- translate research into improving clinical practice, health services and rural community health outcomes.

In commissioning the review, HETI requested the consultant to discuss the program with a broad range of parties. The consultant thanks all who contributed to this discussion and debate for their time and input.

The consultant interviewed 22 current and past participants, mentors, teachers and rural health service sponsors and managers, including one rural LHD CE. The consultant also met with HETI senior executives and the RRCBP staff.

The consultant would also like to place on record the high regard held by candidates and mentors for the support provided by the two RRCB Program Officers in HETI - Emma Webster and David Schmidt.

This Report summarises the consultations, identifies key themes and issues and recommends a way forward.

As outlined in this Report, it is an appropriate time to pause and strengthen the program.

There has been a growth in rural academic health centres, rural health research and research infrastructure over the past decade. In time, there may no longer be a need for a program specifically targeted at novice researchers and/or rural health clinicians. The Report therefore recommends a further in depth review in 2016/17.

The key themes of the Report recommendations are:

- a stronger academic framework with a core curriculum, academic advisory "Board" and an articulated pathway to higher education course for

Program graduates, while retaining the program focus and intake on novice researchers
- a much stronger alignment of the research projects to rural health research priority areas and embedding pathways to effectively translate the project outcomes into practice
- continued management of the program by HETI with a stronger partnership with the ACI, NSW Kids and Families, CEC and key program areas in the Ministry
- restructure of the program into 2 distinct stages, with stage 1 ensuring appropriate scoping of the project, cementing linkages with mentors, sponsors and a translational "entity".

History and context

How did the RRCBP start?

The RRCBP was an initiative of the then NSW Institute of Rural Clinical Services and Teaching, the NSW Department of Health and the University of Sydney's Department of Rural Health at Broken Hill (UDRH). The first intake of candidates was in September 2006.

The Institute (now part of the HETI) was created and funded by the NSW Department of Health following the release of a NSW Rural Health Plan. Funding for the RRCBP was sourced from the Institute's budget.

Discussions with persons involved in the development of the program indicate that the program emerged due to an opportune alignment of factors:

- the NSW Health Rural Health Plan goal of strengthening rural health research and the evidence base for improving health outcomes and health services in rural NSW;
- a perceived need to foster and build research skills and capacity in rural health clinicians;
- strong support from the Institute, UDRH at Broken Hill and the NSW Department of Health;
- the increasing interest of NSW universities in developing rural health schools (driven partly by Commonwealth priorities and funding); and
- a funding source through the Institute.

The program was restricted to rural health clinicians as it was felt that clinicians in urban areas had both a greater exposure to research and easier access to research training and support.

In developing the program, the Institute planned for an annual intake of 25-30 candidates. The first intake was 26 candidates. A further 24 candidates joined the program in 2007, followed by 15 in 2008.

By December 2013, 218 rural health clinicians had applied to join the program, 166 had been accepted and 78 had completed the 22 month program.

The majority of candidates are allied health professionals (43%) or nurses (48%).

What is the Program?

The core of the program is supporting a rural health clinician who is new to research to complete a research project they nominate.

The projects are workplace based and largely self initiated. Candidates are supported by face to face workshops, teleconferences and mentoring. The program is 22 months, spread over three calendar years. The program commences in September of year 1, with the expectation that candidates will finish in June of year 3.

Candidates are supported by a mentor and a structured educational program involving three workshops (5 days in September Year 1, 2 days in February Year 2 and 2 days in February Year 3).

The educational program covers the principles of research (both quantitative and qualitative), literature reviews, introduction to statistics, research methods, submissions to ethics committees and report writing.

The teaching faculty for the program is primarily drawn from academic staff at a number of University rural health schools, supported by a mix of other persons (including past program participants and persons in other training programs) for some topic areas.

Telephone and personal support is provided during the program by the mentors, teachers, two part time program co-ordinators and health service sponsors. Over the past few years a network of past participants providing support has also evolved.

The program is open to all health care disciplines. Applicants must be permanent employees of a rural Local Health district (excluding the Newcastle urban area of HNELHD).[1] The program budget provides up to 97 days funding for backfill to release participants from their working role and funds the costs of attendance at the three workshops in Sydney.

Applicants apply through their health service. Applications supported by the health service are then considered by a HETI committee for admission to the program.

[1] Including rurally based staff of the Ambulance Service and Justice and Forensic Mental Health Network and the Shoalhaven zone of the ISLHD.

The focus of the program is on "novice" researchers – rural health clinicians that have not previously undertaken research. The program aims to provide novice researchers with basic skills in reading, reviewing and assessing research papers, collecting and analysing research data and preparing research reports and presentations.

Candidates who complete the program are encouraged, but are not required, to undertake further accredited higher education studies.

The consultant noted with interest that the NSW program appears to be the only one of its type in Australia.
While geography, travel times and maturation of rural universities differs between states, the consultant assumes that there would be a similar context in Queensland and Western Australia in particular.

What are the research projects?

As discussed later in this report, the research projects are principally self selected by the candidates and reflect their professional background, interests and work role. They are a mix of qualitative and quantitative research.

The completed projects in 2010 included projects on:

- practice model for a rural dementia outreach service
- acquiring and integrating coaching skills for senior nurses and midwives
- evaluation of a hub and spoke multidisciplinary care model for orthogeriatric patients
- medication discrepancies after discharge from a rural district hospital
- impact of the NSW Healthy School canteen strategy on school food service
- experience of living with Hep C
- online learning for nurses
- hand grip strength as an indicator of nutritional status in rural hospital patients.

Details of all projects are available on the HETI website – www.heti.nsw.gov.au/rural-and-remote .

How many candidates and how do they fare?

The table below summarises the program activity together with some process and outcome indicators.

To the end of December 2013, 166 candidates have been accepted on to the program.

The acceptance rate has been 76% and the dropout rate 23% overall. As at December 2013 there were 9 candidates who had not completed their research project and report within the 22 month period.

As noted in the table below, of the 78 candidates who have completed the program, 16 (20%) have gone on to higher education studies (Masters or PhD) and 13 (17%) now have continuing involvement in research in their work role.

NSW RRCBP Overview December 2013

	2006	2007	2008	2009	2010	2011	2012	2013
Applicants	29	30	17	23	27	34	25	33
Acceptances	27	24	15	18	20	20	22	20
Withdrawals	10	10	5	3	4	5	2	0
Completions	17	14	8	15	14	10	N/A	N/A
Further research study	5	1	4	2	2	2	N/A	N/A
Peer review papers	6	2	5	2	4	1	N/A	N/A
Work role now includes research	5	2	2	3	0	1	N/A	N/A

What is the cost of the Program?

The program has a mix of direct costs, in kind contributions and absorbed overheads. Much of the input of mentors and teaching staff is contributed to the program, with HETI only required to cover the direct costs of the workshops.

While a potential backfill of 97 days is factored into the budget (currently at $335 per day - $32,495 per candidate), the actual cost of the backfill depends on the ability of the health service to source the backfill for the candidate. Unsurprisingly, there is often a difficulty in finding a health professional available to work part time in a backfill role. HETI only pays the health service for backfill actually provided.

There are two part time program officers based in HETI.

The current approved "budget" for the RRCBP is $539,000 per annum[2]. Actual expenditure has exceeded this figure, averaging $600,000 per annum. Contributing to this have been delays in completion of the program by some candidates resulting in more than the budgeted number of participants being on the program in any one financial year.

The direct cost to HETI (and the Institute prior to its incorporation into HETI) of the 78 candidates who have completed the program is approximately $3M, around $38-40,000 per person.

[2] Excluding backfill costs which vary according to actual take up, the other costs of the program are Program Officers $108K, workshops, accommodation and travel $70K, other costs $16K.

Earlier RRCBP evaluation

ARTD Consultants were engaged in 2009 by the then NSW Institute of Rural Clinical Services and Teaching to assist in an evaluation of the program by the Institute. ARTD interviewed a sample of candidates, health service managers and mentors across four rural Area Health Services. ARTD provided a report to the Institute in May 2010.[3]

The report highlighted five key findings from the interviews:

- the program offered a unique opportunity that was taken up by motivated rural health professionals
- administrative processes did not always work smoothly
- there were difficulties with candidate managers and connecting with local research networks
- while the impact of the program on the candidates was significant, it did not appear to have a longer term impact on rural health practice
- barriers to increasing research capacity in rural health services remained.

The report commented that the Institute had achieved some success in using the capacity building framework[4] to build partnerships with researchers and universities in rural NSW and in developing the candidates.

The report concluded that overall the persons interviewed were "*extremely satisfied with the RRCB Program*". While candidates faced many barriers and often lacked management support, this was offset by the support received from the program staff and mentors. Candidates who had completed the program felt they had gained increased knowledge and confidence in research and their ability to present research findings and share their research knowledge.

The report noted, "*the main barriers faced by graduates to undertaking further research is the lack of support for research within the candidates' workplace and lack of connections to other local researchers or research networks*".

The report recommended that the Institute consider:

- strategies to enhance workplace management support of candidates
- gaining greater senior executive support for the program
- reviewing the ongoing viability of the mentoring support

[3] Evaluation of the Rural Research Capacity Building Program – Final Report to NSW Institute of Rural Clinical Services and Teaching May 2010. ARTD Consultants Sydney NSW.

[4] The capacity building framework incorporated five strategies – organisation development, workforce development, resource allocation, partnerships and leadership.

- actively linking candidates with other researchers and research networks
- marketing the program to Aboriginal health workers
- greater access to the program by frontline workers
- reviewing provision of ongoing statistical support to candidates while on the program.

The consultant notes that the evaluation supports the consultant's impression that the program is achieving only part of what is required for research capacity building – building skills and confidence of candidates.

Jo Cooke from the University of Sheffield proposed six principles of research capacity building[5]:

- Skills and confidence building
- Close to practice
- Linkages and collaboration
- Appropriate dissemination
- Continuity and sustainability
- Infrastructure.

Progress has also been made on partnerships and linkages with rural health academic units. However, the program does not appear to be succeeding in building the "system" elements needed for sustainable research capacity building.

Key findings and issues from consultations

The overwhelming majority of persons interviewed supported continuation of the program. This does not mean that there were not issues raised and suggestions given on improving the program.

Only one person interviewed recommended that the program cease altogether, arguing that the program created false expectations for the candidates, supported small "boutique" projects, was expensive and was no longer required as other opportunities were now available.

When those who supported continuation of the program were asked should the program be opened up to "urban" novice researchers, the universal response was no – rural health clinicians were still disadvantaged in their access to research skills training and needed affirmative support by the health system.

The consultant discerned ten themes emerging from the discussions:

[5] Cooke J: A framework to evaluate research capacity building in health care. *BMC Family Practice 2005, 6:44.*

1. Selection and scoping of the research project
2. Program length and timing of key stages
3. Content and academic oversight of the program
4. Articulation of the program with further higher education studies
5. Building in effective translation of research outcomes into rural health practice
6. Engagement of health services with the program
7. Marketing of the program
8. Required candidate outcomes to complete the program
9. Requirement for the program longer term
10. Who should run the program?

Selection and scoping of the research project

Candidates select their research project based on their particular interest or a problem or a research issue that has arisen in their work. There is no structured alignment of research projects with research priorities of the health services or Ministry of Health.

This issue is a "two edged sword" as on the one hand, candidates and mentors strongly asserted that this ability to self select the project was a key motivator for candidates, especially as they were novice researchers.

On the other hand, the lack of structured alignment with "system" research priorities means that translation of the research outcomes into wider rural health practice was less likely and probably tempered the degree of support of the candidate and the project by health services.

However, there is an important creative tension with this issue. The consultant accepts that forcing novice researchers to select from a predetermined "menu" of projects may well discourage and de-motivate candidates. There is also a generic "public good" in developing research skills and knowledge, irrespective of the actual research project.

A more structured alignment with system research priorities should assist in engendering greater support of the program by health service management, the NSW Health "Pillars" and the Ministry. It will also provide greater justification for the annual expenditure of $500,000+.

More importantly, a structured alignment should assist in greater translation of the research outcomes into rural health practice in NSW.

The challenge is in finding the right balancing of the creative tension.

A suggested way forward on this issue is for the Ministry and rural LHDs, in conjunction with HETI, ACI, NSW Kids and Families and the CEC, to prepare on a triennial basis a statement of rural health research priorities. These priorities

should be promoted in the marketing of the program and candidates asked to demonstrate how their chosen research project aligns to them. The priorities should also guide assessment of applications at the health service level and recommendations by health service CEs to HETI.

Each priority should also have one nominated lead advocate – a branch/Division of the Ministry or one of the Pillars.

As outlined later in this report, this advocate will provide an important linkage for effective scoping of the research project and support of translation of the research project outcome into rural health practice.

Program length and timing of key stages

The current program is 22 months, commencing in September with a five day research methods workshop in Sydney. All candidates need to gain Ethics Committee approval of their projects.

Discussions with past and current candidates and mentors confirmed that achieving this Ethics Committee approval was a significant timing issue. Increasingly, Ethics Committees do not meet in December/January. If a candidate has not achieved approval by November, it will usually then be February or March at the earliest before approval is received. For many candidates this then means that they have not commenced their project until six or more months has elapsed.[6]

Preparing a submission to an Ethics Committee and gaining approval is, of course, an important learning exercise and skill for all researchers. It is a more daunting task for a novice researcher.

The consultant's discussions also confirmed that considerable time and effort is required in scoping the research project and confirming the research question, study methodology and research subjects.
For many candidates, the September five day workshop brings these issues to the fore.

The consultant discussed the timing of the current program with the Program Officers and was advised that it was largely set to accommodate the availability of university teaching staff and venue availability for the workshops – outside of the academic teaching semesters.

The possibility of shortening the program, perhaps to 12 months, was explored in the consultations. The overwhelming view was that the current 22 months was already a challenge for some participants and that 12 months would be too short.

[6] An analysis of 80 candidates during 2006-2011 provided to the consultant found 26 had made their submission to an Ethics Committee by December, a further 15 by February and 18 after May in Year 2.

This view was supported by academics at rural health research units, based on their experience under an earlier Commonwealth funded 12 month program.

Candidates interviewed also raised the long gap between the two February workshops.

The consultant proposes that these issues be addressed by a two pronged strategy – segmenting the program into 2 stages and bringing the commencement forward to earlier in the calendar year.

Stage 1 could focus on cementing the linkage of the candidate with the health service sponsor, mentor and translation lead advocate; scoping the project and preparing the submission to the Ethics Committee.
Stage 2 would commence once the Ethics Committee approval had been received. Backfill funding would be available for Stage 2.

Commencement on the program in say late February or early March, should enable Ethics Committee approval to be achieved by August/September. This would provide 15 months to then undertake the project and complete the research report and paper for submission to a peer reviewed journal by the end of the following year.

The consultant recognises that this change requires a rearrangement of the current workshops, bringing the September one forward and the two February workshops moved to perhaps October/November in year 1 and mid year in Year 2. Discussion with the academic staff to confirm their availability will be needed.

A change of this nature will also require significant planning. This will require deferral of a 2014 intake by some months or, possibly altogether.

Content and academic oversight of the program

While of its nature, the program is not one based on formal coursework and much of the learning is experiential from undertaking the research project and writing the research report, there does not appear to be a agreed “core curriculum” for the project and the workshops.

The program does need a structured combination of coursework covering theoretical components and tasks, together with the experiential research project, research report and paper for publication.

Discussions with mentors, teaching staff and candidates confirms that there is an underlying consensus on what might the core competencies desired in graduates from the program. Articulation and documentation of these should assist candidates, mentors, applicants and the teaching faculty.

The consultant acknowledges that the current teaching faculty are enthusiastic and committed and largely provide their services at no additional cost to HETI

and the program. It is important that development of a core curriculum and creation of an academic board or advisory committee adds value and constructive rigour to the program, rather than "another committee" and more "red tape".

Development of an agreed academic program structure, competency set, core curriculum and an oversighting academic board for the program should be a high priority for 2014.

This will also have other benefits, including:

- informing and maintaining engagement of an appropriate skill mix for the teaching faculty;
- enabling key participant progress milestones to be developed, to assist participants who are struggling and reducing the drop out rate;
- assisting sourcing learning resources, tools and other materials that HETI could make available to candidates through HETI online; and
- assisting discussions with universities on recognition of prior learning for candidates who wish to proceed to a Masters or PhD or other higher education qualification.

Articulation of the program with further higher education studies

As experience has shown, a significant proportion of candidates progress from being novice researchers to research Masters students due to their participation in the program. This is an important outcome and an element of building sustainability of the research critical mass in rural health.

To both encourage and facilitate this progression, HETI should actively pursue opportunities for formal recognition of the RRCBP and its articulation with the higher education sector.

HETI is a RTO and recognition of the program as a Graduate Certificate or other qualification should be considered. As noted earlier, discussions with one or more universities to gain some prior learning recognition for program graduates wishing to enrol in a Masters or PhD should also be pursued.

Greater academic rigour and articulation with the higher education sector will strengthen the program, while still enabling the program to maintain its focus on novice researchers.

Building in translation of research outcomes into rural health practice

The lack of translation of research outcomes into rural health practice in NSW was a key criticism of the program with many people consulted.

While again recognising that there is an independent generic "public good" in building research skills, the consultant agrees that HETI does need to build in mechanisms to increase the contribution of the program to improving rural health practice and health outcomes for rural communities.

The current program is built around individuals undertaking an agreed research project. Increasingly, research is undertaken and built around "research teams". Expanding the program intake to include teams of researchers would be a significant change to the program and would reduce the number of projects undertaken as funds are not available to increase the program budget to cover more participants.

However, actively linking novice researchers with the research community and other research teams may both assist the participant's learning and help build more effective translation of the research project outcomes into rural health practice.

The consultant recommends six strategies to facilitate this:

1. Agreeing on key rural health research priorities and aligning research projects with one of these priorities.
2. Linking each candidate and their research project with an advocate entity in the NSW health system which can assist in disseminating the research project outcomes and facilitating adoption where appropriate of the research findings into rural health practice in NSW.
3. A stronger involvement of rural Local Health Districts in the program, with an executive sponsor for each project.
4. Linking each participant with an existing active research team.
5. Requiring each candidate to also complete a paper for publication in a peer reviewed journal.
6. Greater promotion of the research projects and outcomes across NSW Health.

Engagement of health services with the program

The 2009 evaluation and the consultations for this review confirmed that the degree of interest and active involvement of rural LHD management in the program remains very variable. There are a number of rural LHDs that are actively involved in the program and in supporting candidates and monitoring their progress.

This variability may be a reflection of changes in personnel, the restructuring of the health system since 2010, awareness of the program and the nature of the research projects. However, it may also reflect the degree to which the program is actually valued. Longer term, the interest, involvement and commitment of rural LHD management will be a determinant of whether the program continues.

Discussion of this review report and its recommendations with rural LHDs will be an opportunity for HETI to explore this issue further. Acceptance of a candidate on to the program should require not only sign off by the LHD, but also confirmation of a senior executive sponsor for each candidate and the continued involvement of that sponsor with the program team in monitoring the progress of the candidate and dissemination of the research outcomes within the LHD.

Marketing of the program

A frequent comment made to the consultant was that people "stumbled across" the program or only found out about it accidentally or close to the closing date. Discussion with LHD staff however indicates that the program is included in staff newsletters and other communication channels.

A formal "relaunch" of the program, maintaining a network of program "alumni" and targeted marketing aligned with the rural health research priorities should be considered.

Required candidate outcomes to complete the program

Currently the primary outcome required of candidates is completion of a 25 page research report. The consultant noted that a number of candidates also prepared a paper for publication in a peer reviewed journal and presented at state, national and international conferences. These are all valuable learning experiences.

The consultant raised the desirability of requiring all candidates to prepare a paper for acceptance in a peer reviewed journal. The academic staff and many mentors and candidates were supportive of this. However, some mentors and candidates thought this would be a burden and if adopted, the requirement for a research report should be dropped.

Publication in a peer reviewed journal will assist in dissemination and citation in literature reviews. It will also assist candidates who wish to proceed to higher education research Masters or PhDs. Most people interviewed agreed that it should be possible to prepare a paper for publication from the research report material.

On balance, the consultant recommends that the program require each candidate to identify suitable peer reviewed journals as part of Stage 1 of the program and to prepare and submit a paper for publication by the end of Stage 2.

Requirement for the program longer term

The consultant asked persons interviewed how long the program should continue. This question lead to discussion of what critical mass of novice researchers needed to be equipped with basic research skills, how would growing availability of online and other learning tools and resources impact on the program and the impact of the growth of university rural health academic units.

Many people commented on the development of academic and research networks and infrastructure along the North Coast and in Hunter New England reducing the need for a specialist novice researcher program.

Most people interviewed were unwilling to nominate a sunset date for the program, but all agreed that a further review in a few years time was very appropriate.

The recent Commonwealth Budget changes to the regulatory framework for higher education fees, Commonwealth funding support and student loans, and its extension to other non university education providers, may significantly change the future landscape in rural NSW. Other budget announcements such as the creation of Primary Health Networks and restructuring of a number of health portfolio agencies will also change the landscape.

The development of alternative programs and pathways to encourage and support rural health clinicians to participate in and undertake research is highly likely.

HETI staff identified a number of university programs currently available with a focus on building research skills.

Courses available by distance education include - Monash University -Graduate Certificate, Graduate Diploma and Masters in Clinical Research Methods; James Cook University - Graduate Certificate of Research Methods and Charles Darwin University - Graduate Diploma in Health Research.

On campus courses in NSW include the University of Wollongong Graduate Certificate in Health Research and the University of Sydney – Graduate Certificate in Qualitative Health Research.

Under the current fee arrangements (which may change significantly in 2016/17), a graduate certificate with say four subjects would be around $10-12,000. Adding say two face to face workshops or on campus attendance would cost around $3,000 per person if held in Sydney.

Funding 20 participants to undertake a graduate certificate would cost around $300,000 in direct costs. Backfill costs while undertaking the research project and program management support costs would also need to be funded. This costing is indicative only, but it does suggest that there would not be substantial cost savings in moving to a scholarship model.

The consultant has not had an opportunity to review these courses and they may not be a suitable substitute for a novice rural clinician researcher or provide the flexibility and support structure of the current RRCBP.

The consultant recommends that a further review occur in 2016/17 with the focus on this review on the availability of cost effective alternative programs to build research capacity and capability in rural NSW Health.

Who should run the program?

In discussing this question, four options were raised:

- continue with HETI
- transfer to a university
- transfer to ACI
- transfer to a rural LHD consortium.

Persons interviewed did not see a rural LHD consortium working due to its complexity and the tension with competing priorities.

There was support in principle for considering transfer to a university, but on reflection there was consensus that this would increase the cost of the program due to university overheads, would "morph" the program away from its focus on novice researchers and reduce alignment with NSW Health rural health research priorities.

Transfer to the ACI was seen as a strategy for strengthening translation of research project outcomes into clinical practice. However, the ACI's focus was seen as being more on models of clinical care and hence potentially narrowing the project's attractiveness to novice researchers in population health, primary health care and broader social determinants of health.

Continuing with HETI is not simply a "fallback" option in the absence of a better alternative. The core objective of the program is to deliver an introductory education program to build research capabilities and skills and create a pathway to further training.

The program began as an initiative of the then NSW Institute of Rural Clinical Services and Teaching. The Institute was subsequently incorporated into HETI. HETI is tasked with supporting and promoting co-ordinated high quality education and training across NSW Health.

Research is a core activity of NSW Health. Supporting the acquisition of research capabilities and skills by NSW Health staff aligns with the role given to HETI. How this is best done, and the degree to which HETI should be a provider of education and training in this area, is an issue that HETI should continue to explore with the Office for Health and Medical Research (OHMR).

The consultant's view is that HETI sourcing, supporting and/or providing an education and training program is appropriate where cost effective alternative

providers are not available or the education and training programs does not have the content and learning outcomes that meet the needs of NSW Health.

If the RRCBP Program is required, and there is not an appropriate and cost effective alternative provider, the consultant supports HETI continuing to provide the Program.

Should the Program continue?

Based on the enthusiasm for the program from the majority of persons interviewed, the opportunity to now strengthen the program and address the issues of concern, the expressed perception that rural clinicians are still at a disadvantage in gaining research skills compared to their urban colleagues and the likely changes in the higher education landscape by 2017, the consultant recommends that the program should continue for another two intakes (2015 and 2016) with a further review in 2016/17.

This review should particularly focus on:

- whether the issues of concern for the current program been effectively addressed;
- the extent to which barriers to access to higher education centres for rural health clinicians have been reduced;
- whether the higher education landscape has changed sufficiently to provide access to other suitable programs, learning tools and resources; and
- if the program continues to be required is there a suitable alternative provider.

Recommendations

The Review recommends:

1. The program continue, managed by HETI, with a further review in 2016/17.
2. The Program be restructured into two stages with Stage 1 focussed on cementing the linkage of the candidate with the health service sponsor, mentor and translation lead advocate; scoping the project and preparing the submission to the Ethics Committee and a 15 month Stage 2 commencing once the Ethics Committee approval is received.
3. The Program commencing earlier in the calendar year with a parallel rescheduling of the three workshops.
4. Development of an agreed set of core competencies and curriculum for the program, overseen by an academic board.

5. Structured alignment of research projects with a NSW Health statement of rural health research priorities updated every 3 years.
6. Formal linkage of each candidate with an advocate entity (Branch/Division of the Ministry, ACI, NSW Kids and Families or CEC) to facilitate translation of the research project outcomes into rural health practice.
7. Introduction of a requirement that candidates prepare and submit a paper for publication in a peer reviewed journal.
8. Recognition of the program as a formal vocational education qualification and articulation of the program with higher education courses.
9. Stronger involvement of rural LHDs through a designated executive sponsor for each candidate accepted on to the program.
10. A proportionate contribution to the funding of the program by ACI, NSW Kids and Families and the CEC.
11. A formal relaunch of the revised program.
12. Consideration of opening the revised program to “full fee paying” candidates from other states and territories, funded by their health service or employer.