Catholic Health Australia's response to the

NATIONAL HEALTH WORKFORCE TASKFORCE DISCUSSION PAPER:

HEALTH EDUCATION AND TRAINING

CLINICAL TRAINING - GOVERNANCE AND ORGANISATION

Catholic Health Australia (CHA) welcomes the opportunity to provide comment regarding the *Health, Education and Training: Clinical Training- Governance and Organisation Discussion Paper*. We ask to be kept informed of the progress of the outcomes of the discussion paper and to be offered the opportunity for further input as these outcomes develop.

BACKGROUND

Catholic Health Australia (CHA) represents the largest non-government grouping of not-for-profit health and aged care services in Australia. By way of summary response to the *Health, Education and Training: Clinical Training- Governance and Organisation Discussion Paper* we submit that:

- The effective planning, organisation and management of clinical places is dependent upon many factors, including:
  - Relationships that have been established between universities, training institutions and health services
  - Geographic location of training institution and health service
  - Available funding to support placements
  - Availability of preceptors and clinical educators
  - Infrastructure within a health service that supports a learning environment
  - Ability of both training institution and health service to commit to ensuring that the students' training and development needs are fully met

- Information regarding best practice models of clinical placement must be disseminated across health services and training institutions. There are currently models in place that work well.

- Imposing a single governance model across the country to improve the current clinical placement allocation process will not address the fundamental issues of:
  - incentives for health services to expand capacity for clinical placements
  - relationship building between training institutions and health services

- The recent recommendations from the National Health and Hospitals Reform Commission suggesting the development of a National Clinical Education and Training Agency and it's associated functions are supported by CHA as the most appropriate model to support clinical placement management.

- Fund holding of the $1.6 billion (*of which $500million is to come from the jurisdictions*) allocated for the Health Workforce Agency must lie with the new agency. Jurisdictions must not be fund holders. The case for change is strong. Jurisdictions have failed in managing Australia's future health workforce and they must not be allowed to repeat the same mistakes into the future.

CATHOLIC HEALTH AND AGED SERVICES IN AUSTRALIA

CHA is a national peak membership organisation representing Catholic health and aged care providers.

Catholic providers comprise the largest non-government grouping of health and aged care services in Australia. Within the CHA membership there are service providers who manage:

- 9,500 beds across 21 public and 54 private health care facilities;
- 550 aged care services comprising 19,000 residential aged care beds,
- 6,000 retirement units, and 14,000 aged care or community care packages.

These services represent more than **13%** of health and aged care services in Australia, and are operated by different bodies of the Catholic Church.

NB These comments pertain to **nursing** and **medical** clinical placements only.

Discussion Questions

What is your experience of clinical training planning, organisation and management?

CHA has previously highlighted our experiences with placements. We re-submit this piece of work, as an attachment (Attachment 1) to this response, and in table format that highlights experience at the planning, organisation and management levels.

Can you identify any other examples of good practice or approaches?

Examples of good practice approaches within CHA submitted by the membership include:

"Partnership arrangements with universities have proven to work well, but sometimes mean that those undergraduate nurses who have only ever worked in a particular facility may choose to work elsewhere (although the reverse can also be true)".
"Because a variety of students come through facilities, it is felt that continuity of student, or aligning students to on organisation, would be more beneficial for both the student and the facility, and would help address some of the socialisation issues that can be difficult for newly graduated students, particularly nurses, who need to undertake shift work, etc".
"Where placements for nurses have worked well and strong partnerships with Universities have occurred it has been found that the "graduation year" can be significantly reduced, in some cases down to 3 months. To achieve this undergraduates are employed as AINs -where they learnt to provide patient care and whilst on placement as students they are socialised to the hospital and get ready for graduation".

In addition, attached to this response to the discussion paper is a PDF file containing two articles by Dr Jennifer Kelly, Senior Lecturer in the School of Nursing and Midwifery (Qld) at the Australian Catholic University (ACU). These articles detail the successful partnership model that has been implemented between the Mater Private Hospital, Brisbane and ACU in terms of management of their nursing clinical placements. The model implemented for clinical placements better addresses the needs of students, the health care setting and the nursing profession.

The ACU / Mater Private Hospital model involves students being allocated to a ward for the semester where they undertake all shifts (including night duty and weekends). Students gained an increased sense of role of the registered nurse and became used to the workplace

and felt like they were part of the team. The ward gained from the experience because there was decreased movement of students through the area and they became familiar with the students over the semester. It also provided opportunities to recruit students as not only RNs but also as assistants in nursing or patient care attendants, in addition to their student role.

ACU have developed a new nursing curriculum to be implemented in the 2010 academic year which incorporates many of the findings from the Brisbane / ACU experience.

What are the strengths and weaknesses of the governance models presented in the paper?

To propose one model of governance assumes that all health services want the same things from the clinical placement experience and are all working towards successfully training health workers that they may or may not successfully recruit. Incentives, and the right incentives, are required for health services to come on board and participate as one unit. The health service would quite rightly ask –what's in it for them? Once funding is attached to the student, and health services are confident that it is enough funding to ensure adequate supervision of students, then behaviors may change and relationships improve. At the moment most health services deal with Universities that are geographically close to them, particularly in rural areas. Most often graduates will want to work in a familiar environment once graduated.

Model	Strength	Weakness
Facilitative Model	• A strength of the model is that it tries to address the reasons why clinical placements have not been optimally used, ie focus is on leadership, best practice and innovation. • The focus on relationship issues is a key issue in successful clinical placements. • The focus on competency based training is positive.	• The broader information technology systems required to support the management of clinical training are not in place.
Brokerage Model	• Difficult to identify strengths, as model is not well articulated.	• It is not a brokerage model, therefore title is misleading. • Offers two different roles –one of identifying clinical placement needs and matching them with health service capacity and then development of solutions that integrate workforce planning, policy & reform –this is not brokerage. • Does not clearly articulate the 'brokerage' function, - for example *develop and support clinical placements systems and broker training responses based on states and territories identified needs?*
Tendering Model	• The alternate model proposed of health services advising placement capacity to education providers who would then bid for places is supported.	• Assumes all clinical placement requirements will be centralized in order to be tendered out. • Who will be the 'owner' of the clinical placement –the university or the tendering agency? • Correct incentives to absorb excess demand must be in place,

		again, 'what's in it for the health service?' who, it could be argued, can run far more efficiently without clinical placements.
Central Allocation		• Does not acknowledge the differences in undergraduate programs. • Holds similar weaknesses to the tendering and brokerage models. • Requires incentives for health facilities to participate. • The proposed central data base would need to ensure the NGO and private sectors were accurately captured.

Is there another model for clinical education governance other than those already identified? If so, please describe and provide an overview of its strengths and weaknesses. Please ensure it encompasses a cross disciplinary approach and is able to adapt to evolving service models and training needs.

The question as to why develop a *clinical education governance* mechanism must be asked. Is it because what is in place has not worked well so far? CHA believe there other levers that could be applied to try and achieve improvement in allocation and planning of clinical places without the introduction of a governance model.

Because there is shared responsibility for clinical education –across health (public, private, not for profit) –and across education (University sector, VET sector) –it is CHA opinion that it would be unlikely that a single governance model could be implemented. There are, as stated in the discussion paper, a number of existing arrangements that are working reasonably well.

Exploring system wide, under utilised capacity for clinical places is a new role for an as yet unidentified stakeholder –perhaps the new agency.
Universities and training institutions are one of the primary stakeholders, as an undertaking to provide clinical placements is often a condition of receiving government funded places. The students themselves are the other primary stakeholder –they cannot practise or graduate until they are deemed competent, which is reliant on adequate clinically based experience.

Health services, particularly the private and not for profit sectors are not primary stakeholders. Mostly they are not dependent upon, nor indeed need, universities and training institutions to provide students. They engage in the clinical placement process as part of their mission, and/or in order to showcase their facilities to potential employees. Often students are viewed as an added burden to an already stressed environment where staff are required to do more with less. This is not the case in the public sector with regard to medical student placements. Salaried medical staff are allocated a teaching and training component. Although not always able to free up enough time for students, the incentive, gained through enterprise bargaining agreement, is in place.

Until the incentive for health services and staff to take on more clinical places changes attempts to implement a governing framework across education and health services will fail – health facilities will not "play ball"- they have no need to.

What are your thoughts on how the new agency could best support clinical placement management?

The National Health and Hospitals Reform Commission has suggested the development of a

National Clinical Education and Training Agency that would have the following functions:

- to advise on the adequacy of projected provision of health professional education in the university and vocational education sectors within each major region;
- to purchase in partnership with universities, vocational education and training, and colleges, clinical education placements from health service providers, including payments for undergraduates' clinical education and postgraduate training;
- to promote innovation in education and training of the health workforce;
- as an aggregator and facilitator for the provision of modular competency-based programs to up-skill health professionals (medical, nursing, allied health and aboriginal health workers) in regional, rural and remote Australia to perform tasks and address health needs met by other health professionals in major metropolitan areas; and
- to report every three years on the appropriateness of accreditation standards in each profession in terms of innovation around meeting the emerging health care needs of the community.

If the new agency was funded appropriately it could fulfill these functions outlined above. CHA supports this recommendation made by the National Health and Hospitals Reform Commission.

Fund holding of the $1.6 billion (*of which $500million is to come from the jurisdictions*) allocated for the Health Workforce Agency must lie with the new agency. Jurisdictions must not be fund holders. The case for change is strong. Jurisdictions have failed in managing Australia's future health workforce and they must not be allowed to repeat that same mistakes into the future. We have already seen examples of how jurisdictions look after the needs of the public sector first –and rightly so –for that is their role. For example the private and not for profit sector seem to have missed out on accessing adequate VET training places because the jurisdictions won the battle to hold the funds for this new initiative. Exactly where and how the funding for the new places has been distributed is not clear. The Federal Government must not allow this same scenario to occur again with the new Health Workforce Agency. It is worthwhile noting that approximately 60% of surgery now occurs in the private sector. Adequate clinical experience must include the private and not for profit sectors. A transparent fund holding arrangement for the new workforce funds must be a high priority.

Are there other opportunities to improve the governance and organisation of clinical education in Australia?

Incentives for health facilities to take on more clinical placements

Clearly if education dollars are attached to students then health facilities may be more open to exploring ways of increasing capacity for placements. This is provided that the dollars:

a) are not taken up by the training institutions - meaning that the current funding arrangements would remain unchanged
b) are adequate in terms of being able to pay for health facility based preceptors and clinical educators

Support provided to the health services in building relationships with the education sector would also be helpful. Anecdotally both the health and education sectors run along parallel lines. Training providers and universities have an interest in ensuring their students graduate in a timely manner having completed all necessary clinical components, in order to make room for the next batch of students. Health services are required to provide a health service first - particularly in the private, not for profit sector, and students on placement need to fit into this imperative. These arrangements are often because of historical or geographical relationships.

What is your experience of clinical training planning, organisation and management? ATTACHMENT 1

Clinical Training - Planning	Clinical Training - Organisation	Clinical Training - Management
Smaller facilities have difficulty consistently accessing students for clinical placements, and often have students turning up on the wrong days.	Many facilities are experiencing "preceptor fatigue" – a heightened level of stress due having students on placement, with the increasing numbers of students and the associated educational responsibility.	Larger groups of facilities can deal with up to 9-10 universities at a time, and the administrative support required to manage this is significant. It works well if the facility employs its own clinical educators.
Often day or time of commencement of placement is not reliable, length of placement is unknown and objectives of the placement are not articulated. It is felt that if placements were consistently organised across facilities, existing capacity would increase.	If students are placed in a rural setting there is often little support provided by the university. Support that is required includes accommodation, orientation and clinical supervision.	Each university uses different assessment tools for student assessments, and these range from one page through to "thesis" size. Paperwork for the student that preceptors may need to complete can be confusing and instructions provided open to varied interpretation.
Students are often not available at times when a facility may have an increased capacity to take on students. Universities seem to all want placements during the same time period.	Some new graduates are not 'work ready'. Often student nurses have graduated with no surgical placement experience and minimal acute placement experience.	Models of clinical support for undergraduates in nursing were introduced where the ratio of clinical supervision for students was 1:8, it has now changed to 1:16. Most facilities are struggling with this new increased ratio.
There is more opportunity in the private sector as a whole to provide clinical placements, but costs to do so must be covered, such as appointing clinical educators.	Some universities cancel placements at short notice. CHA has been told that late cancellations occur intermittently, but not infrequently, from some facilities.	Supervision of students is an issue. It has been some facilities' experience that supervisors, for example, are not skilled enough to provide acute surgical support to students on wards. In addition attendance of supervisors can be fragmented and inconsistent. In response to these issues some facilities second their own staff to the university so that they can provide the supervision. However in the not-for profit sector there is no state funding available to back-fill the supervisor's position, whilst some universities provide funding for back-fill.

Clinical Training - Planning	Clinical Training - Organisation	Clinical Training - Management
The 12 month post graduate nurse program is remunerated within the public sector (anecdotally at up to $15,000 per nurse). This funding is not available to the private sector. CHA would recommend that the funding is attached to the graduating nurse – to be taken wherever he or she chooses (within Australia) to undertake their graduate year.	Students access limited shifts only, and are not required to cover a 24-hour period. If they were required to cover a 24 hour shift it may assist in adjusting their lifestyles to shift work once graduated.	Clinical placements have a greater emphasis on tasks rather than valuing the complexity of care. It seems that universities often have difficulty in keeping up with contemporary models of care and are not teaching students contemporary practice. This situation then adds to an already stressed environment.
Impact of differing approaches to curriculum: Undergraduate medical placements provide challenges to the not-for-profit sector. There is more than one model of medical education currently being taught. One particular model of curriculum is very resource intensive, from a supervisory point of view. Third year students may be on placement for a whole year at a facility, and will be required to cover medicine and surgery as well as pastoral care, in contrast to students from a different university, at the same year level who will have different objectives for their placements. Because of the course accreditation process student curricula should be similar.	Without quarantined time and funding, private hospitals rely on clinician goodwill. Support for teachers, both financial and administrative, is critical.	There is often also a lack of support provided by universities for overseas students. The clinical facility provides the student placement on request, regardless of student category, and does not differentiate between Australian students or overseas students.
It will be difficult to find clinicians who are willing to support an expansion in medical training (medical students and interns) into the private sector unless the following questions are answered: o What is the scope of the issue? o What will be the future demand? o Who will provide the infrastructure to support the demand? o Who will fund? o What is the level of acceptance of	Traditionally, medical training in the private sector has been an added burden to existing administrative personnel. Like nursing, done well it requires significant administrative and infrastructure support. Medical training also requires infrastructure supports such as computer/library access, lockers, common room.	Supervision levels for students in residential aged care facilities is generally poor. One facility reported, for example, that in their first year, students may attend one day a week for eight weeks, with no supervision, then for their second and third year placements attend for two weeks at a time with one phone call a week from their supervisor. This can be very difficult for students as they are often exposed to their first experience of a patient/resident death. In addition objectives

Clinical Training - Planning	Clinical Training - Organisation	Clinical Training - Management
teaching and training in private hospitals by the participating patients? ○ Ensure infrastructure for teaching is available		for their placement are often not developed, and Universities provide little guidance. Some facilities employ these undergraduate nurses as carers where possible and then as registered nurses whilst they wait for the commencement of their graduate year elsewhere.
The primary issues relating to medical clinical placements are ensuring **adequate levels of supervision** and **adequate funding and resourcing**. ○ The public system is essentially funded to teach. For the private sector teaching reduces efficiency (anecdotally by 25% for surgeons with a trainee in theatre) and even the funded Expanded Settings Training Program barely covers costs - and falls well short if the trainee is on-call or working out of hours. Any further significant financial contribution for clinical placements may not be possible.		Students who wish to do extra time on wards after their placement has finished are not able to, as the university insurance does not cover them. Some facilities are employing these students as Assistants in Nursing (AIN) and are finding they are retaining between 75 – 80% of them to their facility once they have graduated. This approach allows the institution to see how the student develops and integrates the student to the team, improves their socialisation and real life experience.
Indemnity is also a major issue for the private system. Multiple complicated arrangements exist with government, private/public partnerships and Medical Defence Organisations. Clarification of indemnity for students, junior doctors and specialist trainees in the private sector is essential.		Timing of Nurses Board registration period
For medical training in private facilities to work well requires a collaborative approach with government, universities and specialist colleges.		Because there are so many part time nurses it is often difficult to obtain continuity of staff in facilities to assist students.
The private sector is often at a disadvantage		Medical students are not part of a ward per se,

Clinical Training - Planning	Clinical Training - Organisation	Clinical Training - Management
compared with the public sector in terms of support for teaching and research. In the public sector academic positions are often funded by jurisdictions in return for a service commitment. For example hospitals may be given University status and be provided a hospital clinical appointment in exchange for being responsible for teaching – at no cost to the facility.		and so it is difficult for them to be socialised into a ward.
		More data is required from the experience of specialist training in private settings and the impact this has had on business – i.e. clinical activity and budgets. This is not an issue in the public sector where the teaching and supervised training is undertaken in the clinician paid sessional allocation. The question of whether there is a measurable slow down in throughput due to specialist trainees will need to be answered.
		For clinical placements to work well for both nursing students and medical students they require their own space within facilities where they can learn together as two professions. (This would be appropriate for allied health staff as well). Space that is currently provided is generally inadequate.
		Infrastructure for medical teaching is not always available. In the public sector most facilities have a budget for research and training. Salaried medical staff are provided a research and training sessional allocation (and payment – within their paid service commitment). This is not the case in the private sector where clinicians are independent

Clinical Training - Planning	Clinical Training - Organisation	Clinical Training - Management
		of the facility. As the intern and registrar numbers increase (particularly in light of the 10 new medical schools that have been established over the past 11 years) supervision and funding of medical training will become critical. It is not likely that these increased numbers will be absorbed within the private sector because it is not possible to have large numbers of interns in the private sector without the necessary resident and registrar structure above them.
		The relationships with public hospitals are also critical and current models of teaching and training have this at the forefront. For junior doctors and specialist trainees it is important that preservation of public entitlements are retained and therefore a secondment model works best.

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