Health Sciences Australia

Australian Council of Pro Vice -Chancellors and Deans of Health Sciences

Health Education and Training: Clinical placements across Australia: capturing data and understanding demand and capacity

The Australian Council of Pro-Vice-Chancellors and Deans of Health Sciences (ACPDHS) is the peak representative body for those Australian universities that provide undergraduate education in allied health sciences. The Council is a forum for representation, coordination and information sharing with the aim of strengthening the training of allied health practitioners in Australia to meet the needs of communities. We welcome the opportunity to provide comment on the recently released discussion paper *Health Education and Training: Clinical placements across Australia: capturing data and understanding demand and capacity.*

ACPDHS supports any initiative that would help to increase the capacity of the national health system to provide quality clinical placements for health professional students across all disciplines and in a variety of clinical settings. Given the national shortages in the health workforce, we believe that an important part of the review of the Australian Health Care Agreements (AHCAs) should be to support the training of a competent health workforce.

The proposal to establish a national clinical placement data collection instrument could help to achieve this; however as recognized in the discussion paper, to be successful, any national data collection system must not impose an extra administrative burden on either the training institutions or the clinical placement facilities. Medicine and nursing are the only disciplines that receive specific funding towards clinical placement; the amount passed on by central university management to the Schools and disciplines varies considerably nationally.

The requirements for clinical placement vary considerably across the disciplines; this is not unexpected given the differences between the professions themselves in their focus and scope of practice. Our experience with the management of clinical placement is that there are considerable administratative processes and therefore costs associated with clinical placement. These include but are not limited to:

- Finding clinical placement facilities with the appropriate clinical load
- Organising/training of clinical supervisors/preceptors
- Matching students to placement facilities to ensure a broad range of experience
- Allocation of students to placement facilities
- Organising travel and accommodation where needed
- Ensuring students comply with HepB immunisation requirements
- Ensuring current Police Checks/Blue Card
- State Health Department orientation and confidentiality requirements
- Student placement assessment and feedback.

The poor response by universities to previous requests for detailed information on clinical placement activities reflects the complexity of the information that universities gather related to clinical placement and the general lack of systems capable of producing useful reports. Training institutions already have in place data systems to help manage clinical placement varying from simple spreadsheets to web based interactive systems. These tend to be tailored specifically to the discipline and institution, and are unlikely to be able to produce the data that would be required by a national reporting system. There is a risk that the national system would impose an extra workload on institutions around clinical placement.

Another challenge for a prospective clinical placement data system is how to ensure the data remains current and therefore its usefulness, in a rapidly changing environment. The capacity of a health facility to take students for clinical placement relies on the availability of appropriate staff being available to supervise. In a health system that is heavily reliant on a part-time and casual workforce, the ability of health facilities to take students can change rapidly, particularly in rural and remote areas.

Discussion questions

Capturing Demand

1. **Are there other data elements needing to be captured to map demand?**
   It could be beneficial to capture location of the placement required to indicate the need for a rural/remote placement.

2. **Can education providers provide the necessary data elements?**
   It could be difficult for education providers to provide accurate prospective student numbers, as opposed to a general indication of numbers. Actual numbers of students due to go on placement can change quickly due to students failing a pre-requisite subject, deferring studies or due to illness. This is more likely to occur in the early years of a course.

3. **Would existing data collections provide this information and enable comparisons across the sector?**
   Very unlikely. As clinical placement requirements vary between programs, most existing data collections have been developed to meet specific needs, usually at the discipline level. It is not unusual for there to be a number of different systems for managing clinical placement and collecting associated data within the one education institution.

Capturing supply and capacity

Capacity issues for clinical placement are, with the exception of university run clinics, the realm of health service providers. There is the possibility of health service providers underestimating capacity for clinical placement, as many facilities struggle with inadequate staffing levels. Conversely, some facilities are very committed to the training of the future workforce and will take more students than bigger and better staffed facilities will agree to. The capacity of smaller health facilities in rural and remote areas is very reliant on the level of staff; this can change very quickly due to staff resignations, leave arrangements and/or illness. Conversely, the ability of students to get to their placement in a rural and remote area can be affected by natural disasters such as floods. The management of student placements in rural, remote and smaller facilities is more of a problem for those universities that are more reliant on a large number of smaller facilities.

If there is to be any real attempt to quantify capacity, serious discussions will need to occur with health facilities as to the benefits of providing clinical placement for students. Incentives may be necessary to encourage facilities to take more students; however past experience has shown that clinical placement payments to facilities tend to be absorbed into central budgets, and the staff who actually do the supervision receive no benefit. Any incentive should also be attractive to smaller facilities that may only be able to take small numbers of students at any one time. Additional capacity could become available if clinical placement supervisory positions within health facilities were directly funded. However, it is unclear if this would be a uniform solution as there are currently no negative consequences for health facilities if they refuse to take students for clinical placement.

There has been an over-reliance on large state run tertiary health facilities to provide clinical placement for students. With the expansion in student numbers and the changing nature of health care, different health settings need to be utilised to increase capacity. These include private hospitals and clinics, Aboriginal Medical Services and non-government organizations. University run clinics have the ability to increase capacity with an increase in resources. However, there may need to be associated legislative change to allow health professional students to provide treatment to private patients. The role of simulation facilities in providing clinical experience for students and the extent to which simulation experience can replace actual experience in health facilities requires detailed exploration.

4. **How can additional capacity be quantified and what specific metrics could be applied?**
   Some issues that could be included in quantifying capacity include:

   - Bed numbers
   - Casemix/ DRGs
   - Staff numbers/qualifications/experience
   - Staff turnover
   - Teaching resources and facilities
   - Location
   - Student accommodation – especially important in rural and remote locations

5. **Who can provide this level of data?**
   Clinical placement capacity across the whole institution incorporating all disciplines is rarely known by the senior executive within a facility. Medicine, Nursing and Allied Health workforce usually have separate administration and management processes. As placement is often negotiated by discipline with individual practitioners or Unit/Clinic managers it is not clear if this data could be easily provided at a whole of facility level.

6. **What are the strategies for identifying potential capacity?**

   Possible strategies could be discipline level meetings between health facilities and training institutions and a desk survey of all facilities to determine what health facilities exist and then surveying these facilities to see if they take students.

7. **What is the capability of health service providers to provide data that might be necessary?**

   Health service providers may have all the data necessary, but it is unlikely to be easily accessed. Given the high turnover of staff in some disciplines, it may become an onerous task for health facilities to keep information up-to-date.

8. **How would data integrity and quality be assured?**

   This would be difficult; however it may include paying people to do it. In other areas of the health sector, making data systems useful for local applications (as opposed to data aggregation and collection) is one vehicle for making sure the data is accurate.

9. **How would capacity be benchmarked?**

10. **What are the potential benefits and challenges of identifying benchmark measures?**

    A challenge will be to get consensus between all stakeholders as to what might be appropriate benchmarks. A benefit would be the ability to identify the limits of health facilities' capacity to take students.

A minimalist approach

11. **What is the most feasible, relevant and beneficial approach for each stakeholder?**

12. **Is there interest in developing a national approach and could this be achieved through capturing data from existing systems and collections or would new systems need to be developed?**

    If a national approach is developed, it must be flexible enough to allow for the diversity of programs offered by training institutions. The responsibility of universities to develop health professional programs with a particular emphasis to meet the needs of their region should not be compromised by national uniform requirements. As both the nature of the data to be collected and the capacity of existing systems is unknown, it is difficult to predict if existing systems would be adequate.

13. **Would a preferred model be one that progresses an active clinical placement management systems that provide planning data as a by product or should it be one that focuses' on only collecting data?**

    The first suggestion would be preferable; however such a system that would meet the needs of education institutions and facilities would be complex.

14. **What incentive would ensure a high level of compliance?**

    Compliance would be highest if the costs of providing data were minimized, the reports provided were really useful to both education providers and health facilities and if the data collection was resourced with financial incentives.

15. What might be barriers to achieving a high level of compliance?

Complexity, frequency and timing of data collection. If the data is requested at a time of high workload and is not able to be easily collected and provided in the format requested, then data collection and reporting will not have a high priority where education providers and health facilities are under-resourced.

16. What is non negotiable at the local, jurisdictional and national levels to ensure improved data for planning placements and identifying capacity?