

Health Education and Training

Clinical training -
governance and organisation

February 2009

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1 Introduction

Health practitioner clinical education is under significant pressure. The demand for additional capacity accompanying increased higher education places is shining a spotlight on the suitability of existing governance, organisational and administrative systems that support clinical training. These issues are not unique to Australia. Other countries with similar health professional education systems are grappling with similar issues. However, Australia's federal system of government presents particular challenges and opportunities and to further develop clinical education, the chance to reform and build potential solutions must be taken. This requires a significant re-think as to the future governance and organisational arrangements that will best meet the growing demand to better manage clinical education.

This Discussion Paper explores clinical placement governance and organisational issues. Its primary function is to raise issues and provoke thought and discussion about the future strategic direction for governance and organisation of clinical education in Australia. To provide context to the discussion of future strategic direction, information about the organisation of clinical education in Australia, including current arrangements, challenges, and responses to those challenges is also presented.

In light of the recent COAG decision to create a national health workforce agency with a role in the planning, coordinating and funding of professional entry clinical training across all disciplines, this Paper considers clinical placement governance and organisation and how the new agency may undertake that role in a manner that best supports jurisdictions, health services and education providers.

It covers medical, nursing, dental and allied health disciplines. For the purposes of this Paper, allied health disciplines include: audiology; chiropracty; dietetics and nutrition; occupational therapy; optometry; orthoptics; orthotics and prosthetics; pharmacy; physiotherapy; podiatry; psychology; radiography; speech pathology; and social work.

2 Overview of current arrangements

Clinical education

All university health practitioner courses, specialist vocational training, many post graduate and some VET courses such as enrolled nursing, include a clinical education component. As a result, the availability of clinical education constrains the number of health practitioner education and training places.

'Clinical training' is the training component that is undertaken in a clinical setting (broadly defined) for the purposes of building practical competencies relating to clinical practice. Clinical placements would normally offer supervision and may involve 'class room' work. For the purposes of this paper, clinical education is defined as compulsory placements in health and health related services, that are intended to ensure students attain the competencies that cannot otherwise be attained in a formal education setting.

Many professionals are required to register to practice and need to complete a course of study approved by the relevant State or Territory registration authority. Registration authorities may directly accredit courses of study or delegate the accreditation function to national bodies which set standards for the relevant courses. These accreditation standards include requirements for clinical training such as specifications of the quantum of clinical training to be undertaken, the settings in which training is to occur and supervision requirements.

Health occupations not required to be registered may also have accrediting bodies that set standards around university and VET curricula, including clinical training requirements. These bodies are most often formed by the relevant peak professional association and, like statutory registered disciplines, the accreditation standards are also used to assess the qualifications of international practitioners seeking the right to practice in Australia.

In both registered and non-registered occupations there is no consistency of approach between disciplines, and in some cases within disciplines, as to the requirements for clinical education. The amount of clinical training required varies considerably both within courses (e.g. nursing requirements vary from 800 hours of clinical placements up to 1700 hours - NNET 2006) and across professions. The quantum of training required may be expressed as a minimum number of hours or sometimes as a proportion of total course hours. There may also be specifications about the clinical settings in which placements must occur (Department of Human Services 2007).

Accreditation criteria often include clinical supervision requirements, usually relating to supervision by appropriately qualified and experienced members of the relevant discipline. The degree of competency assessment on placement varies from course to course, within disciplines and across disciplines.

There is a variety of arrangements for organisation of clinical placements across health settings and disciplines. VET and undergraduate tertiary clinical training is organised by arrangements negotiated between the education providers (universities, TAFEs or Registered Training Authorities) and health services predominantly in the public sector. Many of these arrangements are longstanding. It is also not unusual for a number of undergraduate students to undertake their clinical placement in a jurisdiction outside their place of academic study.

Roles and responsibilities

Federal Government

The Federal Government, via the Department of Education, Employment and Workforce Relations (DEEWR), is primarily responsible for policy and funding of the university sector through an agreed number of places in set discipline clusters. In the case of medicine, new places are jointly determined by the Minister for Education, Employment and Workplace Relations and the Minister for Health and Ageing. Medical and nursing course funding includes an explicit clinical training component. However, allied health course funding does not include a separate allocation for clinical training.

Students in Commonwealth supported places pay a contribution towards the cost of their courses on an upfront or deferred basis. Universities can also enrol full-fee paying international students within set parameters.

The Federal Government contributes to VET funding. In 2008, COAG agreed to fund 50,000 additional vocational education and training places over three years for national priority health occupations, with the majority of funding being provided by the federal government.

State and Territory Governments

State and territory governments are responsible for providing public health services. This also means providing clinical placements in these health services. They also contribute to funding of VET places. Increasingly, health departments are working with education service providers and health service providers to ensure that there is adequate capacity to provide clinical placements across the professions.

ACT has a central system to register placements. All placements must be registered before they commence. Where there is a mismatch between demand and capacity, negotiations take place either with other suitable areas inside ACT Health or with the educational institution to discuss changing the placement time. ACT Health tries to accommodate all clinical placements however this is not always possible and preference is given to local students (ACT region), students of local ACT educational institutions and interstate/overseas students in areas of high workforce need. In allied health, Designated Clinical Educators, either partially or wholly funded by ACT Health, have been used to increase clinical placement numbers in areas where there is a high demand for placements or in areas where there is a low demand, but a high workforce needs for new graduates. ACT Health is currently establishing a database that will map demand and capacity across ACT Health. It is anticipated the process will identify extra clinical placement opportunities for nursing and allied health high demand areas. It has the potential to be extended to include other clinical placement areas.

NSW reports that its involvement differs between professional disciplines and to some extent between well established and newer universities. There are contractual or affiliation relationships for all nursing, midwifery and medical schools and for some allied health disciplines in some schools. Because of the pressure of arranging 58,000 days of clinical placement in nursing and midwifery, NSW Health's Nursing and Midwifery Office (NaMO) manages all requests and approvals for nursing and midwifery clinical placements through the NSW Health NaMO Clinical Placement Capacity Information System (CPCIS). CPCIS is used to develop benchmarks, for example, for like wards, in order to identify potential capacity growth. Management of placements in some disciplines is centralised at the local level through the Area Health Services (AHS). A study undertaken in 2008 of nursing and midwifery placements is informing an assessment of capacity at the AHS level. Education providers can use CPCIS to view potential vacancies and place a request. In medicine and allied health, the AHS negotiates directly with universities based on their capacity to provide appropriate supervision. Matching on the basis of specific training needs depends on the availability of adequate and appropriate supervisors, and remains largely ad hoc. The lack of an overall system to work with the various disciplines across all universities and health services is the main shortcoming reported. The future role out of CPCIS may overcome this to some extent.

Northern Territory has agreements with universities across Australia to clarify responsibilities for clinical placements for nursing, medical, allied health and aboriginal health workers. Involvement varies between professions, with nursing organised centrally, giving preference to the three NT schools, and interstate medical placements being organised by Flinders University's NT Clinical School. A current survey is investigating the level of activity in allied health clinical placements across the NT. Across the professions, the NT has a shortage of qualified staff to act as supervisors and poor infrastructure to support placements. However, there are excess places for medical students. Since 2008, the Principal Nurse has coordinated nursing placements across the NT. There is no centralised information system in place across the Department to collect information about current clinical placements or agreed measures for identifying clinical education capacity. The workload for Departmental staff to manage and coordinate places as well as provide supervision is considerable.

Queensland has historically not taken an active role in clinical placement management. However, with the rapid increase in student numbers, Queensland Health is following the recommendations of the Ministerial Taskforce on Clinical Education and Training on ways to increase capacity. This includes facilitating meetings between potential sites and universities, a placement subsidy scheme for medicine and commissioning a consultant to investigate capacity in medicine. Queensland Health is currently investigating the system needs for a centralised placement system. Most recently, Queensland has established *Clinical Education and Training Queensland*, a body with jurisdiction-wide responsibility for leading a coordinated multi-professional approach to creating training capacity, facilitating training innovation and improvements to clinical education and training quality, efficiency, effectiveness and sustainability across the continuum of training.

South Australia reports that from 2007 its Multidisciplinary Clinical Placement Project is building on previous work by the Nursing and Midwifery Office in coordinating the booking process and providing a state-wide capacity map covering the public and private sector. An iterative feedback process is used to clarify the learning requirements of each course subject, and to clarify the actual nature of the placement site clinical options. Booking requests from Education Providers are matched with available placements. In 2008, negotiations between the State Coordinator

and the stakeholders, successfully agreed outcomes where placement requests overlapped or where specific capacity was tight. The process identified a number of additional placement options and some improved matches of placements to learning requirements. The uptake of the system by nursing and midwifery in 2009 is 78%. In addition, agreement documents and operational guidelines are being developed.

Tasmania does not centrally manage clinical placements, its involvement varies from profession to profession. With no training in allied health at UTas, a Student Placement Protocol for Allied Health Professional Services to promote consistency in administrative arrangements is being developed. In nursing, the school negotiates directly with the clinical setting. A process is being developed for clinical placement management between the Department of Health and Human Services (DHHS) and Clinical Psychology at UTAS. DHHS and UTas jointly support a part time position in each region that coordinates places and assessment for Pharmacy. Overall, DHHS gives priority to students from local courses (Nursing, Psychology, Medical Science, Pharmacy and Social Work), and to Tasmanian students studying at interstate universities. They prefer final year students in some units due to their ability to contribute to the work of the unit, and to contribute to recruitment possibilities. While DHHS is not active in managing capacity, they do encourage managers to take clinical placements (and structure their workplace so that these placements are mutually beneficial), and are considering extending the use of simulation facilities.

Victoria reports a comprehensive strategy for promoting clinical training capacity at professional entry level, including: funding to support clinical placements (both capital infrastructure and direct subsidies); investment in innovative projects; a clinical placement data system (STaRT); and template agreements to articulate arrangements and shared financial responsibilities between universities and health service providers. STaRT has been operational since 2007 and activity-based funding started with allied health in 2007 and will expand to medical and nursing in 2009-10. The template agreements were first used with medical students in 2006, nursing in 2008 and will be modified for allied health in 2009. Moreover, the Department of Human Services (DHS) chairs a state-wide committee to improve clinical placement governance, and undertook a consultation into governance arrangements in 2008. As a result of that project, which supported state and local level coordination, enhanced IT systems and data collection, and better targeted supervision funding, DHS is now developing a clinical placements action plan.

Western Australia reports that it is becoming increasingly active in supporting clinical placements. This includes formal agreements with the universities and supporting negotiations between health service providers and universities. The 2008 survey of demand and capacity is being used as the basis for further involvement in the future. Western Australia Health indicated a range of shortcomings, which vary according to professions. These include a lack of equitable access to placements as a result of competition, seasonal demand, and demand for placements in specialty areas. Limited human and physical resources and paucity of data are also issues..

Health services

Most clinical training occurs in the public hospital sector, with health services supporting this through service funding from state and territory governments. Teaching and training activities in public hospitals are a multiple product nature, inextricably linked to patient care activities. However, as demand pressures on health services have increased, this has constrained the capacity to support clinical training in the absence of dedicated resourcing.

It is clear that clinical placements in hospitals and health services involve a significant cost to those services, but that cost has not been accurately quantified. The quantification itself is difficult, because whilst clinical education involves costs in staff time, supervision, slowed productivity etc, students make a contribution to service delivery which generally increases the further they progress in their training. In some cases, health services charge universities for clinical placements, but this only reduces the financial burden, rather than remove the cost.

NHWT's recent survey of the current situation in managing clinical training placements elicited 45 responses from health service providers. While overwhelming the responses indicate that health service providers work closely with education providers, it is clear that the responsibility for finding places rests ultimately with the education provider. That is to say, the health service providers can limit the number of places according to a number of factors including: willingness and workload of staff, physical environment such as tutorial rooms, patient number and mix, available caseload for learning purposes, availability of clinical and educational staff and staff expertise in the required clinical area. The extent to which health services' capacity to take students on placement is limited by these factors varies within health services and between professions.

Relationships between health service providers and education service providers are extremely important and range from being exclusive, whereby a discipline within a health service will only accommodate students from a single university, to arrangements that seek to accommodate universities on a first in-best-dressed basis. A number of health services give preference to students studying locally, and only accommodate others if capacity exists. While

some health services report that they select students for placement on the basis of interviews, they generally rely on the education service provider to manage matching of student to placement.

The major shortcomings reported by the health service providers related to the workload associated with paper-based or poorly integrated computer-based systems, which place further burdens on a placement site. The growing pressure to supervise students on placement is resulting in a reluctance to accept more students. While some health services identified a lack of available staff to mentor and supervise students, others feel that capacity to supervise is hampered by lack of appropriate training and support for supervisors. The lack of a well integrated, purpose designed management information system appears to be at the base of most of the shortcomings reported. Attachment 2 provides more detailed information on health service providers' responses to the survey.

Education and training institutions

Education and training institutions determine program design and course content and length, taking into account the requirements of registration and accreditation authorities, such as the Australian Medical Council. These authorities, or other discipline specific bodies, are generally responsible for specifying clinical education requirements. Depending on the course, health service or jurisdictional arrangement, they may make a financial or resource contribution to the clinical training.

NHWT's recent survey of the current situation in managing clinical training placements indicated a trade-off between the learning requirements of university's students and the need to find an adequate number of places that satisfy the accreditation requirements of the various professions. In the current competitive environment, universities are also working closely with health service providers to build capacity and to use that capacity optimally. While this extra workload is essential to the ability of the schools to continue to offer more places, it is placing further stress on university staff. Several schools reported that their capacity to offer places to students (domestic and international) is curtailed by their ability to find/create places.

Many schools indicated that stress on staff and students is only partially relieved by sophisticated computer-based systems. This is because the work to build the relationships necessary to encourage health service providers to offer places to the competing universities and disciplines requires personal contact. Similarly, the matching of particular students to particular placements requires considerable personalised attention that the schools are increasingly unable to provide. Therefore, there is considerable potential for mismatch of student's learning needs with placement's potential to offer experience.

The challenges faced vary between universities, between professions, between small and large schools and between single discipline and multidiscipline schools. Overall, medical schools tend to report less stress from the numbers of students and appear to be better resources for managing their demand for placements, have good relationships with health service providers for managing their capacity to provide placements, report less stress in matching students to places (either individually or in terms of overall numbers) and report fewer shortcomings with their current system. Schools offering multiple disciplines (typically several allied health and possibly nursing) have complex problems due to the various accreditation requirements, which are exacerbated for schools offering interstate placements. Large schools (typically nursing) have problems with scale, which are exacerbated if students study in off campus mode in settings where the university may not have a relationship with a health service provider. Individual allied health disciplines and maternity schools indicated that state-wide cooperative relationships with other schools offering that discipline are important in ensuring equity and in growing capacity consistent with increased expectations and demand.

While some schools indicate that their systems are adequate, there is no system that is adequate between schools, between disciplines and between jurisdictions. Rather, there is an assemblage of systems that do not interact and do not serve the wider purpose of facilitating planning and resource management across Australia's health system. Attachment 1 for more detailed information on the education service providers' responses to the survey.

Interaction on clinical education

Given the shared responsibility for clinical education across the health and education and training sectors, mechanisms for effective engagement between the sectors are critical.

National level

Recent concerns about the availability of clinical training places have instigated greater collaboration and policy development across the health and education sectors at the national level.

COAG

In July 2006 COAG announced funding for additional medical and nursing places and states and territories agreed to guarantee to provide high-quality clinical placements and intern training for these students. Further COAG "...noted the importance of ensuring that health education and training is better aligned with workforce needs. To assist with this, the Commonwealth and the States and Territories signed a Memorandum of Understanding for better consultation on health-related university places." (COAG 2006).

Most recently in November 2008 COAG agreed to a range of significant health workforce reforms, a number of which will have substantial impact on clinical education and training.

AHMC/MCEETYA

In July 2006 COAG also agreed that there would be an annual meeting of the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA) with representation from the Australian Health Ministers' Conference (AHMC) to consider national workforce priorities and advice on education and training that addresses current and emerging national skills shortages. Two meetings have been held. However, whilst the meeting provides an opportunity for dialogue, it has no formal role in the allocation of places or consideration of associated issues such as clinical placement roles, responsibilities and funding.

Commonwealth Departments – DEEWR & DOHA

DEEWR consults other federal government departments, as well as states and territories through education departments, about policy issues such as the allocation of additional higher education places. The availability of clinical placements is clearly a consideration in considering additional VET or tertiary places to meet future workforce requirements. Ultimately the decision about the allocation of places and which disciplines receive specific funding for clinical education has been solely a matter for DEEWR and the Minister for EEWR.

NHWT

The NHWT was established to undertake projects which inform development of practical solutions on workforce innovation and reform. The NHWT is a national body created under the Australian Health Ministers' Advisory Council (AHMAC) committee structures and reports directly to the Chair of AHMAC's Health Workforce Principal Committee. Clinical education is a significant component of the NHWT's workforce innovation and reform work program. The NHWT and its work program will be subsumed by a new national agency announced by COAG in November 2008.

State/territory level

A range of relationships have been established at the State or Territory level in relation to clinical placements. For example, South Australia convenes a committee with representatives from the Department of Health, the Department of Education and each of the SA universities to discuss clinical education and placement issues.

To date, where jurisdictional liaison mechanisms for clinical education exist, they tend to focus on system development issues such as a standard agreement to formalise clinical placement arrangements such as Western Australia's Memoranda of Understanding between Health Boards and tertiary institutions regarding clinical education, or funding requirements for health services to provide clinical placements as in Queensland.

There have been moves in some jurisdictions to explore data collection to support better coordination and maximisation of capacity, but to date, no jurisdiction has established a comprehensive regional or statewide approach to coordination of clinical placements. However, some mechanisms specific to particular disciplines have been established eg ACT's allied health clinical educators' network. The mechanisms have not yet extended to matters such as use of Simulated Learning Environments (SLEs), competency based approaches, and coordination of capacity.

Institutional level

At the institutional level, arrangements for clinical placements are made through bilateral relationships between particular educational organisations (universities, TAFEs or Registered Training Organisations) and health services.

Historically, these arrangements have generally been dependent on the particular relationship between the education and health provider(s). Some relationships have existed for long periods of time whilst others have been formed relatively recently. Arrangements are variable. The bilateral nature of these arrangements contributes to the lack of consistency in clinical education requirements.

Current challenges in governance and relationships

There are a number of features of existing arrangements that are working reasonably effectively, particularly at the health service / education provider level.

The current arrangements are characterised by a range of collaborative relationships. Longstanding relationships between health services and educational providers are common under the current arrangements. AHMC/MCEETYA provides an opportunity for dialogue. However, existing relationships focus on specific elements of clinical education arrangements rather than overarching policy, system development and best practice.

There is a range of existing system development initiatives to formalise existing clinical placement arrangements such as standardised agreements. There are also some examples of effective coordination, although these are generally limited to discipline or geographic specific initiatives.

The complexity of the health and education sectors adds to the financial and administrative challenges of negotiating clinical placements. There are 38 universities, which offer 137 undergraduate health courses in sixteen health disciplines. In 2007, there were 131,277 students enrolled in tertiary health courses (undergraduate and postgraduate – Department of Education, Employment and Workplace Relations 2008).

There are numerous health services in which placements may occur. For example, in 2005-06 there were 755 public hospitals nationally, including 19 psychiatric hospitals. There were 547 private hospitals, comprising 291 acute hospitals and 256 free-standing day hospital facilities. In addition, there are many other possible settings for clinical placements, including general practice, specialist rooms, allied health practices, community health services etc.

Pressure on the availability of places is resulting in competition between universities. For example, multiple universities in a state may offer a course such as medical imaging, where there are few opportunities for clinical placements. As a consequence, all these universities must compete for the limited placements available locally and then in some cases, resort to placing students interstate to achieve sufficient numbers of placements for their student cohort (Lombardo 2006). These multi-jurisdictional placements require additional administrative resources, due to the need for educational providers to engage with the different funding and organisational arrangements across states and territories and various providers.

Whilst there may be additional system capacity, there are currently no mechanisms to systematically identify under utilised capacity and limited ability to explore options outside traditional clinical placement settings. There is also no clear responsibility for this task.

There appears to be communication and coordination issues between education providers and health services regarding the further development of new and alternative models of clinical education. This contributes to a lack of consistency in the education systems, standards and organisational practices which support clinical education.

Despite some positive attributes, clinical placement governance and organisation across and between the health and education sectors is characterised by:

- Role blurring and ambiguity, including lack of clarity around funding contribution and responsibilities
- Inconsistent requirements within and across disciplines, in terms of quantum, supervision, extent of interprofessional learning etc
- Relationships between individual health services and educational providers that are often based on historical connections rather than optimal use of capacity
- Barriers to training providers accessing clinical placements, particularly new providers
- Shortage of clinical placements resulting in some health services changing previously agreed relationships based on 'premium pricing' from other education providers
- Duplication and overlap in administrative arrangements
- Inconsistent equity of access to clinical placements between the health disciplines where competition for patients exists

The complexities of the educational policy environment present further challenges. The entire higher education system is currently under review, including the complex and enmeshed relationship between teaching and research. Whilst the review presents opportunities to seek improvements in clinical education governance and funding, future directions for the higher education sector are yet to be determined.

3 Organisational improvements

A number of initiatives have been taken in Australia and overseas in recent years which demonstrate the potential to improve the quality of clinical training and to maximise clinical placement capacity.

Use of networks

In some states and territories, networks of health services have been established to plan and negotiate available postgraduate clinical training such as the network for physician training in Victoria. In NSW the Institute of Medical Education and Training (IMET) has been established following the merger of the Postgraduate Medical Council of NSW and the Medical Training and Education Council of NSW. The main areas of activities for IMET have been the allocation of postgraduate year 1 (PGY1) doctors and the coordination of some vocational training programs to ensure efficient and effective clinical rotations are in place. To date, clinical training networks have only been established at the postgraduate level.

Systems development

All states and territories have initiated aspects of systems development directed at better management of clinical placements, illustrating the importance of these issues. For example, Western Australia currently has a Health Education and Training Taskforce undertaking research to ascertain the demand for clinical placements in health related higher education courses and the capacity of WA Health to meet the demand. The aim of the research is to support ongoing improvement of the existing arrangements, and WA Health has advised that the first part of this work being a report (yet to be released) on the survey on clinical placements is completed, and a second part will document the department's capacity to meet the requirements.

Improved bilateral arrangements

Some initiatives focus on the scope to formalise and clarify existing and sometimes long standing arrangements between an education and training provider and a health service. Formal documentation such as an affiliation agreement can define the roles and responsibilities between the parties, be it funding, availability of facilities and teaching personnel, liabilities and indemnities (both medico legal and occupational health and safety) and the essential administration required to support the clinical teaching program.

A number of states have developed formal, standardised clinical placement agreements:

- Queensland Health requires health services and universities to enter a Clinical Deed to formalise clinical placement responsibilities
- Western Australia uses Memoranda of Understanding between its Health Boards and tertiary institutions
- Tasmania has developed an Affiliation Deed
- Victoria has developed a standardised Relationship Agreement for the Public Hospital Sector.

Internationally, similar approaches have been adopted. In March 2007, the British Columbia Health Council produced "Managing Practice Education". Its purpose is to "clarify the roles and responsibilities of health authorities and post secondary education institutions in practice education" (Health Council 2007). It is described as a work in progress and future versions will be informed by projects underway to build capacity for practice education.

Rural, regional and remote placement brokerage

Specific initiatives have been developed to access clinical places in the rural and regional areas to extend capacity and at the same time provide students with experiences of rural and regional practice.

In Canada the British Columbia Academic Health Council established an Interprofessional Rural Program that places teams of four to six students from a range of health professions into rural communities. One of the objectives of the program is to "expand capacity for educating health professionals in BC". Eight communities have been involved and 10 professions represented on the program.

In NSW, in 1997, the Broken Hill Department of Rural Health established a "one stop shop for student placements" (BRDRH 2008). The BRDRH organises each student's clinical placement, provides accommodation and access to library and Internet facilities. Staff ensure that every student has appropriate support for the duration of their

placement. Close liaison with the student's home university ensures that each student can meet the assessment requirements for their particular clinical placement. Regional coordination provides a platform from which to provide quality rural placements for students from all health disciplines, while at the same time increasing regional capacity to take students. The BRDRH project now accepts students from 22 Australian Universities (Lyle et al 2006).

Funding training and linked placements

Another group of system improvements focuses on funding related placement commissioning or coordination. In NZ, the Clinical Training Agency (CTA), links training funding for post-entry clinical training with future workforce requirements. Post entry training is defined as vocational, clinical, post entry to a health profession, formal and a minimum of six months and nationally recognised. The CTA finalises specifications and training strategies for the training categories and programs are ranked in accordance with government strategic priorities; workforce need and Maori development. Once the ranking is completed, optimal numbers of trainees for each training program are developed, however, because there is more potential and demand for training than there is funding available, reductions are made to trainee numbers to meet the budget available and to ensure that the training funds are spent appropriately. (NZ Ministry of health Clinical Training Agency Strategic Intentions 2004-2013)

In the UK, the 2008 NHS Next Stage Review publication "A High Quality Workforce" has foreshadowed a move to a transparent tariff-based payments system where funding follows the student or trainees to provide a mechanism to incentivise educational activity and to protect the educational investment which is considered to be vital for the quality of patient care. The NHS is proposing to establish Health Innovation and Education Clusters, which are intended to raise the quality and pace of development of healthcare professional education and training. The Clusters are also intended to improve transparency, promote fairness and reward quality in education funding.

Best practice system change

In some jurisdictions, the objective of ensuring that the existing clinical education system operates to its maximum capacity has seen the development of best practice guides.

In 2001 the United Kingdom Department of Health and English National Board for Nursing, Midwifery and Health Visiting and the published Placements in Focus - Guidance for education in practice for health care professions (NHS 2001). The aims of the publication were to:

- Enhance and build in existing guidance and standards relating to practice placements
- Improve the quality assurance procedures relating to students' practice experience
- Focus on common expectations across health care professions
- Support the development of innovative ways of increasing and making best use of practice placements which reflect the varied communities and situations in which health care professionals work
- Share ideas about the identification and development of new opportunities for practice experience
- Facilitate communication between health and social care professionals on practice placement issues

The document contains principles and guidance for good practice and a section on expanding capacity - innovative approaches to practice (including identifying, selecting and increasing placement opportunities).

Whole of system strategic development

There are emerging examples of attempts to achieve system development across the entire clinical education system. Victoria is exploring a more strategic approach with the release of discussion papers on a state wide clinical placement strategy. Clinical Placements in Victoria: Establishing a Statewide Approach (the Strategy) (Department of Human Services 2008) aims to ensure that sufficient clinical training capacity exists in Victoria over the long term, and that training models are effective and efficient, and produce quality outcomes that meet evolving service and community needs and expectations.

The report of initial consultation indicates that there was qualified support for a systemic solution to clinical education challenges, acknowledging that "a funding and accountability solution" is needed but will not resolve all perceived challenges (DLA Phillips Fox 2008 p. 8). Again, assessments of how well the system currently manages tend to correlate with the perceived level of access to either required number or quality clinical placements. This is largely due to the longstanding relationships that have developed over time and are closely guarded, creating a lack of access for recent entrants.

4 Future directions

All states and territories have recognised the need to improve clinical training capacity and organisation, and are investing in a range of policy and program initiatives to address current challenges. Similarly, education providers are engaged in individual and some collective action. Drawing from these examples, initiatives with potential to improve governance and organisation across health and education providers include:

- Clinical education networks, where placements are distributed across a number of linked settings
- Placements brokerage, where a third party acts as a broker between educational providers and health services
- Coordinated arrangements, where a coordinator works across a particular educational provider (s) and health service (s) to coordinate the clinical placements
- Formal agreements between health services and educational providers under a mandated framework
- Arrangements which determine clinical training in light of workforce priorities and available funds.
- Information technology based solutions to managing clinical placements

Efforts by state, territory and Commonwealth governments have typically focused on individual elements of the problem and/or sought solutions at one level of government. Such approaches have had limited success, reflecting the multiplicity of contributing factors and the need for a coherent approach that encompasses all jurisdictions and cross the health and education sectors. The challenge is to identify the combination of reforms that best progress greater efficiency and effectiveness in the training of the health workforce, while preserving accountability, public protection and management of financial risks.

Although, much can and should be done at a state, territory and Commonwealth level to address some of the problems, given the interconnected nature of the health and education systems, health professionals and regulatory authorities, solutions need to be interlocking in order to progress reform.

A new national agency

Reforms announced by COAG on 29 November 2008 provided funding for a number of health workforce initiatives including supporting the training of health professionals, establishing more effective, streamlined and integrated clinical training arrangements and considering funding approaches and incentives to ensure clinical training is delivered in the most cost efficient manner.

COAG agreed to establish a new national agency to manage these initiatives. As a single body with a specific focus on implementing workforce reform, the agency was conceived as operating across both the health and education sectors, complementing jurisdictional responsibilities in health and being able to devise solutions that integrate workforce planning, policy and reform with the necessary and complementary reforms to education and training and be a key source of advice on reform directions and policy, regulatory or funding barriers to implementing substantive workforce change. Governance arrangements will be structured to ensure a national approach that supports all jurisdictions.

It is envisaged that the agency will take a major role in the planning, coordinating and funding of professional entry clinical training across all disciplines, drawing upon funding from all governments. The key driver will be to ensure increased capacity and that funding models for clinical training are based on achieving quality, efficiency and effectiveness. Clinical training for professional entry and post-graduates will need to occur in a streamlined, integrated and educationally effective manner with appropriate support for planning, coordination and supervision at regional, local and health service levels.

It is planned that this would include new structural arrangements that attach clinical training funding to students in whatever service setting they train, thus ensuring the training outcome and enabling an expansion into non traditional training settings including primary, community and mental health, aged care and the private sector.

Funding has also been allocated to build a framework of capability in clinical training, to improve supervision capacity and competence in clinicians and to build up the numbers in the workforce who are prepared to take on this role. Funding is also provided for a coordinated approach to both the use and financing of simulation training.

The agency's role in clinical education and training

Current clinical education capacity, quality, efficiency and effectiveness could be improved by:

- Comprehensively planning, coordinating and funding clinical training across all disciplines to reduce the administrative load borne by health services and training providers in coordinating clinical placements across the various disciplines
- Introducing a focus on achieving competencies, rather than time-based approaches
- Linking clinical education funding to achieving quality, efficiency and effectiveness, to ensure that clinical training for undergraduates and post-graduates (over time) occurs in the most streamlined, integrated and educationally effective manner
- Ensuring training numbers are set to address workforce requirements
- Appropriate support for planning, coordination and supervision at regional, local and health service levels
- Facilitating interdisciplinary learning through clinical education.

There is a gap in the current governance arrangements because no organisation has clear responsibility for addressing these issues. Consequently, the following alternative governance arrangements focus on clearly allocating this responsibility, rather than roles which are already reasonably clear and unamenable to change. There is a need for more effective governance arrangements that can work across and with jurisdictions and the health and education sectors. Uncoordinated or ad hoc approaches may delay national reform and be counterproductive, especially if they focus on immediate problems or ignore inter-jurisdictional issues.

For example, in the following alternative governance arrangements, health services will continue to provide a setting for clinical education, although this may be increasingly supplemented by best practice use of SLEs. Education providers will continue to be responsible for curriculum, subject to accreditation requirements and any best practice clinical education guidelines that might be developed.

Although funding is not the focus of this paper, it is inextricably linked to governance and organisational arrangements. The viability of any new governance arrangements will be enhanced by more flexible, explicit funding. More explicit and dedicated funding and incentives could encourage health services to provide clinical placements. There would also be potential for new funding approaches to support incentives to educational providers and health services to ensure clinical training is delivered in the most efficient and effective manner.

Whilst the Agency's role in allocating funding to support clinical education is clear, its role in the management of the system is not. Models need to be considered that provide the Agency with the ability to influence the factors which determine the availability of placements in health services and to make more effective use of capacity across settings. Funding will be a key influence in this environment. Accordingly, the Agency's effectiveness is likely to be linked to its ability to allocate resources and its authority to make decisions regarding clinical placement issues. As part of this, a national clinical placement IT system will be developed and implemented by the Agency to support placement activity and provide national and local data on capacity and demand. The nature of this system is the subject of a separate discussion paper and consultation process.

The Agency could work across local, regional and state/territory organisations disciplines and issues. Optimal use of clinical education capacity requires the ability to look across the system, not just within professions, individual local or regional areas or even statewide. Issues such as consistency of clinical placement requirements and best use of resources could also be progressed, taking into account needs and demand across the system.

The four models canvassed below are not mutually exclusive. It would be possible to combine the facilitative and brokerage models, and/or to incorporate aspects of the tendering or central allocation approaches. Further, the models are not exhaustive and other approaches would be possible. The purpose is to stimulate consideration and discussion of the potential for new governance and organisational arrangements to deliver better outcomes.

A facilitative model

The facilitative model would focus on leadership, best practice and innovation. It would address the current gap in this area by leading governance policy, innovation and best practice in clinical education. It would be a mechanism for developing and seeking to negotiate relationship principles between health services and education providers, disseminating innovation and best practice approaches, including system improvements to minimise the administrative work associated with allocating and coordinating clinical placement activity in health services. It could also facilitate a focus on competency based clinical training as well as support interdisciplinary modes of

clinical training to effectively prepare students for team-based approaches. In addition, a facilitative model would drive the broader development of information technology systems to support the management of clinical training..

Such an approach would work collaboratively with stakeholders, and build on existing relationships and networks. However, it would not have a role in allocating and coordinating clinical placement. It would not affect existing roles of health and education stakeholders.

A brokerage model

The brokerage model focuses on making best use of scarce clinical education resources. It would also involve the creation of a clinical education broker between education providers and health services. The broker would identify clinical placement needs and match them with health service capacity.

Under this model, the broker would not make allocative or distributional decisions for states and territories. Rather, it would develop and support clinical placement systems and broker training responses based on states and territories' identified needs, particularly supporting placements allocated regionally. It could also ensure that training numbers matched workforce needs, possibly through structural arrangements that attach clinical training funding to students in whatever service setting, coordinated and administered through the organisation.

Under this model, the broker would be well placed to devise solutions that effectively integrate workforce planning, policy and reform with complementary reforms to clinical education.

A tendering model

The tendering model focuses on maximising clinical education capacity. It would establish a process for public, private and not for profit health services and education providers to tender for clinical placements, rather than the current heavy reliance on bilateral relationships.

For example, educational providers would advise of their clinical placement needs and resource costs, and a tender process would be undertaken to determine the allocation of placements across health services. Alternatively, health services could advise of placement capacity education providers could bid for those places with decisions being made based on cost, effectiveness and long term value for the health service.

The tender process could be run on a regional, jurisdictional or cross jurisdictional basis. Any regions or jurisdictions with spare capacity could absorb excess demand in other regions or jurisdictions.

A central allocation model

A further alternative approach would involve determining the priorities for clinical training in light of advice from governments on the priority needs for the health workforce of the future, similar to the New Zealand Clinical Training Agency, although covering both undergraduate and postgraduate education.

A central determination process could specify the content and duration of the clinical training established through accreditation bodies to be offered in light of designated competencies and then determine the training places to be funded and in what location, following a consultative process with key stakeholders.

As with a tendering model, this allocation process could be run on a regional, jurisdictional or cross jurisdictional basis. Any regions or jurisdictions with spare capacity could absorb excess demand in other regions or jurisdictions. Again, there would need to be some financial incentives (for example, funding attached to students) for health services to participate. The actual allocation of trainees to positions could be facilitated through a central data base or undertaken at a decentralised level eg state/territory/health service, in light of the allocation decisions already taken.

Other considerations

Establishing a national agency provides a unique opportunity to establish clear governance arrangements at the national, jurisdictional and institutional levels and address current issues with clinical placements. Specific roles and responsibilities could be conferred on the organisation, leading to increased clarity about the clinical training roles and responsibilities between education providers and the health sector. A central process, with an appropriate regional focus could minimise administrative work for education and health service providers, and maximise system capacity.

The organisation could ensure clinical training occurs in the most streamlined, integrated and educationally effective manner with appropriate support for planning, coordination and supervision at regional, local and health service levels. It could develop and support systems and broker training responses based on identified needs, particularly supporting placements allocated regionally. It would also ensure training numbers are set to address workforce requirements.

The establishment of the Agency also provides an opportunity to clarify associated governance arrangements and roles. For example, if a central allocation model was chosen:

Agency	<ul style="list-style-type: none"> Develop and implement consistent approaches to clinical education requirements Identify clinical education needs (including particular requirements such as location, service setting, supervision, timing, duration, etc) Identify clinical education capacity (seeking to ensure all available capacity is utilised) Allocate clinical placements Facilitate the uptake of interdisciplinary learning through clinical placements
Education providers	<ul style="list-style-type: none"> Provide advice about numbers of students needing placements
Registration and accreditation boards, including national boards and organisations	<ul style="list-style-type: none"> Work with Agency to establish consistent requirements for clinical education
Health services	<ul style="list-style-type: none"> Provide information on clinical placement capacity to agency
Health Departments	<ul style="list-style-type: none"> Provide information on clinical placement capacity to agency
AHMC or AHMAC or Jurisdictions	<ul style="list-style-type: none"> Provide advice on workforce shortages and training priorities

Consideration of an organisation with a focus on innovation, reform efficiency and effectiveness in clinical training has the potential to also provide a range of solutions to current problems. The current arrangements for clinical training have been in place for many years and are largely focussed on the public hospital system. To improve access and capacity in the system it is necessary to consider a broader range of innovative ways that clinical training could be delivered. The Agency could also explore alternative arrangements in private and community settings, timing of placements, potential for combined professional streams, alternate models, modes and duration of training requirements, and the implementation of technology based innovations such as simulation. The investigation and documentation of innovative models in Australia and overseas for clinical training and placement strategies could also be undertaken. Other areas could also be explored such as continuing education, and other areas of education such as leadership and change management.

A more consolidated, interdisciplinary approach to organising clinical placements could accommodate significant discipline-specific differences in clinical placement requirements but facilitate effective interdisciplinary clinical training to assist students' understanding of the roles of other professions, and how they interface with their own roles, while respecting the integrity and contribution of each profession.

5 Conclusion

The availability and quality of clinical placements are a significant constraint on increasing the capacity to educate and train the future health workforce and responding to health workforce needs. The current pressure on clinical placements justifies an examination of how organisational and governance arrangements present opportunities to transform clinical education arrangements, with benefits for capacity, quality, effectiveness, efficiency and innovation.

Fit for purpose governance arrangements will need to take into account stakeholder needs and simultaneously clarify roles and responsibilities. New approaches could extend existing relationships and build new relationships and remove role ambiguity and duplication. There is an opportunity to design a governance approach to maximise system capacity, whilst minimising the administrative burden on education providers and health services.

The Paper raises a range of issues about current clinical placement organisation and governance, and suggests that there is potential to achieve better outcomes from the investment in clinical education. The project will now explore stakeholder views on the issues raised:

Discussion questions

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

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

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

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.

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

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

Next steps

Submissions are invited on the issues raised in this Discussion Paper and the questions above. Closing date for submissions is **20 March 2009**.

The next phase of work will also involve forums with interested stakeholders.

Appendix 1: Clinical training management – health services

As part of the process of consultation on the Discussion Paper *Clinical placements across Australia: capturing data and understanding demand and capacity* surveys were sent to stakeholders asking a range of questions relating to the management of clinical placements. The full details of responses to this survey will be provided as part of the Directions Paper currently being developed on this issue, however, a number of questions in that survey are relevant to consideration of governance arrangements for the new agency and are detailed below.

NHWT received 47 responses from health services, of which 18 did not elect to share their information. Fifteen hospitals responded (some multiple times) as did 6 other health service providers including three ambulance services.

Question 1. How does your organisation manage the demand for clinical training placements?

An overwhelming majority of health services manage demand for clinical placements at the departmental level. In most cases, a senior manager, such as the head of department, clinical manager or education manager, receives and responds to requests from Universities for placements, after consultation with clinicians and an assessment of internal capacity, in terms of staff availability and physical space. While some placements are organised throughout the year, for example, semester by semester, requests for places by universities is generally sought on an annual basis, late in the proceeding year (Sept/Oct/Nov), with ad-hoc requests considered on an individual basis. Relationships between universities and health services range from being exclusive, whereby a discipline within a health service will only accommodate students from a single university, to arrangements that seek to achieve a more equitable result, accommodating universities on a first in-best-dressed basis. A number of health services give preference to students studying locally, and only accommodate others if capacity exists.

Q2 How does your organisation manage the capacity to provide clinical places?

Some health services advise universities, or make offers of their maximum capacity, and universities supply students accordingly, while in other cases, the university makes the request and the health services respond. Some departments within a health service have an agreed fixed number that they take each year, while others in the same hospital will vary depending on changing circumstances.

The availability of clinical placements within health services is determined by a number of factors including: willingness and workload of staff, physical environment such as tutorial rooms, patient number and mix, available caseload for learning purposes, availability of clinical and educational staff and staff expertise in the required clinical area. The extent to which health services' capacity to take students on placement is limited by these factors varies within health services and between professions.

Q3 How does your organisation manage the matching of demand and capacity for clinical training places?

Few of the health services who responded to the survey discussed their role in how students were matched to places. St John's Ambulance and Social Work at Fremantle Hospital and Osborne Park Hospital interview and select students to ensure the match meets training needs and is mutually agreeable.

Appendix 2: Clinical training management –higher education providers

As part of the process of consultation on the Discussion Paper *Clinical placements across Australia: capturing data and understanding demand and capacity* surveys were sent to stakeholders asking a range of questions relating to the management of clinical placements. The full details of responses to this survey will be provided as part of the Directions Paper currently being developed on this issue, however, a number of questions in that survey are relevant to consideration of governance arrangements for the new agency and are detailed below.

NHWT received 59 responses from higher education providers, representing 33 organisations. Of which 27 were universities and 6 were other education provider organisations. Nineteen of the responses did not indicate that we could share their information. The forty responses that agreed to share their data are summarised here by discipline.

Question 1. How does your organisation manage the demand for clinical training placements?

With most respondents having responsibility to ensure that appropriate clinical placements are found for all of their students, and most reporting large increases in student numbers of recent years, the overall sense is one of struggling to cope with multiple demands including increased expectations. Some professions and some universities appear to have greater challenges. Medicine at ANU is a new, relatively small school that enjoys the fruits of thorough planning and preparation including mapping clinical capacity. Another example is Monash's Dept of Community Emergency Health and Paramedic Practice's (DCEHPP), which has a unique relationship with Victoria's Ambulance Service. On the other extreme are very large schools of nursing that deal with large numbers of students in both on campus and off campus modes who require placements all over the state, nationally and internationally. Allied health presents another complexity because of the varying accreditation requirements across the professional disciplines and the lack of funding for clinical placements. Across the all disciplines there is recognition of the value of planning, building relationships and starting early (up to a year in advance) and remaining flexible. A consistent undercurrent is the need to comply with accreditation requirements.

Medicine

Several medical schools indicated the value of planning. ANU is an excellent example that also benefits from being a small new school. *"ANU Medical School is a small medical school, and student admission numbers are matched to local and regional clinical capacity from the beginning. As a new school, curriculum design and rotations were linked to capacity. Within relevant years, demand is managed centrally by either SGPRIH or SCM." In the NT, Flinders NT Clinical School manages well "The NT Clinical School has dedicated student support coordinators and administrative staff that manage clinical placements".*

UWA manages demand by persisting in recruitment of supervisors and venues. *"We recruit new supervisory positions through our network of specialist surgeons and progressively place students over the course of months - years. New venues include private and outer metro area hospitals Infrastructure and other support follows this."*

Still the challenges are great with Griffith University indicating: *"Medicine, Its complex ++. Find more sites, increase beyond capacity, teach more in house, plead, look to the private/NGO sector where possible, plead again!"* Perhaps even more strongly, medicine at University of Sydney indicated that their old method is not scaling well to suit the increased numbers. *"With difficulty – the current number of clinical placements are based on historical figures without evidence of appropriate patient casemix and clinical supervisor number of contact time."*

Other education providers use a range of methods including NSW IMET's algorithm. *"Allocations are based on a workforce distribution formula that takes into account overnight separations, bed numbers and emergency attendance at hospitals. Applicants can either accept/decline the allocation offer."* NTGPET indicated that they modify their approaches for different groups of trainees, some requiring programming one year in advance *"Medical student placements are handled on a first come first placed basis for elective and John Flynn Scholars. Selective student placements are programmed a year in advance at secure locations. PGPPP placements are handled on the basis of placement location preference and location availability. GPR placements are handled on the basis of placement location preference and capacity".* Sturt Fleurieu GPET has had a different problem in that they have previously not had enough applicants to fill their allocated number of places. *"Under the AGPT program SF receives an annual allocation of new positions. Recruitment to those positions is based on a national application process. Placement of successful applicants (registrars) depends on availability of GP training practices (if registrars are general practice ready) and hospital positions (RMO positions/extended skill positions /procedural positions)."*

Even postgraduate medicine is having to change its approach due to the press of numbers. PMC SA says: *"We are actively looking to expand positions via health region/collaboration to fit expanding graduates. There is overlap with undergraduate training."*

Pharmacy

UQ PSA, while a training organisation, is in the somewhat luxurious position of not having to find places. *"PSA is a training provider for the Pre-reg training program, we have no direct link to clinical placements from the perspective of "seeking" them. Graduates are required to find their own jobs."*

Allied Health

Several allied health schools stated that management of the demand for students varies by professional discipline and that relationships within disciplines across universities are very important. Nevertheless, the press of increased student numbers and the increased professional expectations create challenges, for example, RMIT **Medical Radiology** said: *"The profession's and university's demand to increase the number of students is not being matched by clinical site increase in taking on clinical training. These make clinical placements for student very difficult and demanding. How do the staff manage this, with much difficulty."*

Cooperative relationships are lauded by social work and psychology. Flinders University Psychology and Curtin University both stress the role of the state-wide cooperative relationships Curtin University said: *"Field placement coordinators are appointed for each Postgrad speciality in **Psychology and Counselling**. For the Masters in Psychology, all 4 universities in WA meet and negotiate for placements. As there are 4 Clinical Psychology programmes and one Counselling Psychology programme, additional placements are also developed through informal networking. At the start of semester, there are often students still waiting for a placement - either through space limitations of agencies or an inability to find an appropriate supervisor."*

UNDA indicates the value and limitations of the cooperative arrangements across universities. *"From a **Physiotherapy** University perspective - individual negotiation with facilities and/or clinicians to communicate our student numbers, areas of need and ways to facilitate and support clinical placements in a facility. Participation in the Physiotherapy Clinical Placements Working Party (WA) which while not involved in allocating places has helped facilitate collaborative approaches between the universities and the profession in the mapping of placements to match expected demand and models of clinical supervision of students that can help expand capacity."*

Monash University **Social Work** reported in detail on the approach of the Combined Schools of Social Work in terms of objectives and principles and how they use the system to manage placements. *"There are 6 schools of social work in Melbourne. These schools have come together to form the "Combined Schools of Social Work". <http://www.cssw.com.au/>*

Objectives

- *To coordinate a collaborative management system to organise and administer field placements in Schools of Social Work in Victoria.*
- *To provide a cost efficient and better quality method of dealing with the vast number of agencies in the community.*
- *To provide a model of an integrated approach to the procurement of social work field education placements that is useable by other tertiary institutions and adult education programs within the social and community sector.*

Principles

The principles of the Combined School of Social Work are based on core social work values.

- *All schools of social work should have equal access to quality field placements.*
- *Agencies have a right to privacy and schools of social work should therefore minimise the number of calls made to an agency in relation to requests for placements.*
- *Cooperation between all schools of social work and participating agencies.*

The Social Work Department at Monash University employ a fieldwork coordinator to manage Melbourne placements and a Fieldwork Coordinator to manage Rural and Interstate Placements. Coordinators have administrative support. The Melbourne coordinator also has the assistance of another lecturer and casual staff when required. The combined schools of social work Administrator uploads current placements on a data base

which is finalised in March. We access this database and based on our numbers may negotiate individually placements with organisations."

Multi discipline responses

Schools that teach across a range of professional disciplines tended to report a range of approaches, sometimes these are both manual and electronic as in the case of Newcastle University: *"A variety of manual and electronic systems are employed. The University uses SONIA for some placements and a spreadsheet system coupled with information on BlackBoard for others."* UniSA Health Sciences with 5000 clinical placements per year, decided in a 2005 review decided to centralise clinical placements into the Clinical Placement Unit.

Monash University School of Rural and Indigenous Health – Although the Excel DB is managed by HR, the process is much the same as reported by other schools. *"All clinical placements are entered onto an EXCEL dBase, currently managed by Human Resources. Requests are received from education providers or students on an agency application form or may be made directly to the health professional in the first instance, followed by the formal documentation. When the Clinical Place requested can be offered the education provider and student are notified and the requisite 'regulatory' forms are completed by the student and their agency."*

Paramedics

Monash University's DCEHPP – even though DCEHPP has something of a captured audience in the ambulance service, they have to start the process one year in advance. *"The Department of Community Emergency Health and Paramedic Practice (DCEHPP) needs to organise placements with emergency ambulance services and with hospitals. To facilitate this the Clinical Placement Officer commences planning for the coming year approx a year in advance by composing and sending request letters to hospitals, ambulance services and other health care providers etc. This forward planning is essential as it provides the clinical placement officer with an approximate number of placements for the coming year to enable sufficient time to negotiate with providers if placement requirements aren't meet."*

Nursing and Midwifery

Nursing, with its great press of student number requires structure systems. According to UNE even then and with considerable resource allocation they may not have enough places. *"Alternatively, if we do not have enough places allocated in a specific clinical area or specialty, eg mental health, students may be streamed into a number of groups and placed at varying times so that all students can fulfil their clinical practice requirements in that area."* CSU uses NSW Health's CPCIS to help handle the scale and the complexity of multi campuses and students from across Australia studying on campus and off campus but the practical problems remain. *"CSU has over 1300 nursing students across 5 campuses in distance and internal mode. We currently apply through the NSW CPCIS system and place students using a web preference form. The differences is that our students come from all over Australia and trying to give clinical placements which are accessible is becoming increasingly difficult. The cost of travel and the lack of available hospitals that will take larger numbers of students is a huge issue."*

Flinders University Nursing and Midwifery has a purpose built unit for the process of managing demand (including manual entry of data). *"The School has a clinical placement unit where placements are managed by use of manual data entry onto excel spreadsheets. Clinical within the School is guided by professional standards and set requirements. The area is overseen by Academic Clinical Coordinators (Nursing & Midwifery) and a member of senior management in the School who liaise with clinical venues."*

Even when students have to apply to the hospitals themselves, the workload remains. RMIT University stated. *"Graduate Diploma in Midwifery - students apply to the hospital directly for a clinical placement position and then we make them an offer once a place has been secured. Continually talk, liaise with hospital to maintain a positive relationship with industry."*

Midwifery in Victoria has a cooperative approach across the schools. Monash's School of Nursing and Midwifery: *"The MIDAC group facilitates collaboration across all the midwifery education providers in Victoria with regarding access to midwifery clinical placements."*

Curtin University School of Nursing and Midwifery in an extraordinarily comprehensive response reminds us that students are also placed in other sites such as schools, community and child health centres, etc. In WA, such places are allocated centrally by the Child and Adolescent Health Coordinator with WA Health. The process for placing undergraduate nurses in the health system is spelled out. *"The undergraduate nursing curriculum and therefore clinical experience varies from semester to semester. Each year preparations for requesting clinical placements commences in July for the following year. By the end of August a request is sent to the agencies to book available"*

clinical placements for the following year. The majority of the clinical placements are usually secured by the beginning of each semester. Sometimes, however, without prior warning an agency may cancel an allocation, before or after the students have been assigned, hence other placements must be sought. The CO is responsible for the overall organisation of clinical placements for the undergraduate and postgraduate students. SONIA, the School of Nursing & Midwifery at Curtin University of Technology utilises the software package; School of Nursing Innovative Allocation system (SONIA) clinical placement management system for clinical placement in Western Australia. This system has been used successfully since 2003 by secondary and tertiary hospitals and nursing students."

Q2 How does your organisation manage the capacity to provide clinical places?

Education providers with their responsibility to find places for all of their students are increasingly involved in the process of growing capacity. This requires not only considerable effort but also attention to relationship building between educators and health service providers. In the case of ANUM, this was done at the planning stage for the new medicine school. In other universities and disciplines, efforts to grow capacity in the health sector is being done on the hop. However, several responses indicated that they are not active in growing capacity because it is seen to be their responsibility to manage capacity, and others just said "n/a". Competition between schools for places means that even well established schools have to find new places if they are to place all their students. Clever use of existing placements by using the whole year, having buddies and multiple placements is increasingly common.

Medicine

ANU shows the benefit of forethought and planning to maximise the capacity of health service providers to take their students. *"Detailed mapping of capacity in the region was carried out prior to establishment of the medical school. This included mapping individual GP practices, community health resources and the regional hospitals. There is ongoing liaison with the key providers, including local area health authorities, Divisions of General Practice and individual practices. Recruitment and support of new teaching practices within our geographical region is an active and ongoing process."*

GPETNT while all disciplines and education service providers rely on health service providers to grow capacity, this was said very clearly by GPETNT: *"Firstly, our capacity to provide clinical placements across all programs is predicated on the policies and willingness of the individual placement locations. Medical student placements are volatile in the NT, capacity is diminished by the impact of endless issues including work force, accommodation, and the social and political health of the community along with many other issues. As a result capacity to place students is reactive and constantly changing. PGPPP capacity to place junior doctors is bound by the need for clinical supervision and the availability of resident GPs at rural and remote locations to undertake this role as well as to some degree the junior doctor's preference. GPR is complicated by the GPR's location preferences there is a reasonable high request for placement at regional centres which is almost at capacity with rural and remote locations currently under capacity. ... To increase capacity in the NT we identify locations not able to host program participants and support those communities and training locations to develop the ability to allow them to do so, by sponsoring accommodation or developing alternative appropriate supervision models for individual locations, ensuring training locations have the appropriate accreditations in place and providing administrative help to achieve the accreditations etc"*

Flinders University NT Clinical School reported the level and innovativeness of its efforts to eke out new places and to maximise those places capacity to take students. *"We work extensively with the community, including other training providers, health organisations, teaching clinics, and individual supervisors to assess local capacity and training needs. We have developed novel models of clinical training which have increased the number of placements available, and worked closely with clinicians and practise managers to ensure minimal impact on patient load."*

Griffith University (MED and Oral Health) indicates that although they have little control over capacity, they are active, and they are pleased by recent Queensland Health initiatives. *"Medicine We actually have little control over capacity. We work where we can with jurisdictions and local health services – seeking processes that recognise and reward clinical teaching – financial and pro bono. Go to Ministers and DGs! QH has just developed a Medical Schools Liaison Committee – very positive."*

Sturt Fleurieu GPET report on the contractual nature of their arrangements with sites committed to training. *"SF select practices for training of registrars based on their commitment to education and training. The number of practices available for training is determined by a contractually defined geographical area (eg Riverland, Fleurieu)*

Within these areas practices are supplied with registrars according to their level of accreditation. New practices are only considered when the demand /supply balance changes. For hospital extended skill and procedural places SF has limited access to the availability of any dedicated positions. The lack of ongoing supply positions is significant limitation."

UWA remains optimistic of the capacity in the wider health sector. *"I feel there remains sufficient capacity in clinical areas where students/trainees have not been previously. Yet training in supervision, support and close monitoring must follow these new placements to ensure that teething problems are identified as early as possible."*

NSW IMET has previously used an algorithm to identify capacity, but is now reconsidering. *"NSW IMET matches the demand and capacity of places for interns through a workforce distribution formula based on overnight separations, bed numbers and emergency attendance. However we allocate all applicants as this was perceived as the demand and it is currently being reviewed."*

Deakin University starts a year ahead of time. *"We need to be proactive and plan about 12 months in advance to ensure clinical placements have been secured to meet demand for following year."*

Allied Health

While all schools report a broad range of strategies to manage and build capacity in the health sector and in the community sector. For JCU, this including overseas placements. *"JCU in general manages capacity by having some placements early within the programs, usually not within QH facilities. As well, intake into programs is limited for programs which have clinical placements. **Occupational therapy** has also organised overseas placements and project placements which do not need local full time supervisors but this adds workload to academic staff who provide most of the supervision."*

Even so, there is a need to beg as RMIT **Medical Radiology** reported. *"By individual phone calls, pleas for allowing an additional students, seeking out new clinical training sites; much goodwill is needed. We are also liaising with the other university in Victoria who offers such program to coordinate the clinical placements to reduce the overlap of students attending clinical training so to hopefully reduce the impact on the clinical sites of having student undertaking clinical training."* Where this has proved inadequate, they have taken steps that impact on student learning opportunities. *"We have had to reduce many semesters from 12 weeks to 7 weeks due to clinical placements. This has had the effect of placing greater academic demands on students in relation to their learning."*

In order to make it easier for sites to offer places, UNDA **Physiotherapy** provides a range of support to sites in order to manage capacity. *"From a Physiotherapy University perspective - we assist managing the capacity that the clinical facilities cope with when we place students through clinical educator workshops; sharing of ways to manage the clinical educational process; tutor or other forms of support within facilities and for the students and the clinicians."*

Monash University **Social Work** balances the need to build capacity and the accreditation requirement that each placement be supervised by a qualified social worker by providing supervision themselves in sites with no social worker on staff as well as training existing social workers in supervision. *"Where an organisation may not have social workers on staff, they are encouraged to provide task supervision and our department organises and provides social work supervision to support this. Organisations are also provided with training on supervision information and support. Fieldwork coordinator usually meets with new organisations and discusses capacity and need. We also assist supervisors to manage any issues that they may face with students."*

In **psychology**, schools constantly seek out new sites and work to develop and improve relationships with organisations. Flinders University reports that they work with UPAC to build capacity by recruiting and training supervisors. *"UPAC regularly seeks additional supervisors in the field to supervise clinical placements through mailouts etc. UPAC also runs an annual skills workshop for supervisors who currently supervise students as well as with a goal to encourage more clinical psychologists to supervise. Individually the 3 universities also liaise with relevant health organisations in an effort to ensure adequate numbers of placements."* University of Wollongong has established its own on site clinic to deal with early year requirements for **psychology** placements, which they use as part of a multi-pronged approach. *"This has not been a major problem in the past, but is quickly becoming a major issue because recent changes have led to increased demand for clinical placements and decreasing capacity. We manage the problem in several ways:*

- a) this is an important consideration in determining the number of persons recruited into the clinical psychology program,*
- b) Students sometimes do placements during holiday periods,*

c) *Students work additional hours in university clinics to make up gaps in placement hours required,*

d) *One of the roles of the Practicum Coordinator is to scout around for new clinical placement opportunities and to maintain a good rapport with existing Field supervisors.*

This is sometimes accomplished by the University offering field supervisors a few perks such as providing them access to the library and its services (e.g., scientific literature searches), offering Field supervisors professional development activities (e.g., occasional workshops) and so forth."

Multi discipline responses

As can be imagined, multi disciplined schools offering have a broader range of needs and commensurate persistence and resourcefulness in meeting them. Newcastle University, for example, takes a range of practical steps in order to make the most of the placements available. *"Nursing employs a 'streaming' process for placements. Other disciplines stagger the clinical calendar across the years of study, limit the clinical placements in first year, and provide a range of part-time placement opportunities. We are also moving beyond traditional hospital placements and provide limited supervising resources."*

In a particularly comprehensive comment, UNE expressed extreme concern with the capacity of the health system to provide places for its students, especially in their rural location given the accreditation requirements. *"All undergraduate nursing students must complete the number and type of clinical placements indicated in the approved curricula. For UNE nursing students this totals 35 weeks over 3 years. At present, we are able to place all nursing students by utilising a number of strategies such as placing students during university breaks or streaming students into alternative placement dates. However, if we were to have increased numbers of nursing students the healthcare system would not have the capacity to provide the required volume of clinical placements."*

The fact that UNE is located in a rural area adds an additional challenge to the capacity of the system to provide sufficient clinical training places, as nursing staff shortages, which are particularly acute in rural and remote areas, impact on the ability of clinical areas to accept nursing students. In addition, some clinical placement venues are reluctant to take certain students, for example some paediatric settings will only take 3rd year students, when paediatric placements are required for 2nd year UNE students. Similarly, while we acknowledge that there is a lot more capacity to place students in the healthcare system, the timeframes for additional placements do not fit in with university calendars; for example, students cannot be on placement during lecture or examination periods."

Identifying innovative alternatives to traditional clinical placements is also problematic as the regulatory body, which is the Nurses & Midwives Board of NSW, required that all clinical placements are undertaken in health care settings, and in particular core clinical areas. Alternative clinical training strategies, such as the use of simulation and clinical skill laboratory work is not counted toward the total clinical placement hours approved in the accredited curriculum."

In a comparably comprehensive response, UniSA Health Sciences report on the importance of relationships and flexibility for building capacity, the restrictions imposed by accrediting bodies and the complexities of working across a range of professional disciplines. *"Capacity is enhanced through ongoing positive relationships with industry partners, developed by the Clinical Placement Unit and academic staff, and by being responsive to changes in the external environment. The Heads of Schools in the Division, and the Manager: Clinical Placement Unit, have strong relationships with industry partner staff and relevant staff of the SA Department of Health. Contact is regularly made across the year, but also as necessary should there be a critical issue around the number of available placements. This direct contact between education provider and placement provider is critical to the success of clinical placements and it will be important for this not to be impacted on by any centralised system."*

It should be noted that accreditation agencies including registration boards, professional associations, and incorporated bodies enacted to undertake accreditation have requirements for placement hours, competencies and areas of practice that often dictate a placement model that limits capacity. Capacity is not just about the placement and educator sectors but about the enablers and constraints placed on providers by these accrediting agencies."

Whilst increasing capacity through innovative models of placements is an ongoing endeavour by UniSA, restrictive demands by accrediting agencies have limited the

potential of these innovative models to increase capacity. Often the interpretation of what constitutes a competent graduate entry professional varies across different disciplines with some having prescribed areas of practice that need to be covered in an undergraduate program, and some having broader and more easily accommodated clinical competency development with flexibility about the environment in which these competencies are developed. In

multidisciplinary university departments with, for example, five disciplines there will be five differing accreditation requirements around placement activity that need to be met. Often these requirements impact on capacity."

Newcastle University indicates the effort to which they go. *"With difficulty demand generally across the disciplines is greater than the supply. In some discipline areas we utilise the following: Going to non-hospital based placements; Limited funding of clinical supervisors to provide student supervision where absolutely necessary; Funding of community clinics where necessary."*

Nursing and Midwifery

Schools of nursing report that, although they are typically very active in supporting health service providers to offer placements, they are failing to keep up with demand. The outcome is that the number of students accepted into some schools is restricted. There is a need to balance student learning needs with the need to find a placement that will satisfy accreditation requirements.

UWS uses a range of strategies to find places but finds it difficult from a student learning perspective. *"Multiple approaches are used from requests to individual facilities, people and through data base programs to area health services. We have a data base developed that supports examination of need based on curriculum requirements. Difficulty to find enough placements to support foci of students learning. Difficulty to identify from names of places provided the actual foci that would be offered for student learning."*

Flinders University reports the stress incurred by staff and students in finding enough placements for nursing and midwifery students. *"It is difficult to obtain enough clinical placements initially. This usually sorts itself out by actual placement dates after student withdrawals and negotiations with venues to take more students, but not without a lot of stress on the part of the placement team and students.; It is difficult to obtain enough clinical placements initially. This usually sorts itself out by actual placement dates after student withdrawals and negotiations with venues to take more students, but not without a lot of stress on the part of the placement team and students."* It also reports that because placements have become more difficult to find in recent years with the growth in student numbers, they have put quotas on international students.

The issue of finding places is made more difficult by the fact that each education provider typically deals with several hospitals, each with their own approaches. RMIT University indicates an awareness that hospitals are also dealing with a range of universities. *"Varies immensely between hospitals. Some will allocate numbers of places to different unis. Others will take the student and then tell them they can decide which uni they want to go to. Other unis sit down with hospitals and tell the hospital who they can take."*

Monash University reports that in midwifery schools across Victoria work with DHS and maternity managers to build capacity to offer placements. *"The MIDAC group is working with DHS and the maternity managers group to identify the existing barriers to increasing the number of midwifery clinical placements across the state. Strategies are expected to be trialled to address these barriers once identified."*

Flinders University reports on a range of innovative approaches for growing the number of midwifery places. *"The Department of Health is currently trialling a system put in place to find much needed midwifery placements. Currently nursing placements are found by negotiation with venues and other teaching institutions. Demand for places usually outweighs availability at least until just prior to placement dates so it becomes quite stressful for staff and students."*

Q3 How does your organisation manage the matching of demand and capacity for clinical training places?

Ideally each student would be matched to a location and supervisor suited to their learning requirements. However, given the press of student numbers, most responses to this question indicated that they focus on finding sufficient places rather than finessing to match each student to a particular placement. Where possible, student preferences and the preferences of the site are considered, but this is not always possible. There is the suggestion that learning opportunities may thus be a secondary consideration. It seems that this is less the case in smaller schools.

Medicine

ANU, with its well planned start-up phase, uses a two-stage process in which sites indicate their preference for timing and placements and then students select or are allocated. Other medical schools are less systematic. While Griffith University (Med and Oral Health) admits that their approach is *ad hoc*, and GPETNT uses a first come first serve pragmatic, Flinders University nominates matching as the most difficult even at the level of just matching numbers. *"This is of course the most difficult issue. For example matching the increased medical student numbers*

with available places has proved a recent challenge. The opening of our Rural Clinical School and our placements in the Northern Territory have assisted us in this. For the other health professional courses the Course Coordinators are in very close contact with providers to negotiate placements."

The range of approaches across schools within a single discipline university is evidenced when comparing this last statement by Flinders University with the following two statements. Flinders University Medicine and Paramedical take a different tack by seeking to match students to rural and regional placements where their contribution is seen as a useful adjunct to clinical services. Flinders University NT Clinical School uses close cooperation and flexibility to ensure successful matching. *"We work collaboratively with other clinical placement organisations in the area, individual teaching sites, and students to align the needs and capacity of the training sites with the needs of the individual student. We rely on a flexible system to ensure best-fit between student and site, and are committed to maintaining positive, symbiotic relationships with our supervisors and clinical training sites."*

Allied Health

Overall, allied health disciplines report making great efforts to match students according to their needs and to do so equitably. Monash Social Work, for example, asks students to select three preferences and then decides through interviews. Nevertheless, Griffith University reports that sometimes students options are limited by the placement capacity. Edith Cowan University reports that waiting for a placement to become available lengthens some students courses. UNDA highlights the circularity of the problem of not having enough professionals to supervise clinical placements for physiotherapy, and the inequity of government funding between disciplines. *"From a Physiotherapy University perspective - this is a circular argument in that on one hand the profession cries out for graduates to meet longstanding workforce shortages (albeit in some sectors more than others) but in meeting this demand from the profession this then creates a problem of providing the clinical education by the profession when there may not be the clinical placements available or the staff to support the clinical education needs of the students. There is inequity of support from the Federal Govt for supporting the clinical education needs of allied health professions compared with Nursing and Medicine."*

Multi discipline responses

While the process may differ within and between schools, it remains manual for many disciplines. JCU uses manual processes except for nursing which has a software system, which other disciplines would like to modify for their use. *"Except for nursing, matching of offers and allocating students to those offers is done manually to meet the accreditation requirements of the program. Nursing use a customised software package to allocate offers to students. Other disciplines are currently trying to find the money to modify that program to meet their needs. All disciplines have a least one dedicated clinical education coordinator and one administrative officer to organise placements, allocated offers etc."*

UniSA's response focused on matching the number of students to the number of places and reports that their capacity to take on new Commonwealth funded students is limited by the shortage of clinical placements, which they attribute partly to the historic lack of participation by the private sector. *"The places in each program are limited to the capacity in terms of known availability of placement sites. This is an issue because it limits the University's capacity to accept additional Commonwealth supported places when these are offered (eg in Nursing.)The need to limit places to the known placement opportunities affects all programs but has a more consistent impact on Nursing, Midwifery, and Physiotherapy."*

It should be noted that UniSA's undergraduate Nursing program has large student numbers (1,920 students in 2008) and this impacts on a placement opportunities. In this program we schedule placements across the 12 months of the year to gain the maximum number of opportunities. The program has a large external cohort. Many of these students live interstate. Recent retraction of interstate clinical places, particularly in Victoria, for universities outside of that State, has impacted significantly on these students who, as they live in the State where the placement has been requested (but refused) are more likely to work in that State after graduation. This means that interstate students must travel to SA for placement during their program, resulting in an additional cost for them. This results in some of these students withdrawing from their program.

Physiotherapy (390 undergraduate and 40 graduate entry students in 2008 at UniSA) has placement primarily in the public sector in which only about 35% of the clinicians work (the rest being in private practices). Physiotherapy private practitioners (65% of clinicians) do not have a tradition of taking students in SA and there is no incentive in the system for them to change this practice."

Monash School of Rural and Indigenous Health are using a new system in 2009 in an effort to grow capacity through better matching. *"We plan to change this process in 2009 to map actual capacity for clinical placements to*

clinical placements requested; to explore potential for any additional underutilised capacity and to implement some Interprofessional Clinical Placement options eg: Palliative care."

Paramedics

DCEHPP has had to adjust to fit university policies on semesters, etc, while looking for innovative opportunity to places students. *"DCEHPP has had to adjust the university semesters according to University policies so that the essential professional requirement of clinical placement can be meet. Students are also made aware that shift work, weekend shifts and public holidays are not exempt from clinical placements to enable the department to maintain flexibility when obtaining placements."*

Nursing and Midwifery

Even though nursing schools generally have large numbers of students, several report working hard to match according to student preferences and learning needs. UNE, for example said: *"The clinical coordinator allocates students to available places based on their preferences, the learning outcomes they need to achieve, their transport and accommodation needs. The clinical facilities are informed of the dates, numbers and names of students allocated to them prior to the placement and students are provided with information about the location and requirements of that placement."*

UNE also reports that NSW Health's CPCIS lacks flexibility and therefore adds to the problems of too few places. *"The matching of students to allocated placements is made even more challenging as we are required to request places on CPCIS by September of each year for the following year, which required that we make a 'guesstimate' of the number of students we will need to place each year. UNE manages the mismatch of supply and demand by 'streaming' students into groups for certain placements, this may require students to attend placements in university breaks or following final examination periods. This causes delays with final ratification of these students' marks, as clinical placement results are not available until well past university deadline dates. Similarly, when students cannot attend their allocated clinical placement for reasons such as ill health or family emergencies, re-allocating them is difficult due to the lack of flexibility in the current NSW Health allocation system."*

Other schools admit to taking a 'beggars can't be choosers' perspective in order to place all their students. For example, CSU said *"It is often get what we can get and hope it is OK. We have made our curriculum less specific which allows students not to require specific ward areas. Generic skills are also used. We have to stagger our 5 campuses as all students cannot go out at all times which causes issues with lectures etc."*

Focusing on matching the number of students to the number of places, Monash Nursing and Midwifery highlights the significance of reducing midwifery places due to placement shortages. *"The number of students admitted into the midwifery courses across Victoria have been capped to reflect the current capacity for midwifery clinical placements. This number is too low to replace the annual losses to the workforce."*

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