CATHOLIC HEALTH AUSTRALIA

Catholic Health Australia's response to the

NATIONAL HEALTH WORKFORCE TASKFORCE DISCUSSION PAPER:

HEALTH EDUCATION AND TRAINING – CLINICAL PLACEMENTS ACROSS AUSTRALIA: CAPTURING DATA AND UNDERSTANDING DEMAND AND CAPACITY

Catholic Health Australia (CHA) welcomes the opportunity to provide comment regarding the *Health, Education and Training – Clinical Placements across Australia: Capturing Data and Understanding Demand and Capacity Discussion Paper*. We ask to be kept informed of the progress of the outcomes of the discussion paper and to be offered the opportunity for further input as these outcomes develop.

BACKGROUND

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

- The discussion paper appears to reflect issues relating to the **public health sector only.** CHA recognises that the COAG agreement for the establishment of a national health workforce agency may address the nature of the not-for-profit /private health sector as 'other' and may recognise the duality of the health workforce in Australia.

- The aim of capturing data in order to understand demand and capacity for clinical placements is necessary but not sufficient. CHA has briefly responded to the discussion questions. There are, however, a range of other issues relating to clinical placements across the country that require closer examination.

- Extra resourcing for better management of placements must occur. In the past, when there was not a workforce shortage, there was more capacity within the system to support students on placement, and as a result students' and the facilities' experiences were largely positive and well coordinated.

- Best practice models of clinical placement must be explored, as well as the idea that nurse graduate funding, currently allocated to hospitals, follow the nurse instead. These initiatives could lead to greater competition for clinical placements –leading to better outcomes and a more streamlined system.

This brief submission in response to the discussion questions raised is an initial expression of the concern of CHA for the impact of not addressing clinical placement issues, particularly concern raised about the lack of clearly articulated roles of both the education institutions and facilities.

CATHOLIC HEALTH AND AGED SERVICES IN AUSTRALIA

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

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

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

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

CHA'S EXPERIENCE WITH CLINICAL PLACEMENTS

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

Prior to addressing the discussion questions contained within the NHWT Discussion Paper CHA wishes to raise a number of issues.

The idea of trying to capture data and understand demand and capacity for clinical placements is a necessary initiative, **but it is not sufficient**. A more efficient and appropriately funded process of clinical placements is essential for the success and transparency of the process.

CHA has consulted its members at length in regard to the issue of clinical placements and multiple, consistent themes have been raised. Outlined below is a précis of comments received from CHA members in relation to clinical placement issues. These comments are useful to think about when considering how a data collection system could be developed that would identify capacity (current and potential) for clinical placements.

Impact on Facilities

- Smaller facilities have difficulty consistently accessing students for clinical placements, and often have students turning up on the wrong days.
- Larger groups of facilities can deal with up to 9-10 universities at a time, and the administrative support required to manage this is significant. It works well if the facility employs its own clinical educators.
- Partnership arrangements with universities have proven to work well, but sometimes mean that those undergraduate nurses who have only ever worked in a particular facility may choose to work elsewhere (although the reverse can also be true).
- Many facilities are experiencing "preceptor fatigue" – a heightened level of stress due having students on placement, with the increasing numbers of students and the associated educational responsibility.

University Issues

- Each university uses different assessment tools for student assessments, and these range from one page through to "thesis" size. Paperwork for the student that preceptors may need to complete can be confusing and instructions provided open to varied interpretation.
- If students are placed in a rural setting there is often little support provided by the university. Support that is required includes accommodation, orientation and clinical supervision.
- Often day or time of commencement of placement is not reliable, length of placement is unknown and objectives of the placement are not articulated. It is felt that if placements were consistently organised across facilities, existing capacity would increase.
- Models of clinical support for undergraduates in nursing were introduced where the ratio of clinical supervision for students was 1:8, it has now changed to 1:16. Most facilities are struggling with this new increased ratio.

- Some new graduates are not 'work ready'. Often student nurses have graduated with no surgical placement experience and minimal acute placement experience.
- Students are often not available at times when a facility may have an increased capacity to take on students. Universities seem to all want placements during the same time period.
- Some universities cancel placements at short notice. CHA has been told that late cancellations occur intermittently, but not infrequently, from some facilities.
- Supervision of students is an issue. It has been some facilities' experience that supervisors, for example, are not skilled enough to provide acute surgical support to students on wards. In addition attendance of supervisors can be fragmented and inconsistent. In response to these issues some facilities second their own staff to the university so that they can provide the supervision. However in the not-for profit sector there is no state funding available to back-fill the supervisor's position, whilst some universities provide funding for back-fill.
- Clinical placements have a greater emphasis on tasks rather than valuing the complexity of care. It seems that universities often have difficulty in keeping up with contemporary models of care and are not teaching students contemporary practice. This situation then adds to an already stressed environment.
- There appears to be a lack of communication between education providers and the health sector. The roles and responsibilities need to be clearly articulated so that greater communication develops between the two sectors. An absence of this can lead to an inferior teaching program.

Student Issues

- Because a variety of students come through facilities, it is felt that continuity of student, or aligning students to on organisation, would be more beneficial for both the student and the facility, and would help address some of the socialisation issues that can be difficult for newly graduated students, particularly nurses, who need to undertake shift work, etc.
- Students access limited shifts only, and are not required to cover a 24-hour period. If they were required to cover a 24 hour shift it may assist in adjusting their lifestyles to shift work once graduated.
- There is often also a lack of support provided by universities for overseas students. The clinical facility provides the student placement on request, regardless of student category, and does not differentiate between Australian students or overseas students.
- Supervision levels for students in residential aged care facilities is generally poor. One facility reported, for example, that in their first year, students may attend one day a week for eight weeks, with no supervision, then for their second and third year placements attend for two weeks at a time with one phone call a week from their supervisor. This can be very difficult for students as they are often exposed to their first experience of a patient/resident death. In addition objectives for their placement are often not developed, and Universities provide little guidance. Some facilities employ these undergraduate nurses as carers where possible and then as registered nurses whilst they wait for the commencement of their graduate year elsewhere.
- Students often don't consider aged care as 'real nursing', and anecdotally groups of students talk about skipping entire lecture sets because they are seen as worthless.
- Students who wish to do extra time on wards after their placement has finished are not able to, as the university insurance does not cover them. Some facilities are employing these students as Assistants in Nursing (AIN) and are finding they are retaining between 75 – 80% of them to their facility once they have graduated. This approach allows the institution to see how the student develops and integrates the student to the team, improves their socialisation and real life experience.
- Because there are so many part time nurses it is often difficult to obtain continuity of staff in facilities to assist students.

- Where placements for nurses have worked well and strong partnerships with Universities have occurred it has been found that the "graduation year" can be significantly reduced, in some cases down to 3 months. To achieve this undergraduates are employed as AINs -where they learnt to provide patient care and whilst on placement as students they are socialised to the hospital and get ready for graduation.

Cost

- There is a level of inconsistency to funding of hospitals by Universities.
- There is more opportunity in the private sector as a whole to provide clinical placements, but costs to do so must be covered, such as appointing clinical educators.
- The 12 month post graduate nurse program is remunerated within the public sector (anecdotally at up to $15,000 per nurse). This funding is not available to the private sector. CHA would recommend that the funding is attached to the graduating nurse – to be taken wherever he or she chooses (within Australia) to undertake their graduate year.

Medical Clinical Placements

- Undergraduate medical placements provide challenges to the not-for-profit sector. There is more than one model of medical education currently being taught. One particular model of curriculum is very resource intensive, from a supervisory point of view. Third year students may be on placement for a whole year at a facility, and will be required to cover medicine and surgery as well as pastoral care, in contrast to students from a different university, at the same year level who will have different objectives for their placements. Because of the course accreditation process student curricula should be similar.
- Medical student placements in the not-for profit sector is a new innovation in some jurisdictions. With the increase in graduate numbers there will be an expected increase in demand for intern training.
- Medical students are not part of a ward per se, and so it is difficult for them to be socialised into a ward.
- More data is required from the experience of specialist training in private settings and the impact this has had on business – i.e. clinical activity and budgets. This is not an issue in the public sector where the teaching and supervised training is undertaken in the clinician paid sessional allocation. The question of whether there is a measurable slow down in throughput due to specialist trainees will need to be answered.
- It will be difficult to find clinicians who are willing to support an expansion in medical training (medical students and interns) into the private sector unless the following questions are answered:
    - What is the scope of the issue?
    - What will be the future demand?
    - Who will provide the infrastructure to support the demand?
    - Who will fund?
    - What is the level of acceptance of teaching and training in private hospitals by the participating patients?
    - Ensure infrastructure for teaching is available
- For clinical placements to work well for both nursing students and medical students they require their own space within facilities where they can learn together as two professions. (This would be appropriate for allied health staff as well). Space that is currently provided is generally inadequate.

The primary issues relating to medical clinical placements are ensuring **adequate levels of supervision** and **adequate funding and resourcing**.

- The public system is essentially funded to teach. For the private sector teaching reduces efficiency (anecdotally by 25% for surgeons with a trainee in theatre) and

even the funded Expanded Settings Training Program barely covers costs - and falls well short if the trainee is on-call or working out of hours. Any further significant financial contribution for clinical placements may not be possible.

- Infrastructure for medical teaching is not always available. In the public sector most facilities have a budget for research and training. Salaried medical staff are provided a research and training sessional allocation (and payment – within their paid service commitment). This is not the case in the private sector where clinicians are independent of the facility. As the intern and registrar numbers increase (particularly in light of the 10 new medical schools that have been established over the past 11 years) supervision and funding of medical training will become critical. It is not likely that these increased numbers will be absorbed within the private sector because it is not possible to have large numbers of interns in the private sector without the necessary resident and registrar structure above them.
- Without quarantined time and funding, private hospitals rely on clinician goodwill. Support for teachers, both financial and administrative, is critical.
- Indemnity is also a major issue for the private system. Multiple complicated arrangements exist with government, private/public partnerships and Medical Defence Organisations. Clarification of indemnity for students, junior doctors and specialist trainees in the private sector is essential.
- Traditionally, medical training in the private sector has been an added burden to existing administrative personnel. Like nursing, done well it requires significant administrative and infrastructure support. Medical training also requires infrastructure supports such as computer/library access, lockers, common room.
- The relationships with public hospitals are also critical and current models of teaching and training have this at the forefront. For junior doctors and specialist trainees it is important that preservation of public entitlements are retained and therefore a secondment model works best.
- In summary, for medical training in private facilities to work well requires a collaborative approach with government, universities and specialist colleges.

The private sector is often at a disadvantage compared with the public sector in terms of support for teaching and research. In the public sector academic positions are often funded by jurisdictions in return for a service commitment. For example hospitals may be given University status and be provided a hospital clinical appointment in exchange for being responsible for teaching – at no cost to the facility.

CHA notes that the discussion paper appears to reflect issues relating to the **public health sector only**. The not-for-profit sector also undertakes clinical placements, as evidenced above, and currently sits outside jurisdictional data collection systems. It is however acknowledged that the COAG agreement to establish a national health workforce agency may address the nature of the not-for-profit /private health sector as ‘other’ and recognise the duality of the health workforce in Australia.

DISCUSSION QUESTIONS

CAPTURING DEMAND
Are there other data elements needing to be captured to map demand?
Can education providers provide the necessary data elements?
Would existing data collections provide this information and enable comparisons across the sector?

CHA is of the opinion that demand could also be mapped across the public, not-for-profit and private sectors.

It has been CHA's experience that education providers operate at variable levels – for some it would be relatively easy to provide the necessary data elements in a timely and prospective fashion, for others this will not be the case. Any process should be built on existing data collection systems with the aim of conducting annual prospective data collections.

As described above, it has been some CHA members' experience that placements, whilst rostered in advance, do not always occur on the days indicated. A data collection mechanism that ensures certainty of placement dates and times on education providers would be welcomed. In addition quality and efficiency would be improved.

Comparisons across the sector could only occur at an aggregate level, due to the variable nature of clinical placements. One issue that would need to be considered is the timeliness of data collections. Will this data be collected prospectively or retrospectively? To be meaningful any data should be collected annually and prospectively.

CAPTURING SUPPLY AND CAPACITY
How can additional capacity be quantified and what specific metrics could be applied?
Who can provide this level of data?
What are strategies for identifying potential capacity?
What is the capability of health service providers to provide data that might be necessary?
How would data integrity and quality be assured?
How would capacity be benchmarked?
What are the potential benefits and challenges of identifying benchmark measures?

CHA notes that specific data relating to supply and demand can only be provided by the education providers and the health institutions.

Again, capturing supply and capacity appears to favour a public sector approach to data collection – specifically where mention is made of incorporating weighted formulae that are already in use by jurisdictions. However if it was possible to benchmark capacity through measurement of degrees of complexity, remoteness and staffing ratios, then CHA may support this initiative. The purpose of the benchmarks would need to be made clear. However the data elements included in the discussion paper appear adequate.

Feedback from CHA members indicates that because of the current variable nature and timing of placements it will be difficult to accurately measure actual capacity, let alone potential capacity.

CHA recommends that a standard process of placement have regard for hospital size and facilities available and whether rural or regional. CHA agrees that a national minimum data set from the key elements described would be essential in order to establish teaching activity.

OPTIONS FOR A NATIONAL APPROACH

What is the most feasible, relevant and beneficial approach for each stakeholder?
Is there interest in developing a national approach and could this be achieved through capturing data from existing systems and collections or would new systems need to be developed?
Would a preferred model be one that progresses an active clinical placement management systems that provide planning data as a by-product or should it be one that focuses' on only collecting data?
What incentives would ensure a high level of compliance?
What might be barriers to achieving a high level of compliance?
What is non negotiable at the local, jurisdictional and national levels to ensure improved data for planning placements and identifying capacity?

A national approach to data collection would ensure timely annual prospective reporting of the data items. Again the issue of how to ensure the not-for-profit and private sectors are included must be examined. The discussion paper suggests a link to funding on a transparent and rational basis to ensure compliance. How would compliance to reporting occur in the private sector? We know that reporting Casemix data to the Department of Health and Ageing is not mandated, but hospitals are strongly encouraged to do so. But because there is no funding requirement to report, the issue of reporting becomes a lesser priority than other tasks, and hence may not happen at all. Response rates for Casemix data from the private sector could be improved.

CHA supports the development of a comprehensive approach to data collection as the ideal, but acknowledges that there are many system and access issues, including data validation, that would need to be addressed. The cost of such a far reaching system would need to be weighed up against the actual need for, and value of, the system, as well as quantifying how it would be able to 'make a difference' in understanding demand and capacity.

Any data collection should include allied health professional education and training in order to assess the same issues. There is a paucity of this type of clinical placement data.

Clearly barriers to a high level of compliance would be adequate funding and resources - which must be provided as an incentive.