

Clinical Placements in Victoria

Considering a Clinical Placement Agency

Discussion paper

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Executive summary

Victoria faces a number of challenges over coming years to meet the clinical placement requirements of an increasing number of health students across the state. The growth in health student numbers is essential for increasing the supply of health professionals into the system to, in turn, address emerging workforce shortages and future community demand. However, with the associated growing demand for clinical placements, there is a need to assess the capacity of health services to accommodate the requirements and to evaluate the most effective mechanism to coordinate the process.

It is recognised that a range of factors can impact upon the efficiency and availability of clinical placements. Some of these are course accreditation requirements, existing relationships between teaching institutions and health services, administrative burdens and physical infrastructure needs. While the responsibility for tertiary education funding rests with the Commonwealth Government, the responsibility for providing and coordinating adequate and appropriate clinical training lies with both teaching institutions and health services.

The Department of Human Services (the department) has implemented a number of initiatives to address clinical placement capacity and is working with education providers and health services to formulate a range of solutions. The broad strategic direction is outlined in the document *Clinical placements in Victoria: Establishing a statewide approach*. The approach targets improved data collection and planning, capacity building, innovation, streamlined funding and improved governance.

One aspect of this strategy is to explore the feasibility of a ‘clinical placement agency’ as a means of increasing capacity and improving statewide planning. The clinical placement environment is complex, involving numerous stakeholders and working with multiple health disciplines. As such, a clinical placement agency could potentially take many forms and functions in its role to meet identified needs. This document raises issues regarding what an agency might do, and how it would operate. A series of options for the mechanism of a potential agency are presented as a starting point for debate.

Considering the available resources and the future pressures on the clinical placement environment, this paper asks for input from stakeholders on the potential statewide agency concept. It should be noted that the aim is not to duplicate current processes, but to build on those that work well and improve or rule out those that do not.

Written responses are invited to this paper, and consultations will be held to build consensus on the viability of an agency.

1. Background

1.1 Introduction

Improving the supply of suitably qualified staff in the Victorian health workforce is critical to meeting the public's expectations of safe, timely and accessible health services. Increasing and sustaining the number of students studying health courses will be central to achieving this goal. Over recent times, Victoria has successfully secured substantial growth in the number of Commonwealth-supported undergraduate health places allocated to this state. Similarly, Victoria has increased availability and continued to encourage uptake of vocational education and training (VET) qualifications in the health sector in areas such as Division 2 nursing.

Although welcome, this growth also places an increased burden on health services due to increased demand for clinical placements, which form an essential component of most undergraduate health courses. The Commonwealth has lead responsibility for funding higher education, including clinical training. Victoria, however, recognises its responsibility in ensuring a continued supply of staff to the health workforce. To this end, Victoria wishes to pursue a model that promotes a more coordinated, cross-service and cross-discipline approach to organising, managing and delivering clinical placements. Such an approach will address a number of issues identified by stakeholders in order to assist health services to engage in clinical training and promote best use of available resources.

Given the growth in demand and the move to more strategic, statewide planning approaches, it is timely to consider whether there are more effective and efficient ways of undertaking clinical training, and the potential benefits and limitations of these. One strategy involves exploring the feasibility of establishing a clinical placement agency to enable a more streamlined approach to organising and managing clinical placements in Victorian health services. The aim of such an agency might be to increase capacity for placements, foster innovation and support implementation of effective models by liaising across sectors, and promote team-based approaches.

Building on existing practice and research, this paper provides a platform for discussing some of the key issues to consider in establishing a clinical placement agency.¹ The issues include the structure and function of an agency, how an agency could reduce administrative burden, increase clinical placement capacity, and implement innovative approaches. A range of options for the structure and functions of an agency are presented, and stakeholder views are sought on these.

1.2 Purpose of paper

Ideas related to developing a clinical placement agency concept are presented here for discussion. In doing so, this paper addresses:

- the policy context in which this work is being considered, and the rationale for considering reform
- the desired outcomes to be achieved, and principles to underpin such an approach
- an examination of the evidence for an agency-type approach
- issues to be taken into consideration in developing an appropriate model, including the potential impact on existing arrangements and evolving service and training models
- potential options for both the scope and structure of a clinical placement agency.

The department recognises that many stakeholders are experienced and knowledgeable in clinical placement coordination and that there are a range of initiatives (many discipline specific) that may inform and complement a clinical placement agency. The intention is to build upon, rather than replicate, these initiatives.

¹ It is important to note that the term 'clinical placement agency' is used for ease of reading, and should not be taken to reflect a preference for a particular structural model. The paper identifies several options including a single, stand-alone statewide agency or a series of agencies involved in managing and coordinating clinical placements.

This paper addresses current undergraduate clinical placements occurring in Victorian public health services where many difficulties in coordinating clinical placements have been reported. It is recognised that these issues are also directly relevant to:

- clinical placements in other health or community service settings (such as community health services)
- disciplines not currently placed in Victorian public hospitals
- relevant VET courses (such as those for Division 2 nursing).

A successful agency concept should have the capacity to accommodate this diversity across public hospitals, community and primary health settings, and potentially in the private and not-for-profit sectors. The final model of an agency would be contingent on both stakeholder support and available resources. Whatever its form, an agency would be expected to address the key issues faced by organisations involved in clinical placements such as:

- the need to increase capacity for clinical placements and maximise existing capacity
- coordination challenges
- implementing innovative approaches
- planning for the future.

Section 4 of this paper addresses the scope of a clinical placement agency in more detail.

1.3 A clinical placement strategy for Victoria

The concept of a clinical placement agency is part of a broader body of work, namely, the department's strategic approach to clinical placements in public health services as set out in *Clinical placements in Victoria: Establishing a statewide approach* (the strategy). The strategy aims to create an improved environment for clinical placements in Victoria, in order to help health services meet forecast growth in clinical placements associated with growth in training numbers. A copy of this document can be found at: www.health.vic.gov.au/workforce/placements

This discussion paper is intended to be read in conjunction with the strategy.

The strategy aligns to broader Victorian Government policy as well as emerging policy directions for the health workforce at a national level. These include Victorian Government policies such as *Growing Victoria Together*,² *Victoria – A better state of health*,³ and *Care in your community – A planning framework for integrated ambulatory health care*.⁴ At a national level, the 2005 Productivity Commission report⁵ identified clinical training as a workforce priority.

The primary goal of the strategy is to ensure that there is sufficient high-quality clinical training capacity in Victoria. As such, the strategy is intended to ensure that training models are as efficient and effective as possible; coordination and administration of clinical placements do not place unnecessary burdens on health services, their staff or patients; and that coordinating clinical placements produces outcomes that align to evolving service and community needs. A combination of short, medium and longer term strategies are being pursued to achieve these objectives. Appendix 1 summarises the major initiatives being undertaken from 2007 to 2009.

The department has supported a range of projects and initiatives to progress these objectives, which are summarised in the strategy.

² [www.dpc.vic.gov.au/CA256D800027B102/Lookup/GVTIIBooklet/\\$file/growing_vic_together%20final%20report.pdf](http://www.dpc.vic.gov.au/CA256D800027B102/Lookup/GVTIIBooklet/$file/growing_vic_together%20final%20report.pdf)

³ www.health.vic.gov.au/betterstate

⁴ www.health.vic.gov.au/ambulatorycare/careinyourcommunity

⁵ www.pc.gov.au/study/healthworkforce

Community health placements

One of the projects initiated by the department has been to increase the capacity of community health services (CHSs) to take students for clinical placements.⁶ The project uses a regional model where CHSs, in a given geographic region, form a network with one point of coordination to collaborate with education providers to facilitate clinical placements across the network. Issues have been cited by both CHSs and education providers with respect to the difficulty of arranging clinical placements in individual CHSs. It is envisaged that this project will address barriers to clinical placements in non-acute settings, improve workforce recruitment and retention in this sector, and contribute to an increase in the overall clinical placement capacity of Victoria.

Joint planning

Planning for clinical placement growth in medicine in Victoria has been taken forward through the Clinical Placement Joint Planning Group (now superseded), which brought together health services, education providers, and State and Commonwealth governments. The successful planning of future medical undergraduate clinical placements in this way indicates that a third party (in this case, the department) mediating planning issues can be beneficial. Joint planning proves a useful starting point for a possible clinical placement agency. Ongoing collaborative processes between health services, education providers and government agencies will now occur through the department's Education Liaison Committee.

Innovation

Several innovation projects, funded as part of the strategy, have identified issues that have led to the proposed establishment of a mechanism such as a clinical placement agency. Fostering a greater interdisciplinary approach to planning and managing clinical placements has also been highlighted as a key objective. Significant differences in the nature, duration and structure of clinical placements undertaken by medical, nursing, allied health and VET students are recognised, however there are a range of benefits associated with adopting a more interdisciplinary approach to the planning, allocation and support of clinical placements associated with the proposed functions listed here in Section 4.

A clinical placement agency can contribute to the strategy's success by improving the efficiency of clinical placement mechanisms and capacity in Victoria.

⁶ For further information about this project visit: www.health.vic.gov.au/communityhealth/service_provider/tarp

2. Clinical placements context

2.1 Current arrangements and related issues

The majority of undergraduate health courses, and some community services and health VET courses, require clinical training as essential components of their curricula. Clinical training generally occurs through ‘clinical placements’: experiencing the practical aspects of working in a health service or other relevant attachment. It is important for all parties that the purpose of each clinical placement is defined, and the expectations placed on each participant are clarified.

Individual courses are subject to periodic accreditation, which requires compliance with established standards specific to that discipline. For health disciplines subject to statutory registration, eligibility for registration (and thus entry to practice) is contingent on successfully completing a course of study approved by the relevant state registration authority. Registration boards either directly accredit courses of study for this purpose, or delegate this function to national accrediting bodies, which set national standards that such courses must satisfy. For registered professions, it is through this accreditation function that minimum standards for clinical training are set.

Although a range of disciplines are not subject to statutory registration, they usually have accrediting bodies that set standards around undergraduate curricula, including clinical training requirements. In such instances, successfully completing an applicable course of study is usually required to be eligible for membership to the peak professional association and, like statutory registered disciplines, the accreditation standards are also used to assess the qualifications of international practitioners who seek the right to practise in Australia.

As research commissioned by the department illustrates,⁷ the nature of these requirements varies significantly in terms of:

- the increment of training required – typically cited as a minimum number of hours but, in some instances, as a percentage of total course hours
- the specificity of requirements – such as in relation to the service settings in which students must undertake their clinical placements
- supervision requirements – such as specifying the supervision of students by members of that discipline (with appropriate qualifications and a minimum level of experience).

While the onus is on education providers to ensure clinical placements undertaken by their students meet the standards set by accrediting bodies, staff from both health services and education providers are involved in planning, organising and coordinating clinical placements. It is acknowledged that there are a variety of organisational arrangements regarding coordinating clinical placements across health settings and disciplines.

2.2 Future opportunities and challenges

In considering options for developing a clinical placement agency, it is critical to consider not just current arrangements, but to also recognise that growth in training numbers and evolving service models are likely to drive a range of changes to existing relationships and approaches in this area.

Although there may be reluctance from some stakeholders to consider changes to existing relationships between teaching institutions and health services, some changes (such as establishing new schools) are already occurring as an unavoidable consequence of the substantial growth in training numbers required in disciplines such as medicine. Similar impacts are also being experienced in both nursing and allied health disciplines, where there has been significant growth in Commonwealth-supported training places since 2005.

⁷ www.health.vic.gov.au/workforce/downloads/mapping_course_accred_requirements.pdf

At the same time, factors such as changes in population demographics, shifts in the burden of disease, technological advances and changing patient expectations will significantly change service models and thus will be reflected in the training required to effectively equip graduates for practice. It is anticipated that there will be an increasing emphasis on community-based, client-focused, interdisciplinary models that will potentially lead to considerable changes to clinical training requirements and settings. It is likely that community health centres and other community-based services will become the setting for many more clinical placements. This is particularly true for students in disciplines that frequently work in such settings, for example medical students and Division 2 nursing students. Other new service models, such as that delivered by the Alfred Centre and day hospitals, may also offer new clinical placement opportunities.

It is therefore considered timely to explore alternative approaches to organising and managing clinical placements, not just to address existing problems, but to provide capacity to identify and respond to the challenges and opportunities that are likely to be encountered in organising clinical education into the future, and to ensure there is a way to systematically tap into underutilised capacity and settings not previously used.

2.3 International approaches to clinical placements

The organisation of clinical placements in Victoria occurs through a variety of methods, and sometimes in an ad hoc way. In introducing a more strategic approach to maximise capacity, it is important to learn from existing models. Governments in Canada and the United Kingdom have employed various techniques to ensure there is sufficient capacity for clinical placements to meet the training needs and future direction of their health workforces. These models provide an evidence base from which Victoria can ground its response to a clinical placement organisation.

Canada – British Columbia

The province of British Columbia (BC) in Canada has developed a unique program to address problems experienced with securing enough clinical placements at the post-secondary level. Cooperation of the major stakeholders in clinical training provided an opportunity to collaborate on developing a new system to overcome problems and to plan to meet future needs. The ministries of Advanced Education and Health worked in partnership to initiate the Practice Education Innovation Fund (PEIF), administered by the BC Academic Health Council,⁸ and provided funding (CA\$3 million) to sponsor clinical placement projects. Work funded by the PEIF includes innovative approaches to clinical placement coordination, interprofessional learning models,^{9,10} and rural placement and recruitment. The cornerstone of this work is a clinical placement information system called HSPnet,¹¹ which other provinces in Canada have since adopted. HSPnet provides a web-enabled database and tools to manage clinical placement coordination. Stakeholders are kept informed of innovation and development in clinical placements, as well as the results of evaluation of programs. The issues addressed through this work are similar to questions raised about the Victorian system (see Section 1.2), and this program will be used to inform an evidence-based statewide approach.

⁸ For more information see: www.bcahc.ca

⁹ BC Academic Health Council 2004, *Interprofessional Rural Program of BC Final Report*, November 2004, viewed March 2007, <www.bcahc.ca/pdf/IRPbc-FinalReport-Nov04.pdf>.

¹⁰ BC Academic Health Council 2007, *Program Evaluation of the Interprofessional Rural Program of BC (IRPbc): Final Report*, January 2007, viewed March 2007, <<http://www.bcahc.ca/irpbc/jan12report.pdf>>.

¹¹ www.hspcanada.net/#HSPnet

United Kingdom – National Health System

In 2001 the UK Department of Health released a document called *Placements in focus*¹² providing guidelines for clinical placements to assist educational institutions and health services. This document is not prescriptive, however it offers a model of best practice for relevant organisations to follow. The report encourages relationship building between health trusts and educational institutes, such that students have a mentor who crosses both institutions, ensuring that theoretical learning is transferred into practice. A checklist is supplied for providers to work through together in planning student placements, which assists in meeting the guidelines presented by the Ministry of Health. There is no discussion in the document regarding stakeholder consultation or the evidence base for the guidelines.

Australia

Various activities regarding clinical placements are being undertaken in different states across Australia. For example, to address the need for clinical placements in rural areas, the governments of New South Wales (NSW) and Western Australia (WA) include providing some funding for students who travel to a rural setting to perform a clinical placement. The Victorian Government also does this for nursing students.

The Broken Hill model – a successful regional approach

A regional clinical placement project has been set up in Broken Hill in NSW to improve the procedure for organising clinical placements in this rural hub, as well as increasing capacity.¹³ The project involves a collaborative effort between local health providers and the University of Sydney's Broken Hill University Department of Rural Health (BHUDRH). The program places students from over 22 universities across Australia and overseas. The collaboration has been working for nine years to achieve greater efficiencies in program delivery, increased support for students during their clinical placement, and enhanced educational opportunities. In this time, the number of students on clinical placement in the region has increased, as well as the time spent on placement. In 1998 there were 339 weeks of student placements in the region, and by 2004 there were 1,024 weeks of student placements. This impressive and rapid trebling in capacity for student clinical placements points to the advantages of implementing a collaborative regional approach.

Social work placements in Victoria

In contrast to training networks across health services, some efforts have been made to increase clinical placement capacity through discipline-specific approaches. While there are benefits in this method, such as coordinated approaches to health services, it maintains professional silos and does not encourage interdisciplinary student learning. The various Victorian schools of social work are working collaboratively through the Combined Schools of Social Work placement project to plan and implement fieldwork for all courses in Victoria using a joint database and shared administration. This project streamlines the organisation of clinical placements, thus attempting to reduce administrative burden on health services and encourage an equitable process.

¹² This document can be accessed from <http://www.nsch-tr.wmids.nhs.uk/files/users/wilsos/Downloads/DoH%20-%20ENB%20Placements%20in%20Focus.pdf>

¹³ Lyle D, Morris J, Garne D et al 2006, 'Value adding through regional coordination of rural placements for all health disciplines: The Broken Hill experience', *Australian Journal of Rural Health*, 14 (6), 244–248.

3. Issues

3.1 Impacts on current arrangements

Establishing a more cohesive, coordinated approach to managing clinical placements has the potential to deliver a range of benefits for health services and other stakeholders including:

- increasing clinical placement availability to meet forecast growth in demand
- streamlining administrative processes for organising and allocating clinical placements, which would reduce the administrative load borne by health services and training providers in coordinating clinical placements across the various disciplines¹⁴
- maximising use of existing capacity within the system by avoiding situations reported in some services where clinical placements are initially booked by training providers and not subsequently filled
- achieving economies of scale and building capacity through a consolidated approach which, in turn, could contribute to improved quality of training and supervision by building on the experiences of particular courses, disciplines and training providers
- planning for future clinical placement needs over the medium to long term
- advocating for the implementation of evidence-based innovations to increase the quality and efficiency of clinical placements
- working in partnership with health services and education providers to increase clinical placements in an expanded range of settings and sites, in particular primary health, residential aged care and mental health.

Establishing a clinical placement agency must not compromise the quality of, or access to, clinical placements. Rather, an agency should ensure that best use is made of available clinical placement capacity and, as far as possible, reduce the administrative burden associated with allocating and coordinating clinical placements.

Existing relationships

As noted previously, many health services (particularly the major teaching hospitals) have established relationships with particular teaching institutions, some of which have been in existence for many years and which may be accompanied by significant related infrastructure and/or other investments. With the recent establishment of rural clinical schools, stronger relationships have also been forged between these teaching institutions and a range of rural health services.

Some stakeholders have suggested that these relationships can create barriers to other training providers accessing clinical placements, particularly new providers. A primary function of any proposed agency would be to reduce barriers to training providers while respecting existing arrangements. Participating health services and training institutions would need to work in a collegiate manner to provide information regarding both used and unused capacity. It is hoped that this transparency will give all providers the opportunity to utilise spare capacity while forging their own relationships with health services. The agency would also play a role in ensuring that a diversity of clinical placement sites are utilised, reflecting recent health policy directions regarding community-based settings and patient-centred health care.

Other stakeholders have highlighted concerns that the apparent shortage of clinical placements has resulted in some health services changing previously agreed relationships based on ‘premium pricing’ from other teaching institutions. These stakeholders argue that a ‘preferred provider’ arrangement should be established between teaching institutions and health services to give certainty to clinical training programs and to enable longer term investment by all parties in the necessary infrastructure and supports.

¹⁴ It is recognised there would still be a requirement for staff in health services to be actively involved in both organising arrangements for incoming students, as well as managing students once on placement.

Educational diversity

There are significant differences in the nature, duration and structure of clinical placements undertaken by medical, nursing, allied health students and VET trainees that reflect broad differences between professions and the philosophies underpinning their practice. There are also variations in teaching models and curricula employed between institutions and disciplines (including variations for the same discipline within different institutions and for different disciplines within the same institution). While diversity has benefits, it should be acknowledged that it complicates the planning and delivery of clinical training.

Any proposal to establish a more consolidated, interdisciplinary approach to organising clinical placements could generate concerns among some disciplines that access, quality, and professional relevance of clinical training will be compromised. As highlighted throughout this document, the purpose of the agency would be to facilitate access without compromising quality. Any significant discipline-specific differences in clinical placement requirements can be accommodated through this process. Effective interdisciplinary clinical placements will 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.

Existing networks/clusters

Across Victoria, publicly funded health services have formed various network arrangements. Public hospitals are clustered into 'health services', while public mental health services are organised into over 20 area mental health services (the 'catchment areas' of which vary according to client groups). Community health services have informal regional and sometimes sub-regional arrangements for coordination and planning. Primary Care Partnerships (PCPs) provide a platform for enhanced service coordination across community catchments, including community health services, divisions of general practice, local government and often acute and mental health services.

Furthermore, a range of other networks and clustering arrangements exist including some specifically related to education and training, such as the department's recently established training consortia (see Appendix 3), which is currently being piloted for basic physician training and will be expanded to include medical interns in 2008. There are also training clusters established by certain medical specialist training colleges, and the department's mental health education and training clusters. It would be desirable for an agency to build on existing networks if possible, to reduce the number of structures operating across health services and education providers.

3.2 Potential impacts of future trends

In future, the scope, organisation and management of clinical placements will need to respond to significant growth in the number of undergraduates, as well as changing service models. Evolving service models, such as the increasing emphasis on community-based interdisciplinary service delivery, will necessitate changes in the nature and settings in which all health students undertake clinical placements, and new service settings should provide additional opportunities for clinical placements.

Student numbers

Over the past three years, the Australian Government has announced substantial increases in Commonwealth-supported places in Victoria with 439 new allied health and nursing places commencing in 2005 and a further 220 medical, 410 nursing and 85 allied health places phasing in from 2007. The following additional factors will also impact on the demand for clinical placements:

- removing the cap on domestic full-fee-paying (FFP) students, which was previously held at 25 per cent of Commonwealth-supported places (CSPs)

- the flexibility given to universities to over enrol and receive up to an additional 5 per cent of total funding for CSPs over and above that agreed
- the new Commonwealth Government pre-election promise of 1,500 additional nursing CSPs to be allocated during 2008 and 2009
- the University of Notre Dame Australia is seeking to place medical students in Victorian health services from 2010
- the Victorian Government announced that funding for 1,500 additional VET places in Division 2 nursing and other related health courses, over the next four years
- growth allocated to other states could also see increased pressure on clinical placement requirements in Victorian health services, but might also provide opportunities for interstate clinical placements for Victorian students.

When the associated growth in places is added, the future requirements for clinical placements are even more substantial.

- By the 2012 academic year, it is estimated that about 180,000 additional medical clinical placement days will be required, per annum.
- By the 2009 academic year, it is estimated that growth in demand for clinical placements (if existing models are retained) of more than 67,000 additional nursing placement days will be required, per annum.
- By the 2009 academic year, it is estimated that over 31,000 additional allied health clinical placement days will be required per annum in public acute settings alone.

Changing population and workforce

Health service delivery is constantly evolving to adjust to the changing demographics of the population and the workforce, technology and a growing body of knowledge. The burden of disease is shifting to multiple chronic conditions, particularly in older people, and service models will need to respond to reflect care required for these types of conditions. Shorter hospital stays and care in the home are fast becoming the norm for health care as technology and support in the community improves. As such, to ensure the future health workforce is adequately prepared, the curriculum and clinical training of future health students must also adapt. New models of care are less hospital-centric and clinical skills must be developed in a range of settings, consistent with new models of care.

An ageing population is creating an increased demand for health and community services. At the same time, this presents a workforce challenge for the sector, with 46 per cent of the current workforce over the age of 45 years¹⁵ compared with an average of 37 per cent across all industries. As fewer people are entering the workforce and more are leaving it, the job pressures upon remaining workers will increase. This may impact upon the ability of time-poor staff to supervise increasing numbers of students participating in clinical placements, particularly given the already increasing workload. This environment will drive the need for a more efficient system to organise and deliver clinical placements that accommodates both the requirements of the student and the health service.

¹⁵ Australian Jobs 2007, Australian Government, Department of Employment and Workplace Relations, Canberra, ACT, 2007.

4. Functions of a clinical placement agency

The option of establishing a clinical placement agency has been proposed to the department by a range of stakeholders. However, there has not yet been any formal consideration of such a mechanism or how it might be structured.

Streamlining coordination of clinical placements

There appears to be significant allocation of resources and potential duplication of functions undertaken by both teaching institutions and health services to support the current discipline-specific approach to coordinating clinical placements.

A clinical placement agency may assist in promoting a more efficient, streamlined approach to coordinating and allocating clinical placements by:

- receiving requests from training providers for clinical placements and identifying the overall level of demand for clinical placements (including the particular requirements associated with these, in terms of location, service setting, supervision, timing, duration and other relevant issues)
- identifying the clinical placement capacity of health services to meet this demand (and over time, seeking to ensure all available capacity is utilised)
- allocating clinical placements across health services within a designated ‘catchment area’ or cluster
- providing advice to students on available accommodation and other supports
- facilitating the uptake of interdisciplinary learning through clinical placements.

These functions could be underpinned by the department’s IT system, which is currently used to make activity-based payments to health services for allied health clinical placements, and is under further development to take on a greater role (more detail is provided at Appendix 2).

Some clinical placement support functions that span services and disciplines may be amenable to a consolidated approach. For example, establishing a consolidated database of accommodation options available to all students on placement within a geographic cluster may assist in some locations.

Regardless of the final form of a clinical placement agency, staff in both health services and educational institutions would continue to be appropriately involved in organising arrangements for students on clinical placement.

Maximising capacity and facilitating links

At a practical level, establishing a clinical placement agency could maximise use of existing capacity by avoiding situations reported in some services where clinical placements are initially booked by training providers and not subsequently filled by a student, resulting in wasted capacity.

An agency could build capacity through interdisciplinary and cross-service approaches to link services and training providers into initiatives to support innovative approaches regarding the design and delivery of clinical placements, and to facilitate information dissemination between health services, training providers, policymakers and other parties. Consideration of the most effective mechanisms for the agency to facilitate these actions is required.

Fostering innovation and supporting more efficient and effective models of workforce education

Over time, clinical training models will need to evolve in response to the range of drivers previously identified in this paper (see Section 1.2). The department has funded 19 innovation projects over 2006–07 to pilot alternative approaches to the structure, organisation and delivery of clinical placements in Victoria, and to identify potential options for change over the short, medium and long term.¹⁶

These projects aimed to identify more efficient and effective training models, promote interdisciplinary training approaches, expand overall clinical placement capacity, and increase the number of suitable clinical placements to incorporate growth across Victoria. In doing so, the goal was to promote an optimal alignment between training models and service and patient needs, and to identify opportunities for broader implementation across Victoria.

While these projects piloted options for change, there would be benefit in having a mechanism through which rollout of such change could be implemented at a local or regional level. A clinical placement agency could be designed to assume such a role.

Similarly, given that national accrediting bodies often set clinical training standards, a more consolidated approach could also promote discussions with such bodies around how innovations could be progressed within accreditation frameworks. Such an approach would be consistent with themes emerging from the Productivity Commission’s recent Health Workforce Study.

What are your views?

Q1. Describe the functions that you believe a clinical placement agency should undertake, and why. Where possible, provide examples or evidence to support your views.

¹⁶ Further information, including a report on these projects, can be accessed from the following website: www.health.vic.gov.au/workforce/placements

5. Structural options

Regardless of the scope of its functions or coverage, there are various options for how a clinical placement agency could be structured. The following section provides an overview of three options the department has identified, addressing some of the relative benefits and limitations of each option based on the issues discussed in earlier sections of this paper. The three options considered are:

Option 1: Create a new stand-alone structure to manage a single statewide clinical placement agency.

Option 2: Create a number of agencies linked to designated health services.

Option 3: Alternative cluster-based models.

Option 1: Create a new stand-alone structure to manage a single statewide clinical placement agency

Option 1 is to establish a new stand-alone structure with statewide coverage to manage clinical placements. It is recognised that the workload that would be undertaken by a single, statewide agency would be significantly greater than any of the existing statewide processes, particularly if such an agency were to have an interdisciplinary scope. Furthermore, consideration would need to be given as to how rural and regional interests are represented (for example, regional committees could be established). Considering the range of education and training structures that already exist across the state, it would also be important to carefully consider whether the potential benefits of any statewide approach would outweigh the costs (from both a resource and longer term strategic perspective).

Given the desire to avoid duplication, minimise impost on health services and achieve sustainable approaches, the preferred approach to an agency structure would ideally build on an existing scheme or, at a minimum, ensure a close alignment. In considering alternative clustering structures, there is a need to consider the alignment of services, the scope and role of the existing structures, and its alignment to education and training functions. The next two options explore the application of existing clustering arrangements to a clinical placement agency.

Option 2: Create a number of agencies linked to designated health services

Another option for structuring a clinical placement agency is to adopt a model that creates a number of clusters, or consortia, to manage clinical placements for designated health services and teaching institutions. This could build on the lessons learnt from the department's basic physician training (BPT) consortia pilot. The consortia model clusters inner metropolitan, outer metropolitan and rural public hospitals, with each consortium responsible for overseeing delivery and monitoring outcomes of training within its allocated health services. Details of this model are provided in Appendix 3. A consortia model could be applied to health services and training providers within each DHS region or across a cluster of hospitals that span different DHS regions, as in the BPT pilot.

Lessons from the BPT pilot could be applied to a new consortia-type model for clinical placements across all disciplines. This option builds on experience with existing training structures and offers the opportunity to leverage off current investments and build service capacity and relationships between health services.

Option 3: Alternative cluster-based models

Another option involves utilising the area-based catchment-planning framework of PCPs currently being used as part of the *Care in your community* strategy. Such an approach provides a structure to link a broad spectrum of health services including public hospitals, community health services, local government, nursing services and divisions of general practice. PCPs are defined at sub-regional level, are built around local government authorities (LGAs), and fit within whole-of-government regional boundaries (based on department regions). There are 12 metropolitan Melbourne PCPs and 19 rural PCPs.

It is recognised that adhering to the current configuration of 31 catchments may be impractical and thus aggregation of the catchments to form, say, five to six agency clusters incorporating a number of rural and metropolitan catchments within each cluster may be more practical. The final membership of each agency cluster would be subject to negotiation with the sector. Under this model students could be matched to an agency cluster and undertake all their required clinical placements within that cluster. Such an arrangement would ensure that clinical placements could occur across the full spectrum of health settings, within rural and metropolitan settings while also considering the student’s base and travel implications.

A range of other networks/clustering arrangements also exist, including several specifically related to education and training, such as the training clusters established by certain medical specialist training colleges and also the department’s Mental Health Branch. At the same time, other education and training functions, including policy development, are currently undertaken at a statewide level.

It is recognised that, should an alternative model be adopted, there will be a need as part of implementation to ensure that there are appropriate governance structures (and/or other mechanisms) to oversee the clinical placements function and to ensure that relevant stakeholders are appropriately engaged, particularly if an interdisciplinary approach is adopted.

Other options

The department recognises that stakeholders may be able to identify other options for structuring a clinical placement agency, which have not been outlined above. The department encourages interested parties to put forward any alternative options they may have identified, and requests an outline of the strengths and weaknesses of the proposed model.

Preliminary view

On balance, it is the department’s view that there is significant merit in establishing a clinical placement agency, and that this entity should:

- support more effective approaches to the coordination, allocation and delivery of clinical placements, and build capacity to implement innovations in clinical training
- make best use of available resources and be financially sustainable over the medium–long term
- where possible, link to other structures to support more sustainable, integrated approaches to workforce education and training that create strong links to health services
- support interdisciplinary modes of clinical training to effectively prepare students for team-based approaches.

If sufficient support for a clinical placement agency (or agencies) is forthcoming, its final structure will be based on feedback provided through an ongoing consultation process and written submissions from the sector.

What are your views?

Q2. Do you have a preferred model? If so please provide evidence or examples about which model is appropriate to enhance the coordination of clinical placements.

In considering your preferred model, please provide comments regarding the timing and priorities for implementation. For example:

- a) Would it be preferable to implement the clinical placement agency on a statewide basis (including all undergraduate health students)? What are the benefits of such an approach? What are the constraints?
- b) Should the clinical placement agency initially focus on a limited number of health disciplines, with progressive rollout to other professions and settings in the second and subsequent years?
- c) Is there another approach to implementation and timing that you would like to propose?

Q3. Can you propose an alternative option for the structure of a clinical placement agency, other than those already identified? If so, please describe in detail and provide an overview of the strengths and weaknesses of your model. Please ensure your model encompasses a cross-disciplinary approach, and is able to adapt to evolving service models and training needs.

6. Consultation

6.1 Timeframe

Subject to the outcome of consultations on a preferred model, it is envisaged that some elements of a clinical placement agency could be in place for the 2009 academic year. The following provides a broader indication of proposed activities and consultations.

- Issues paper released and circulated, written submissions invited
- Forums held for interested stakeholders
- Department to develop preferred model
- Consultation on preferred model
- Finalisation of model and implementation plan
- Establishment of a clinical placement agency in accordance with the agreed model
- The agency's activities for the 2009 academic year commence

6.2 Consultation processes

This paper identifies a range of issues on which stakeholder views are sought. There will be opportunities for interested parties to comment via:

- participating in information forums
- preparing written submissions
- further consultation on the preferred model.

Written submissions are to address the three questions within this discussion paper (on pages 12 and 15). Stakeholders making written submissions should submit by email to workforce@dhs.vic.gov.au.

For further information please go to www.health.vic.gov.au/workforce/placements or contact:

Steve Kozel: 03 9096 6944

Sally Dennis: 03 9096 7280

If you wish to be kept informed of developments in relation to a clinical placement agency, please email workforce@dhs.vic.gov.au. Those who attend forums and/or make written submissions will automatically be included in any future project updates.

Appendix 1: Overview of the department's *Clinical placements strategy*

PLANNING AND EVIDENCE	Improve data quality and approach	Establish regular, consistent CP data collections
	Promote evidence-based approaches	Map existing CP arrangements across allied health and nursing
	Promote consistent planning processes	Consolidate statewide planning processes
	Align training numbers to clinical placement capacity	Update & refine priorities for additional places (u/grad & VET) annually Develop IT system for statewide application that links into broader planning and allocation processes Consolidate new Commonwealth/State processes for allocation of u/grad growth
CAPACITY BUILDING	Streamline data collection, analysis and reporting	Consult on and pilot clinical placement agency concept
	Support more efficient organisation and allocation of placements	Health service and university template agreement
	Develop tools and resources for statewide application	Clinical placement coordination pilot project in Community Health Services
		Support conduct and dissemination of research
FUNDING	Address funding inequities	Establish activity-based funding models
	Create incentives for innovation in clinical placements (CPs)	Pursue an increase in federal funding for undergraduate clinical placements
	Support health services to meet growth in placements	Consolidate medical cost sharing arrangements between universities and health services and establish new arrangements for nursing and allied health Targeted infrastructure and clinical academic supports
		Establish alternative processes for ongoing Commonwealth/State engagement
RELATIONSHIPS AND GOVERNANCE	Promote Commonwealth/State collaboration on training issues	Participate in national health/education activities and forums
	Promote collaboration and debate on strategic issues for Victoria	Promote cross-sector engagement
	Maintain effective linkages between health and education	Disseminate materials, conduct stakeholder consultations, conduct forums to showcase project outcomes and highlight current and emerging issues
	Increase training capacity	Fund projects piloting innovative approaches such as simulation and competency-based assessments
INNOVATION	Improve efficiency of training	Reform training models and accreditation to meet evolving service and client needs
	Improve effectiveness of training	Establish/expand training in non-acute settings

Appendix 2: Development of the Student/Trainee Reporting Tool

Background

Previously, a range of data related to training and development activities within public hospitals was collected manually from both health services and universities via a range of collection instruments including:

- allied health undergraduate clinical placements data collection
- other undergraduate clinical placements data collection
- public hospital medical census
- early graduate data collections.

This information is used by staff within the Service and Workforce Planning Branch for a range of planning and funding purposes including:

- output-based funding of clinical placements
- validation that performance targets tied to various funding streams have been met
- broader workforce analysis and planning purposes (for example, planning for medical undergraduate and specialist training requirements).

Objective

There is a need to improve both the consistency and quality of these data collections to:

- provide a sounder basis for future allocation of funds and other planning activities
- establish standard reporting generating processes, to promote consistency in data analysis and reporting over time (as this links to subsequent funding decisions)
- facilitate more integrated reporting and planning approaches and ultimately, a more systems-based approach to workforce analysis.

Online data collection

In doing so, the intention has been to establish a system that:

- minimises the administrative burden placed on parties that provide this data
- facilitates rapid analysis and report generation
- has the capacity/flexibility to respond to changes in training models and providers
- utilises data definitions common to other established workforce data collections.

A web-based IT system, the Student/Trainee Reporting Tool, has been developed to streamline collection, storage and analysis of these data collections. This system includes the following features:

- a central database to store all data collected
- a web-based user interface through which teaching institutions and health services can provide relevant data electronically over the internet
- a report generator, that enables ready analysis of data and production of a range of standardised reports.

A recent enhancement to the system includes establishing a voluntary 'clearing house' to match university demands to health service capacity. The system has been implemented and is currently collecting 2007 clinical placement data, and 2008 student placement requests. On an ongoing basis, teaching institutions will provide clinical placements data via the web-based system, which will then be verified by health services, before being 'accepted' by the system.

Appendix 3: Basic physician training consortia

The current consortia model

The current consortia model, which comprises five training consortia, was developed in response to difficulties reported by some health services in filling specialist medical training posts, particularly in rural and regional Victoria. This model has been trialled for doctors undertaking basic physician training (BPT) in Victorian public hospitals. The primary reason for initiating the consortia pilot with this group of doctors was because public hospitals rely heavily on medical registrars in vocational training to deliver their services, and there was a widespread view that the system of allocation of registrars in BPT needed to be made more equitable.

The benefits delivered by the consortia model to date include:

- more equitable distribution of basic physician trainees across Victoria
- more consistency in BPT across health services
- linking metropolitan and rural health services to give a more complete training experience, and to foster greater partnerships between these health services
- better capacity for health services to accommodate workforce planning.

The department is currently evaluating the consortia.

Table 1 provides an overview of this pilot, and Table 2 outlines the health services currently allocated to each consortium.

Table 1: Training consortia – overview of the BPT pilot

All Victorian hospitals with accredited physician training posts have been allocated to one of the training consortia. Each consortium oversees the delivery of training and monitors outcomes within the training sites of that consortium. Each consortium also addresses issues relating to the quality of training offered at each site, and identifies inequities in the distribution of the medical workforce and any mismatches between service needs and workforce supply. Hospitals and health services within each consortium are linked to ensure effective communication and cooperation.

To enable the consortia process to function effectively at a hospital level, a consortium management committee (CMC) has been established for each consortium. Given that each consortium is working on behalf of its constituent hospitals, the CMCs include representatives of all their constituent hospitals, as well as BPT representatives. Each CMC is required to ensure all BPTs are provided with training that meets the Royal Australian College of Physicians (RACP) training requirements, and provides a forum to ensure equity in training and workforce needs of all constituent hospitals, to resolve grievances, and to foster collaboration between training sites.

At the state level, the Statewide Governance Committee (SGC) governs the consortia. Key tasks for the SGC in its oversight of the consortia are to ensure that all consortia have comparable educational standards, to provide an avenue for arbitration and dispute resolution, and critically, to ensure that all consortia comply with consortia governance guidelines.

Table 2: Training consortia used in the BPT pilot

Compass Six	Bayside/Peninsula Consortium	Greater Western Basic Physician Training Consortium	Central North West Consortium	Greater South Eastern Consortium
Barwon Health Geelong Hospital Grace McKellar Centre Central Gippsland Health Service (Sale) Mercy Werribee Hospital St Vincent's Health Melbourne Caritas Christi Hospice St George's Health Service St Vincent's Hospital South West Healthcare (Warrnambool) Western District Health Service (Hamilton)	Bayside Health Caulfield General Medical Centre Sandringham & District Memorial Hospital The Alfred Calvary Health Care Bethlehem Goulburn Valley Health (Shepparton) Mildura Base Hospital Peninsula Health Frankston Hospital Mount Eliza Centre Rosebud Hospital Swan Hill and District Hospital	Ballarat Health Services Ballarat Base Hospital Queen Elizabeth Centre Melbourne Health Royal Melbourne Hospital – Royal Park Campus Royal Melbourne Hospital – City Campus Northeast Health Wangaratta Western Health Sunshine Hospital Western Hospital Williamstown Hospital Wodonga Regional Health Service	Austin Health Austin Hospital Heidelberg Repatriation Hospital Royal Talbot Rehabilitation Centre Bendigo Healthcare Group Bendigo Hospital Anne Caudle Campus Echuca Regional Health Northern Health Broadmeadows Health Service Bundoora Extended Health Care Centre The Northern Hospital Wimmera Health Care Group (Horsham)	Bairnsdale Regional Health Service Eastern Health Angliss Hospital Box Hill Hospital Healesville Hospital Maroondah Hospital Peter James Centre Latrobe Regional Hospital (Traralgon) Southern Health Casey Hospital Dandenong Hospital Kingston Centre Monash Medical Centre – Clayton Campus Monash Medical Centre – Moorabbin Campus West Gippsland Healthcare Group (Warragul)

