CDNM COUNCIL OF DEANS OF NURSING & MIDWIFERY
AUSTRALIA & NEW ZEALAND

Submission in response to the National Health Workforce Taskforce Discussion Paper 'Clinical Placements across Australia: capturing data and understanding demand and capacity' (December 2008)

Submitted by the Council of Deans of Nursing and Midwifery (Australia & New Zealand)

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The Council of Deans of Nursing and Midwifery (Australia and New Zealand) sends this response to the discussion questions in the National Health Workforce Taskforce (NHWT) document: "Clinical placements across Australia: capturing data and understanding demand and capacity."

Section 1- Demographics

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Section 2- General Comments

Preamble
Collecting comprehensive data that accurately reflect the current and future demand for clinical training places and the capacity of the health system to take students must be derived from all the placements being used currently by all tertiary education providers, public and private, urban, rural and remote. We note from the document that the two most populous States discuss clinical placements only in the public health system. This proposed data collection will have limited value if it does not include private hospital providers. Until an accurate audit of current usage is completed there is no baseline from which to begin to make projections about capacity and load.

Section 3- Responses to Discussion Questions

1. **Are there other data elements needing to be captured to map demand?**

The data elements seem appropriate. The range of variables included is certainly all important and necessary. However, mapping capacity and availability does not always give the whole picture and needs to be viewed with caution as it can create a false impression. Places may be available at times that cannot be used, for example, when students are taking examinations; or too early in the theoretical program so that students do not have the requisite knowledge base to attend clinical placement.
More sensitive data that capture projected growth (or reduction) in certain programs will be needed. For example, if there is a net increase in medical undergraduate places (which are invariably all filled) then a 4-6 year pipeline of increased clinical places will be required. This is recurrent for every new annual intake of students. An increased supply of students naturally increases demand for placements.
It is unlikely that increased clinical simulation will reduce the need for clinical placement; simulation should be seen as an adjunct to rather than a replacement of clinical placement.

2. **Can education providers provide the necessary data elements?**

Probably, but as noted compliance is a major problem; we are asked for the same data from multiple sources. It is time consuming and resource intensive to enter these data in the many and various forms and tools. Education providers are not equipped to gather the depth and breadth of data required – it is time consuming, resource intensive, outside their core business and perceived to be of little or no direct benefit to the organization. Clearly, education providers do not have the time or human resources available to gather such data. Greater collaboration between the State/Territory and Commonwealth jurisdictions needs to occur, to avoid duplication.

3. **Would existing data collections provide this information and enable comparisons across the sector?**

Possibly, though current State/Territory collections probably lack the specificity required to enable comparisons to be made.

4. **How can additional capacity be quantified and what specific metrics could be applied?**

Capacity is difficult to quantify, and highly variable; it is not simply a matter of counting numbers. Staff varies in experience and comprises a complex mix of full-time, part-time, contract staff, overseas trained staff and agency staff. Patient load (numerically and in terms of acuity) fluctuates widely also and directly impacts upon the time available to provide clinical education. The use of a variety of types of clinical education involving educators, mentors, preceptors, supervisors adds to this complexity. Funding arrangements for these differ, and also across the various programs. Comparison of the funding for a medical student against that for a nursing or pharmacy student needs to demonstrate equity. Metrics could possibly include evaluation of the impact of the placement upon the workplace and workload of staff, the effectiveness of the placement in meeting the student's educational objectives, and assessment of key risk indicators where students are interacting with and practising skills on patients/clients/residents.

5. **Who can provide this level of data?**

Again, this is time consuming and would need to be independently gathered.

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

Students can have valuable learning experiences in non-traditional health service areas. There is a vast array of potential sites that could offer useful educational opportunities and we need to think much more broadly than we do currently. Capacity needs to be linked to ability to supervise/educate, therefore the full range of models need to be available: one size doesn't fit all in terms of the types, numbers and levels of students being clinically educated. The provision of targeted education courses to fully prepare

preceptors and clinical educators is urgently required. They should be sponsored to attend and remunerated for the students they educate. Increasing the incentives for staff and organizations to take students will increase capacity. We are long past the days of altruism and quid quo pro.

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

Like education providers, they can probably generate the data but lack the time and human resources to do so. Developing a software package will assist this and employing administrative staff to gather the data will be necessary. This may need to be Commonwealth funded.

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

By rigorous development, thorough testing and piloting, and evaluation of the data gathered. It would need to stand up to statistical manipulation, be in a stable and user friendly format, and enable projections to be carried out reliably.

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

Identifying 'best practice' is a first step. No studies currently have identified what constitutes best practice in relation to student clinical placements. Thorough research is required to enable benchmarking to occur. There are many types of benchmarking that apply here, including that pertaining to educational processes, financial/economic benchmarks versus effectiveness, and performance of staff and the organization.

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

Benefits are manifold: such identification enables quality improvement, injects efficiencies into the processes being benchmarked, highlights potential and actual problems, and focuses education providers and clinical 'partners' on complementary rather than disparate goals. Challenges include the applicability of such measures across myriad clinical settings, for all the different levels and types of student programs. Benchmark measures would thus have to be very broad.

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

The collection of yet another lot of data is a problem. More information is required as to the type of tools to be used. The survey in 2007/8 required very detailed information. This was very resource intensive for administrative staff and seemed to repeat other data previously supplied.
Data already gathered must be made available to all stakeholders. There appears to be a lack of feedback regarding the use of the data and thus no perceived benefit in supplying

it. Government agencies must communicate more effectively with each other, with clinical agencies and education providers to ensure that common goals and needs are being met.
Education providers and their clinical partners value the relationships that are developed through student placements. Clinical agencies identify good students and target them as potential employees.

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

A national system for student placements would face the difficulty of the sheer volume and variety of student placement needs. A national system of data collection is essential, using existing systems but centralising them. It must not deal only with public hospitals; several universities rely heavily on private hospitals and agencies to provide student placements. For example Deakin has major partnership arrangements with two very large private hospitals that place hundreds of students each year.

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

There would be little if any support for a national clinical placement management system that interfered with current partnership arrangements and took away from education providers and clinical agencies the ability to negotiate placements. Data collected must be fed back to education providers and clinical agencies and processes put in place that enables the needs of both parties to be met. This must be done collaboratively and not be taken away and done by a third party.

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

This question is ambiguous and thus difficult to answer with any sureness. The notion of ‘compliance’ smacks of heavy handedness and a top down approach which is ultimately disempowering and oppressive, particularly for those that are already in a state of relative power imbalance such as small health services, universities or TAFEs in regional areas, or programs that have less professional power than others. In respect to more reliable data gathering, an incentive would be to fund it externally so it isn’t yet another task for existing staff.

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

Asking for data repetitively, a data collection tool that is not user friendly, poor feedback from the data provided, no clear benefit to the data provider, lack of any real investment in or commitment to bringing about meaningful and sustainable improvement. Collection needs to be funded appropriately and not tied to political cycles.

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

The process must be conducted by an external agency, rather than an extra demand on already overloaded staff.
Data must come back to education providers and clinical agencies to enable them to collaboratively negotiate placements. The data must not become a lever by which to force agencies to take more students.
Strategies to build capacity must be appropriately funded and not increase the workload of already overworked staff.
Clinical simulation must not be seen as a substitution for clinical placement.