Submission

on

Clinical training: governance and organisation

for the

NATIONAL HEALTH WORKFORCE TASKFORCE

PO Box 345W
Ballarat West
Victoria 3350

March 2009
Executive Summary

1. The Australian College of Ambulance Professionals (ACAP) is the national body representing paramedic practitioners engaged in the delivery of out of hospital emergency health care. ACAP has an abiding professional interest in policy matters that affect the delivery of Emergency Medical Services (EMS) and is uniquely positioned to provide insights into the role of EMS in the continuum of health care.

2. In preparing this submission, ACAP has placed a focus on identifying issues of broad policy significance that have an impact on clinical training outcomes.

3. The submission outlines the importance of appropriate recognition of the scope of demand for clinical training placements in determining suitable pathways for training and the funding and other provisions designed to support clinical training.

4. The submission draws attention to the continuing omission of out of hospital EMS as a critical component of health care requiring exceptional clinical interventionist skills and competencies derived from suitable practicum training.

5. The submission notes the deficiencies in the current arrangements for regulation of paramedics and the urgent priority to redress the situation by the inclusion of paramedic practitioners within the COAG scheme for the regulation of health professions.

6. It highlights the anomalous and disconcerting situation where paramedical education and paramedic practice remain virtually unrecognised as an allied health profession by all levels of government.

7. The submission recommends the immediate acknowledgment of out of hospital emergency medical services as a discrete field of allied healthcare and the recognition of paramedicine as an allied health profession with consequential clinical practice needs.

8. The submission makes a number of observations in the form of response statements to various consultation proposals.

For further information, contact:

Mr Les Hotchin
National Secretary
Australian College of Ambulance Professionals
PO Box 345W
Ballarat West
Victoria 3350

Tel: +61 3 5331 9584
Fax: +61 3 5333 2721
Mob: +61 417 336 490
Email: secretary@acap.org.au
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Acknowledgement is made to the staff of Edith Cowan University and other members of the Australian College of Ambulance Professionals for their valuable input and insights in the preparation of this submission.
Australian College of Ambulance Professionals

The Australian College of Ambulance Professionals (ACAP) is an incorporated body representing the professional interests of paramedics engaged in the delivery of out-of-hospital emergency medical care. ACAP is a professional association with an abiding interest in policy matters that affect the quality and effectiveness of Emergency Medical Services (EMS) in Australasia.

ACAP activities encompass programs of professional development, voluntary regulation, publication and other professional activities designed to enhance the standards of EMS and thereby better protect the health and safety of the community.

ACAP philosophy of health care

The primary goals of ACAP are to provide professional guidance and support for members in developing EMS as part of a system that will deliver quality health care to all Australians. To achieve this objective, ACAP believes that health care policy should:

• recognise the benefits of holistic care delivered by health professionals operating in a multidisciplinary environment;
• ensure an equitable health system by providing EMS for all Australians according to need and regardless of race, creed, gender, location or economic circumstances;
• establish funding arrangements at Federal, State and Territory levels that facilitate the delivery of integrated health care services and minimise inefficiencies by optimising the use of available physical and human resources of the private, public, not-for-profit and defence sectors;
• ensure responsiveness and quality of service through community engagement that recognises the role of consumers in the planning and delivery of healthcare;
• provide educational opportunities for the recruitment, training and professional development of EMS practitioners that will ensure a sustainable workforce; and
• provide a national regulatory regime for paramedics and EMS providers that will ensure consistent service standards and public safety, and improve access and equity through facilitating the mobility of the health workforce.

Why is ACAP concerned about clinical training?

ACAP’s interest in clinical training is based on its primary concern for public safety and the need for seamless interaction of paramedics with other health care professionals. EMS delivered by paramedics working independently or through various government agencies and private or charitable organisations has a pervasive impact on the community. Paramedics work from a position of unique responsibility and community trust, and deal with people in their most vulnerable circumstances.

The contribution of paramedics to the wellbeing of Australians should not be understated. The Productivity Commission1 reports that for ambulance service organisations in 2006-07 the number of full time equivalent salaried personnel in the categories of qualified ambulance officers and clinical staff was 6582 and the number of volunteer ambulance operatives was 5265.

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While the number of personnel employed by the major service providers is significant, they tell only part of the story. The figures above do not include the contributions made by the Royal Flying Doctor Service, the private sector, by industrial paramedics or those paramedics who work in the defence force, universities, and other peacekeeping and humanitarian roles funded by the Australian Government and Aid agencies.

Although the infrastructure made available by government-sponsored and private service providers is important in the same way that diagnostic tools and hospitals support other health care practitioners, it is the expertise of paramedics and their clinical interventions that are the mainstay in providing high quality out of hospital emergency health care. To put it bluntly, paramedics must be able to make appropriate clinical decisions and execute complex interventions whenever the need arises.

It is thus axiomatic that emerging practitioners should receive appropriate clinical training and placements that will ensure they can enter the workforce and exercise these very individual skills according to best practice principles.

When considering health care policy, ACAP is gravely concerned by the potential risks to public safety and health workforce productivity arising from the inexplicable omission of paramedicine from the group of occupations commonly referred to as allied health professionals. Along with the policy void created by this omission, is the further concern held because of the absence of an appropriate national system of registration of paramedics.

ACAP is disturbed that paramedic practitioners who administer restricted medications and perform complex clinical interventions have to date fallen outside the scope of any national regulatory system or government recognition as allied health practitioners.

ACAP is strongly of the view that there should be universal and national regulation of paramedics whether operating as full time, fractional time or volunteer practitioners. This coverage should cater not only for practitioners employed by the traditional ambulance service organisations but also for private practitioners and qualified members of the defence force as well as those paramedics working in industrial settings, in Occupational Health and Safety roles and on relief and humanitarian endeavours.

Only a mandatory national scheme would have the independence, objectivity and scope to realise the desired regulatory objectives and sustainability criteria envisaged by the reform agenda for health care in Australia. ACAP therefore will seek the national registration of paramedics under the COAG National Registration and Accreditation Scheme for Health Professions at the earliest possible date.

However, regulatory reform alone will not address the current need for clinical training and clinical placements for paramedics. Faced with the present educational and operational environment and armed with the experience of paramedics’ daily struggles to realise good health care outcomes, ACAP is compelled to draw attention to the issues of paramedical practice recognition and the clinical practice requirements of the profession.

**Out of hospital emergency medical services in Australia**

While emergency medical care in one form or another has existed for many years, EMS as we know it today is a relatively recent development. The benefits of appropriate emergency care in greatly improving patient outcomes has resulted in EMS practices evolving at a rapid pace along with technological advances.

Initially, emergency care was provided by nearly anyone who would take on the task regardless of their training. Often the fire brigade would "rescue" a patient and take them to hospital. Medical practitioners made house calls for cases that EMS now commonly
respond to. Early EMS practitioners did the best they could with limited training and resources. Ambulance vehicles were poorly designed and equipped and typically operated from one, two or three person centres.

Major community EMS providers have evolved from these small local and regional ambulance enterprises to the current large and more coherent state-based organisations operating as government agencies or long term contractors. Despite wholesale changes in practice regimes, the vernacular terminology has remained relatively static with the common use of terms such as “ambulance bearer” still widely applied to EMS personnel.

Indeed, the word *ambulance* is derived from the Latin word *ambulare* meaning to walk or move about - which is a reference to early medical care where patients were moved by lifting or wheeling. It does not properly describe the breadth and depth of modern EMS practices and clinical interventions other than the associated speedy and safe transportation of patients to more intensive care regimes as needed.

Governments have had to cope with rapid changes in technology and clinical practices while at the same time grappling with the hybrid nature of the EMS role and its transition from a largely volunteer-based activity to a more salaried workforce. The intermingling of clinical and transportation roles and the common association of EMS with catastrophic physical events have contributed to a situation of widely variable funding and administrative arrangements. One serious negative consequence is the omission of EMS from many health care planning and policy considerations.

The result is that EMS today is carried out under disparate organisational arrangements instead of forming part of a seamless and equitably-funded health care system².

For example, the charitable order of St John Ambulance is the contracted principal EMS provider in Western Australia and the Northern Territory. In other States, community EMS is the primary responsibility of state agencies which operate under different Ministers and have different funding and cost recovery arrangements. In Queensland, EMS is located within the portfolio of the Minister for Emergency Services rather than Health, as in most other jurisdictions.

Volunteers remain powerful contributors to the overall EMS effort with substantial contributions in all states³ except New South Wales and the Australian Capital Territory. The distribution varies widely, with EMS providers in Western Australia, South Australia and Tasmania relying substantially on volunteers in rural and remote areas. The problems faced by educationalists in those States with a major commitment for regional and remote EMS is reflected in some of the difficulties met with clinical placements for paramedics.

Health care policy must change to better meet community needs by recognising that emergency care often begins well before the hospital or clinic entrance, and that without the expertise of paramedics, the clinical outcomes for many patients would be far worse.

EMS should be funded appropriately as a national commitment to emergency health care and held to account in the same way as for other health care practitioners and service providers by being incorporated in all deliberations on national health care policy.

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³ Emergency Services in Australia and New Zealand:, *Problems and Prospects for Volunteer Ambulance Officers. Report of the Stand Up and Be Counted Project, May 2002* University Department of Rural Health, Tasmania


**Education and training of paramedics**

The evolving role of the paramedic, increasing community expectations and the threat of litigation, have all contributed to increased EMS training requirements. Other drivers for change have been advances in triage and available out of hospital procedures for medical emergencies such as cardiac arrest and asthma attacks.

The widespread introduction of mobile defibrillators, advanced clinical procedures and administration of medications have dictated the introduction of clinical technology that allows paramedics to safely administer a high order of emergency care and patient management strategies. These advances have highlighted the need for greater clinical knowledge, continual professional development and regular validation of competency.

The educational demands to meet the clinical and operational requirements of paramedic practice now go well beyond the application of mechanistic protocols and technical skills. They include studies in anatomy, physiology, pathophysiology, pharmacology and other areas designed to increase the capacity of paramedics to make immediate and independent health care decisions in the field.

Like their counterparts in other allied health professions, paramedics must hold formal qualifications, ranging from a basic qualification through to advanced degree status.

In the past, the employing agencies were tasked with the provision of education and training as well as quality control of services and professional discipline of practitioners. EMS providers in each jurisdiction set their own unique standards (although many features of training were similar).

EMS infrastructure providers generally have supported the introduction of tertiary (university-based) qualifications. Some jurisdictions have formally adopted university programs as the basic entry requirement for a professional paramedic, although others have continued to support nationally consistent VET programs in the face of critical staff shortages.

The result is a complex web of training arrangements and routes to professionalism, with paramedic education currently provided internally and through outsourced agencies, the VET sector and university degree programs.

The university-based programs are growing rapidly and it is likely that they soon will form the only entry route to professional practice at a national level. As these programs develop, the demand for appropriate clinical training and placements likewise will continue to grow.

**Accreditation of paramedical education and training**

Despite wide-ranging educational developments, until recently there has not been any nationally recognised external course accreditation system for paramedic education.

Accreditation (as distinct from regulation) is normally defined as a formal assessment process conducted by an independent and recognised authority to confirm that educational programs meet quality assurance requirements and are responsive to the needs of the community.

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4 Emergency Services in Australia and New Zealand.; Problems and Prospects for Volunteer Ambulance Officers. Report of the Stand Up and Be Counted Project, University of Tasmania, Department of Rural Health May 2002


With EMS course programs now being conducted by institutions in multi-disciplinary formats and across a range of locations and jurisdictions, a robust process of accreditation is needed to ensure consistent and acceptable program standards. Clinical practice requirements form part of this mix.

ACAP sees educational accreditation as an important component of a much more extensive regulatory regime needed to protect the public and ensure the delivery of the health care outcomes envisaged by the guiding principles of the National Health and Hospitals Reform Commission (NHHRC).

Accreditation issues ultimately should be catered for by bringing paramedical practice within the domain of the COAG regulatory scheme for health professionals (see earlier). The nature and appropriateness of clinical practice training are likely to be significant factors in the accreditation process.

Program accreditation and qualification recognition issues also raise concerns about the further COAG agreement to ask Skills Australia to advise on the possible allocation of up to 50,000 additional vocational education and training places for areas of national skills shortage (including vocationally-trained nursing, emergency care and allied health occupations).

Any advice on workforce training must take cognisance of practical workforce developments, the suitability of programs to meet actual workplace needs and the continuing recognition of qualifications. For paramedic and other healthcare students, the system capacity to meet clinical training and placement requirements for the suggested number of student places is likely to be insufficient.

Workforce matters should not be examined in isolation and the long term employability of graduates must be considered in the face of fundamental changes already underway in educational and career pathways for allied health practitioners.

The COAG regulatory proposals for health care professionals in association with other health care inquiries therefore provide a timely opportunity to revisit the whole question of paramedic roles, education, accreditation and regulation. These issues are inextricably linked to the provision of clinical practice needs.

**Overview of discussion paper**

The NHWT Discussion Paper raises a number of issues facing educational institutions and health services that provide clinical placements. It acknowledges the pressures placed on existing service providers by the growing demand for clinical placements as well as the diversity and at times, inconsistent processes involved in clinical placement activities.

In considering likely improvements to clinical placement practices, ACAP has reviewed the potential concerns of stakeholders. These have been identified as primarily comprising the following groups:

- **patient** – the clinical skills development of the attending paramedic must be such as to protect the safety and welfare of the patient;
- **beginning practitioner** – the level of clinical training must be such as to engender confidence in the competent application of various procedures and an appreciation of the limitations of the practitioner’s expertise;
- **students and mentors** – student paramedics must be able to avail themselves of suitable practicum opportunities and embrace the learning and development experiences of clinical placements, while workplace mentors must fulfil a critical role in ensuring positive developmental experiences;
• educational bodies – the educational institutions have an obligation to seek out and identify appropriate clinical training opportunities and placements as part of their moral contract with students in offering a professionally based paramedic course;
• employers, service providers and practitioners – there is a both a moral and practical obligation for health facilities and service providers to contribute towards the professional development of the (various) professional areas to ensure workforce sustainability, quality of service and patient safety;
• government and regulatory agencies – government should facilitate opportunities for appropriate placements by providing additional funding where needed for rural and disadvantaged practice situations, while regulatory agencies must ensure that accreditation and other regulatory functions acknowledge the importance of clinical training for program accreditation and practitioner registration purposes.

With these stakeholder interests in mind, ACAP notes the following general issues arising from the Discussion Paper.

1. There appears to be limited consideration of the quality of clinical education in favour of administrative governance and related processes. ACAP views the quality of clinical supervision, including the role of mentors, as being particularly important. Good outcomes are sought and generally realised, but the negative experiences also bear consideration.

   Based on anecdotal evidence and feedback from students and health complaint investigations, allied health practitioners are probably the more seriously affected demographic. Clinical placements include nursing students registered with agencies that provide short term staff with minimal notice. There are numerous accounts of students with limited clinical experience being used by such agencies as little more than cheap labour with only cursory mentoring support.

   At times health facilities may be so overloaded they cannot give appropriate and mutually beneficial mentoring support and supervision to the placement student. Anecdotal tales abound of bullying, harassment, and general mistreatment, with the result that students can be profoundly affected by the experience and decide to leave the profession. In the case of a formal longer term placement, similar situations occur, including mentors or placement supervisors regaling their charges with horror stories of mistreatment, the imperative chain of command and the health care culture.

   The busy nature of the healthcare professions generally does not foster productive student placement experiences, and in some circumstances students are seen more as a burden than an opportunity to contribute towards their future professional roles.

   Added to these difficulties are the cultural and personal issues often encountered in Australia (including communication, gender, religious, indigenous, rural and remote settings etc.) where overseas trained personnel are required to supervise students.

2. The Discussion Paper is perceived as giving inadequate attention to the quality of the clinical experience and the importance of tailoring clinical placements to meet individual student needs. Among these are the relevance to current course content, alignment of placements close to home, the availability of childcare arrangements or the provision of supplemental financing for high cost regions.
3. The Discussion Paper appears focused on health services in the context of the public hospital sector, and largely ignores the many clinical placements available in other settings – for example, defence, schools, aged care and disability centres, community health centres, private practices and EMS service providers. Clinical education, coordination, and data collection needs to incorporate many different models of healthcare outside the hospital system.

4. ACAP supports the current policy move towards holistic and integrated multi-disciplinary care with expanded career pathways and inter-professional learning opportunities. In that context, clinical placement demands must be balanced across many factors and across the broadest range of settings by taking into account:
   - patient-focused care within suitable safety and quality frameworks;
   - student needs including geographical, financial and family requirements;
   - improved access through enhancing placement capacity;
   - suitably comprehensive contributions from all stakeholders (including all tiers of government, employers, educational providers and professional associations);
   - well-structured placements that offer true workplace mentoring and professional development and training experiences that facilitate communication, team work and learning; and
   - effective supervision and clinical education pathways.

5. The Discussion Paper appears to assume the adequacy and contemporary state of knowledge of facility staff in clinical settings. For students, a deficiency in knowledge and skills of health service staff is unsettling. It detracts materially from the student learning experience that should accompany a placement.

   Negative placement experiences can ultimately lead to workforce shortages as students are discouraged and leave the profession and those areas perceived to hold an inadequate skills base are unable to attract graduates. Such outcomes are a natural consequence of seeking the best (or avoiding the bad). The impacts of perceived competency and negative experiences during student clinical placements should never be discounted. As part of a greater commitment to professional practice there is a need for the clinical workforce itself to be educated and responsive to satisfying placement requirements.

6. Placements in less traditional venues and across a broader range of situations may do much to enhance the ultimate relevancy and skills base of a profession but may involve additional costs. For example, the availability and cost of residential accommodation can prove an impediment to rural placement programs unless special arrangements obtain. One consequence of excess demand (or limited supply) may be preferential treatment in satisfying certain demands e.g. medical student placements, that disadvantages other groups such as allied health students. Additional financial support may be needed above and beyond current Department of Education, Employment and Workplace Relations (DEEWR) commitments.
7. There is always the potential for the availability of practicum placements to have self-fulfilling outcomes on a demographic and regional basis. If regional placements are not available and students must obtain metropolitan-based experience, then there is little incentive for change. This may ultimately lead to fewer rural and remote workforce practitioners and depletion of supervisory expertise in those locations.

ACAP welcomes the Discussion paper’s commitment for review and potential change but believes a national external administrative body is unlikely to result in an increase in students’ capacity to engage in collaborative practice, without at the same time diminishing profession-specific opportunities. For example, the practice needs of an emerging paramedic practitioner are seen to require certain specialist training that is unlikely to be available outside that field of practice.

**Paramedicine and allied health care practitioners**

ACAP draws attention to two fundamental and practical healthcare facts:

- Paramedics are often the first point of contact that an individual ‘in extremis’ need has with the health system and the quality of clinical care exercised in this encounter is a critical factor in enhancing the outcomes; and

- the transfer of paramedical education to the university sector has created and will continue to place a growing demand on the health care system for clinical training and placements.

It is therefore disconcerting that the Discussion Paper has omitted reference to EMS and that the specific clinical practice and competency requirements of paramedical students have not been addressed.

ACAP notes the generic nomination of allied health disciplines which are defined in the paper as audiology; chiropracty; dietetics and nutrition; occupational therapy; optometry; orthoptics; orthotics and prosthetics; hospital pharmacy; physiotherapy; podiatry; psychology; radiography; speech pathology; and social work.

However, given the nature and scope of the clinical functions performed by paramedics, ACAP remains deeply concerned that the roles played by emergency health service practitioners and community paramedics have not been recognised by the NHWT.

While many allied health professions have a part to play in the provision of primary health care, they are generally ill-equipped or trained to carry out the often highly invasive clinical interventions that are an integral part of EMS and for which the paramedic is uniquely qualified.

There is a place for all in the health care team, and paramedics hold the expertise to provide primary community health care through the application of EMS. Greater efforts clearly must be made to achieve a fuller integration and more flexible utilisation of paramedics within the health workforce.

The resolution of an issue often begins with the recognition of the problem, and in this respect, that must begin with a greater awareness of the clinical and primary health care dimensions of the paramedic’s role.

A significant impediment to the recognition of EMS as an integral component of health care might be the historical omission of paramedicine from the list of allied health professions in various Commonwealth Government publications and policy papers under which provision is made for numerous scholarships, educational and clinical support (and in this case, the consideration of clinical placements).
ACAP views the identification of an allied health profession as being unrelated to jurisdictional issues or historical funding and administrative arrangements. The definition of an allied health profession is properly founded on the functional activities of the profession and the associated responsibility for patients according to the following criteria:

- the provision of health care and related clinical services and interventions, other than the disciplines of medicine, nursing and health administration;
- requiring advanced knowledge for which tertiary (or equivalent) qualifications exist and which are essential for admission to a relevant professional body, registration or employment; and
- whose activities involve patient diagnosis/evaluation, treatment and/or primary health care.

ACAP contends that paramedical practice amply satisfies these criteria, and as part of the federal government’s commitment to community healthcare, EMS must be acknowledged as a key element in the provision of seamless and high quality patient care.

ACAP therefore strongly recommends that to avoid continuing distortions in the delivery and assessment of health outcomes, and to support the implementation of long term paramedic workforce arrangements, the NHWT must act without delay to nominate paramedicine as a discrete field of allied health care and use the term paramedic as the designated title for the professionals qualified and working in that field.

Recognising paramedicine as a distinct field of allied health care will give rise to a number of consequential changes in policy coverage and implementation outcomes consistent with those arrangements applying to other allied health professions. These changes might include potential access to educational support and scholarships, specific rural and remote support, clinical placement provisions, and continuing professional development assistance.

**ACAP’s response to the consultation details**

The following responses to the Discussion Paper outline the views of a significant professional group with first-hand experience of health care under a wide range of environmental settings across Australia. Comment is provided on the consultation proposals only where deemed necessary to reinforce a view, nominate a preferred option or offer supplementary viewpoints.

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<th>Q1: What is your experience of clinical training planning, organisation and management?</th>
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**ACAP response**

ACAP has no direct role in this activity at the primary undergraduate course level but is intimately involved in a wide range of clinical training activities as part of its commitment to continuing professional education. ACAP members have a wealth of experience as practitioners and educationalists across all aspects of paramedical education and training. Some members have managed clinical placements for more than 15 years, both in Vocational Education and Training and tertiary education environments.

This collective experience includes:

- providing support to undergraduate and postgraduate clinical placements across all workplace sectors;
- oversight of the request for, and allocation of, clinical placements across the public, private, rural and community sectors; allocation of clinical supervisors to placements; and allocation of students to placements;
- ensuring the integration of placements with theoretical content;
- engagement of clinical supervisors, including consideration of staff student ratios, orientation, University policy and procedures, administration and debriefing;
- investigating ways to increase capacity, building relationships, conducting a needs analysis of stakeholders, communicating and collaborating with other providers, meeting with other training institutions and universities to plan deployment;
- managing ad hoc placement requests and issues (e.g. service closures, staff reductions, student withdrawals etc.);
- evaluation of practicum adequacy for accreditation and registration bodies;
- longitudinal clinical partnership studies; and,
- Negotiating formal agreements and Memoranda of Understanding, and other forms of Service Agreement with operating agencies.

**Q2: Can you identify any other examples of good practice or approaches?**

**ACAP response**

**Collaborative supervision**

A. The engagement or secondment of staff from clinical workplace environments as clinical mentors or supervisors can help ensure that students are taught the policies and procedures of that healthcare facility by an expert in the field. This can provide insights into the facility operations and relevant culture which one hopes will be positive.

B. The ‘university clinic’ operating as a dental hospital or general teaching hospital is another model that increases the capacity for close, one-on-one clinical education. It also can assist teaching and research staff by maintaining patient contact and expertise. Even in those circumstances there is a certain degree of ‘simulation’ and for some professions these arrangements may not hold the immediacy of dealing with ad hoc patient presentations and in responding to unpredictable situations.

**Systems arrangements**

A. The NHS Education for Scotland (NES) Educational Solutions for Workforce Development has been suggested as an example of an agency that provides support to education providers, employers and clinical educators without imposing burdensome operational restrictions. The NES provides both a strategic and operational model with a particular focus on cross-disciplinary and multi-disciplinary strategies.

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7 [http://www.nes.scot.nhs.uk/default.asp]
B. The NHWT proposals appear oriented around a national clinical placement system with the aim of supporting placement activity and providing national and local data on capacity and demand (p. 11). There are some reservations about this approach in the face of evidence that locally managed clinical placement systems have performed well when administered by the agency requiring the placements.

The experience of many health educationalists is that the clinical needs of students and placement settings change on an almost daily basis and the preferred system is one that can be managed locally and is appropriately responsive to local conditions.

Placement coordination

A. Some universities have employed a centralised placement system across disciplines with dedicated administrative staff working in combination with disciplinary clinical coordinators to organise and track clinical placements.

Reported advantages of this approach include rapid response to placement offers and in negotiating placements (academic staff are often not always accessible due to other commitments), establishment of a database that is accessible to all disciplines and more systematic tracking of placements. Disadvantages include the relative loss of personal intra-professional contacts with teaching staff which can often assist in placement negotiations. Close contact between administrative and disciplinary staff is still required in order to match placement offers with specific student needs.

In some locations this type of operation has extended to a wider university consortium which coordinates placements to reduce multiple requests being made of service providers from individual institutions. Each year, a consortium request goes out to all registered service providers, asking them to state what placements they can offer. Six monthly requests have also been trialed because service providers may not be able to anticipate available staffing and capacity potential in advance.

While the consortium system has yielded some placements, the universities report that less than half their placement needs are met by this approach. Among the reasons advanced for this limited success are that:

- the impersonal nature of the requests make them easier to reject; and
- health service providers have established student placement coordinators who act to some degree as gatekeepers to the available opportunities.

B. Clinical education in the past has not typically formed part of the clinician’s job description. Including this role within engagement contracts may prove productive and in South Australia this responsibility is now part of a paramedic’s job description. Speech pathology employs a competency based model of clinical education and has a nationally accepted set of competencies (Competency Based Occupational Standards for Speech Pathology – CBOS) which is used as the basis for all university programs across Australia for accreditation by the national professional body.

In 2006, a new evaluation system COMPASS based on the CBOS, was introduced into the majority of Australian and some New Zealand universities. This ensures that clinical standards are measured across these programs on a nationally adopted basis.
Complementary clinical education and simulation techniques

A. Various forms of simulation have proved productive in the education of paramedics just as flight simulators reduce the time required for pilot training and evaluation. Edith Cowan University has developed the ECU Health Simulation Centre, which in its first 6 months of operation, won the State Award for Innovation and gained external funding as a centre of excellence. Based on experience in the field, and given projected improvements in equipment and student evaluations of simulation and laboratory work, the team leading this Centre believes there is scope for a proportion of simulated clinical hours to be counted towards the total hours of clinical practice.

This is not to suggest that simulated learning experiences should replace the direct exposure to clinical practice, but rather that a mixture of scenario based learning, simulation and direct clinical practice may be appropriate in the preparation of students for professional practice.

Simulation will never be able to replicate the total vocational and clinical environment, and while extremely useful in introducing the student practitioner to the vocational context cannot at this stage reproduce the variety of contextual, clinical and interpersonal variables experienced in the field.

Q3: What are the strengths and weaknesses of the governance models presented in the paper?

Some concern is held about the benefits (or even feasibility) of a central agency attempting to broker clinical placements when there are more fundamental problems of supply capacity and effectiveness. Contrasting with the remoteness of a centralised approach is the experience that local knowledge and professional relationships have been found particularly beneficial in identifying and gaining clinical placements in emerging and innovative program areas and for nascent institutions.

A central administrative agency does not directly address one of the principal issues, which is a dearth of available placements. As an administrative process, it is unlikely to create more placements although it may help to publicise the need and bring about some redistribution of existing supply. It is not clear how a centralised activity might deal with the resolution of differential fee structures should local health services move towards a model of charging more for clinical placements, unless such fees were also part of a unified national approach.

On the surface there may appear to be gains in administrative efficiencies and economies of scale. These benefits are problematical since there remains a need for appropriate communication and support in conjunction with the course content in the planning, coordination and supervision of clinical practice at the workplace level.

Localised administrative systems have demonstrated the benefits of close links between the administrative and clinical staff on both sides. Achieving adequate communication under a centralised system would seem improbable, in which case local needs would still need to be fulfilled, thereby limiting any potential savings.

Rather than facilitating relationships between education providers and health services, a centralised approach could have a negative impact by distancing health services from education providers. Care would need to be taken to avoid such an outcome.
Further issues are foreseen in the case of multi-stream and interdisciplinary programs and from combined professional streams where the overall training requirements are substantially mandated by professional and accreditation bodies.

Centralisation may prove inflexible and unresponsive to the needs of individual students and the exigencies of health systems. Rigid rule-based systems do not easily accommodate the complexity of health and education systems.

Issues of equity and access may arise, with the prospect of better endowed universities squeezing out smaller institutions under certain delivery scenarios, thereby reducing workforce diversity and access to disadvantaged groups.

The Discussion Paper does not outline the relationship between a centralised placements body and the implementation of the Intergovernmental Agreement on health workforce with the creation of a single national registration and accreditation system for health professions.

A move towards centralised models for both clinical governance and registration and accreditation suggests the need for a measure of alignment between these bodies and that both agencies would need to include all health professions whilst making allowances for disciplinary variations.

Paramedics and other health professions not among the health professions to be covered by the initial COAG scheme, would need to admitted to a national registration and accreditation body to gain equitable access to clinical training resources and support.

In summary, while acknowledging that the concept of a centralised placements system holds many attractions, the proposal has a number of practical issues to be resolved.

Central allocation model:

**Potential Strengths:**

- May facilitate cross-jurisdictional (interstate) placements;
- May reduce some of the present administrative load on education providers;
- May provide the most equitable outcome for education providers on an allocation basis;
- May open up new and broader placement opportunities for some institutions;
- May improve the supply of places;
- May facilitate the negotiation of offshore placement opportunities.
- Presents a single point of contact for placement providers making it easier for followup and system changes.

**Potential Weaknesses:**

- Loss of local control may reduce the scope for innovation;
- May diminish linkage benefits between the education and clinical sites;
- Existing relationships and partnerships may be lost for some institutions;
- External allocation may increase the difficulty of integrated course planning;
- May be unresponsive to the needs of accrediting bodies;
Does not address the fundamental issue of supply and demand which may not respond to funding of placements because of other structural difficulties such as inadequate staffing, supervision and appropriate patient loads;

May result in preferential allocations favouring certain professions;

May not have the flexibility to accommodate last minute changes in placement arrangements;

May diminish the incentive for local educational providers to seek out and identify lesser known or less visible placement opportunities;

Under the Discussion paper’s definition of allied health professions, would directly disadvantage paramedical education providers, students and employers. Nine universities in Australia currently offer undergraduate paramedic programs that feed into the public, private and defence workforce and which require suitable clinical training.

Brokerage model:

**Potential Strengths:**

- May assist in identifying placement capacity in both existing and non-traditional areas (this capability should also exist in a central allocation model);
- May create a higher level of awareness and more equitable marketplace for all programs and education providers;
- May facilitate the management of larger regional or system placements through greater capacity, understanding, influence and size of operations;
- Tailored rural, regional and remote brokerage models may enable better use of small regional centres and facilities.

**Potential Weaknesses:**

- Few discernable benefits beyond the existing arrangements between education providers and health providers since it does not allocate places or provide the necessary on-going support – in addition to identifying capacity (which is good) a seamless placement capacity is needed to enhance the system;
- Does not fully address the issues of supply and demand. Even if all placement sites are ‘brokered’ it is not clear how that would overcome the perceived (and projected) needs. The Discussion Paper suggests that the broker will be responsible only for the allocation of funds “ … to ensure training needs matched workforce needs”. No detail is provided as to the source of funds or whether the service will extend beyond the mechanical distribution of funds;
- The proposal may be less responsive to individual student needs;
- There is a perceived potential for partiality in placements and strong safeguards would be required to ensure any broker was totally unbiased in their placement recommendations.
Tendering model:

**Potential Strengths:**
- Provides a formal and well-understood approach to placement governance and funding;
- Enables the entry of new education programs alongside established programs during any cycle of negotiation;
- May suit major hospitals and larger or cohesive area health services for certain placement groups such as nursing and medicine.

**Potential Weaknesses:**
- May not suit placements with smaller service providers (including private practices) who most probably would not engage with a tendering model;
- Provides no incentive for facility engagement unless the funding is such that it encourages the creation of additional placement capacity;
- May disadvantage certain education providers and groups on the basis that bidding will be determined by financial capacity rather than merit or need;
- May be inflexible and may prove infeasible to match the numbers of clinical places required in a semester to submit for tender. Uncertainty arises from variable enrolment numbers, unknown repeat placements or additional placements required in any clinical rotation. The use of a special form of ‘term’ or ‘supply’ form of tender is most likely to be required;
- Will require a learning curve and additional work by institutions for personnel unaccustomed to tendering processes;
- While potentially feasible for well established programs, a tender approach may disadvantage emerging and rapidly growing areas such as paramedicine because the clinical practice requirements are unable to be determined with any certainty a long time in advance of delivery.

Facilitative model:

**Potential Strengths:**
- May provide a central source or repository of best practice guidance;
- May contribute towards a more comprehensive inter-sectoral approach to clinical training, and expand the focus on the clinical needs of the tertiary health sector;
- May facilitate the dissemination of best practice principles throughout the workforce and service providers;
- May encourage inter-professional health education research.

**Potential Weaknesses:**
- Has no direct involvement with the allocation and coordination of clinical placements and appears only to provide a framework or set of principles in which health and education providers should operate. Such principles arguably should be developed and implemented regardless of which model is adopted;
• Depending on the level of satisfaction with current placement arrangements, there is little incentive for stakeholders to participate;
• Offers few new or innovative approaches (largely disseminates existing data).

**Q4: Is there another model for clinical education governance other than those already identified? If so, please describe and provide an overview of its strengths and weaknesses. Please ensure it encompasses a cross disciplinary approach and is able to adapt to evolving service models and training needs.**

There are many models for optimizing the allocation of scarce resources and clinical placements are by no means unique. Whether there ever will be sufficient supply to satisfy the demand is a moot point, but ACAP believes developing practitioner competency and public safety demand that every reasonable effort be made to increase the number of placements offered by clinical facilities. These should be accompanied by appropriate mentoring and supervision of students during placement.

The number of available places is controlled essentially by factors external to the educational bodies, such as availability of clinical facilities and practitioner willingness to engage and contribute to the educational and development process.

Any measures that may foster that commitment would be advantageous, such as mechanisms to reduce clinical workload and staff patient ratios so that clinical facilities feel sufficiently supported and confident to receive students.

Additionally the NHWT could identify ways in which the health workforce could receive education and support about mentoring roles that will improve the level of student learning and cultural adjustment to on-going workplace activities and stresses.

The Discussion Paper draws considerable attention to situations where education providers pay health facilities to secure placements. This ‘fee for service’ culture may be inescapable in the present context, but is seen to be contrary to the objectives of collegiate responsibility that should be endemic within professional practice.

While an agency may directly reimburse health facilities for certain elements of a placement contract, this should be on the basis of providing an incentive or cost-neutral contribution rather than constitute an income generating activity.

An idealized system would be one that in some way combined the benefits of the various proposed models. It might draw the leadership and best practice elements from the facilitative model, the identification and matching of placements and health provider capacity from the brokerage paradigm and the allocation of placements and administrative capacity from a centralised allocation process.

This hybrid model has been described as a hub and spoke model, with the ‘hub’ responsible for governance, policy and evaluation activities, and reporting to COAG. The ‘spokes’ would be based at State/Territory levels and would be responsible for localised or regional operations including publicity, training, local research, tendering, and relationship building with significant stakeholders.
Among the potential benefits of this model would be the retention of flexibility for each jurisdiction to adopt a variety of approaches including

- partnerships between health facilities and educational facilities;
- linked networks;
- formal agreements to manage the allocation of placements depending on enrolled numbers.

The localised nature of this model should facilitate the appropriate distribution of placements that is sensitive to regional issues by acknowledging the need for increased financial support to help students with placements in regional, rural and remote areas in addition to the existing scholarship-based schemes.

Different health disciplines and clinical environments have different operational modes, and the placement process should address the employment modes peculiar to the particular discipline. For example, most allied health services are offered 5 days per week whereas paramedics operate on a 24/7 call-out basis. The reported shortage of midwifery clinical placements may stem from similar patterns of work.

Q5: What are your thoughts on how the new agency could best support clinical placement management?

A suitably structured agency could assist in workforce planning (such as mapping future health workforce requirements). The agency might also link with DEEWR and education providers to match funding to educational outputs and work with healthcare providers to balance clinical placements with student requirements as well as setting governance arrangements and standards.

Any proposed new agency must develop a framework that can accommodate flexible educational pathways and transferability together with responsiveness to the realities of student life and institutional changes. It must have the capacity to facilitate clinical placements rather than attempt to micro-manage them.

Some specific strategies might include:

- identification of needs and advocacy for sufficient resources and facility design that will support the clinical education of students in addition to meeting immediate patient care. If a well-trained workforce is to be realised, hospital and clinic design should cater for educational and student needs within the clinical setting and provide spaces for supervisors and visiting university staff for staff development, tutoring and assessment purposes.

- provision of infrastructure support such as on-site accommodation and travel allowances to enable access to clinical placement opportunities particularly in rural and remote locations. These resources should be shared across all health disciplines.

- engagement with professional associations and accreditation bodies (and ultimately the national registration and accreditation system) to ensure realistic expectations for clinical educational opportunities that reflect practical workforce and employment situations.

- Co-operative planning of placements that will foster interdisciplinary clinical education and promote effective teamwork.
- Awareness training for the agency and its personnel to ensure they are sensitive to the needs of all health related disciplines. Given the multi-disciplinary demands it is important that different disciplines are represented within the agency. Affirmative action may be needed for allied health clinical placements (such as paramedicine) since they currently are excluded or overshadowed by nursing and medical clinical placement issues.
- Provide a clearing house for information, consultation, policy and practice development.
- Ensure a visible local presence within each jurisdiction.
- Arrange the collation of data on placement allocations to clarify the current situation in terms of quantity, quality and equity of placements
- Develop multi-disciplinary and cross-institutional placements coordinated through the new agency.

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<th>Q6:  Are there other opportunities to improve the governance and organisation of clinical education in Australia?</th>
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The involvement of consumers (patients) and the various professional and regulatory bodies from the health and educational sectors should be an integral part of the role of an agency established for clinical training governance and organisation.

Greater consultation with stakeholders should be initiated and maintained at the Commonwealth Government level. While numerous seminars and meetings have been convened across a number of health disciplines to discuss clinical placements, it is notable that on a national scale, linkages with some disciplines (e.g. paramedicine) are rarely if ever undertaken, despite the vital healthcare role of their practitioners.

The proposed hub and spoke model may improve the organisation of clinical education and appears consistent with the structure envisaged for the national registration and accreditation agency. The analogy may be extended to a structure where communication is also fostered between the various jurisdictional satellite operations to meet particular needs e.g. remote area support.

Discussion between universities and service providers should be encouraged and not left to the universities to initiate. Professional associations also may play a part in facilitating such discussions through advocacy of the professional responsibility to support clinical training needs. Moreover, the federal and state governments should provide leadership by offering placements where feasible.

Clinical placement of overseas students who are likely to return to their home country needs further consideration. Health facilities tend to resist providing clinical placements where there are few demonstrable returns in either a monetary or longer term professional context through adding to the intellectual capacity of the health system. Not surprisingly, they are reluctant to offer placements on the same basis to overseas students as for local (Australian) students.
Additional comments

While this submission has addressed several awareness, governance and structural issues surrounding clinical placements, ACAP stresses that the quality of mentoring and supervision of placement students remains a key factor at all times.

The difficulties faced in providing appropriately prepared and qualified supervision for students in clinical areas are acknowledged, and careful consideration is needed to ensure improved performance through various initiatives within the on-going safety and quality agenda.

Glossary

The following terms are used in this submission.

- **ACAP** Australian College of Ambulance Professionals
- **ADF** Australian Defence Force
- **AHMAC** Australian Health Ministers’ Advisory Council
- **AHP** Allied Health Professional
- **CAP** Certified Ambulance Professional
- **COAG** Council of Australian Governments
- **DEEWR** Department of Education, Employment and Workplace Relations
- **EMS** Emergency Medical Services
- **NHHRC** National Health and Hospitals Reform Commission
- **NHWT** National Health Workforce Taskforce
- **Paramedic** An allied health professional whose education, training and skills enable them to provide a range of out of hospital emergency procedures and clinical interventions