Untapped capacity for clinical placements in the Riverina ICTN:
Does it exist, where is it, and can it be used?

Project Final Report
May 2013

‘...the issue is about growing the pie, okay? ...if people can work together we’ll grow the pie, grow the placements, and get better relationships with the providers, which will suit us all.’
- Education Provider

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Acknowledgement

The project team would very much like to thank all the people who contributed to this project in their own ways. The enormous generosity of spirit, wisdom, expertise, support and encouragement made this meaningful and important work a joy to be involved in. We appreciate the time you made in your busy lives to engage in being part of the solution. We trust it will assist you to move forward with more direction and clarity.

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Abbreviations and Glossary

AH  Allied Health

AIN  Assistant in Nursing

AISR  Australian Institute of Social Research

CEC  Clinical Education Coordinator

CLEEF  Clinical Learning Environments Evaluation Framework

Clinical Placements
Clinical Placements provide opportunities in a relevant professional setting for the education and training of health sector students for the purposes of: integrating theory into practice; familiarising the student(s) with the practice environment; and, building the knowledge, skills, and attributes essential for professional practice, as identified by the education provider and/or external accrediting/licensing body. During clinical placements the provision of safe, high quality patient care is always the primary consideration. It is recognised that a clinical placement may be conducted in any number of locations, including non-healthcare settings for some allied health professions, and that the setting and/or location of a placement will necessarily vary both within and across professions (Health Workforce Australia, 2011c).

Clinical supervisor/facilitator and clinical supervision/facilitation
A clinical supervisor or facilitator is an appropriately qualified and recognised professional who guides students’ education and training during clinical placements. The clinical supervisor or facilitator’s role may encompass educational, support and managerial functions. Clinical supervisors provide clinical supervision or facilitation to a student/s through providing oversight, either directly or indirectly, as the student/s engage in the professional procedures and/or processes. Clinical supervision is completed within a clinical placement for the purpose of guiding, providing feedback, and assessing personal, professional, and educational development in the context of each student’s experience of providing safe, appropriate, and high quality patient care (Health Workforce Australia, 2011c).

CSU  Charles Sturt University

DEU  Dedicated Education Unit

Disciplines included in the scope of this project are those professional-entry courses nominated by Health Workforce Australia (HWA) plus Aged Care, Enrolled Nurse, Allied Health Assistant, Health Services Assistance and Dental Assisting
ICTNs have been established in NSW to facilitate a collaborative cross-sector and inter-professional approach to clinical training at a local level to enable quality improvement and build clinical training capacity in NSW. ICTNs provide a forum for strategic planning and dialogue between education providers and health service providers to build capacity and foster excellence in clinical placements for health professionals in NSW. The Riverina ICTN boundaries are aligned with the Murrumbidgee Local Health District.
Rural The broad and inclusive term “rural” has been adopted for use in this report to refer to all locations outside metropolitan centres.
Executive Summary

Introduction
The project was instigated by the Riverina Interdisciplinary Clinical Training Network (ICTN), one of eight Networks across NSW. The geographic area of the Riverina ICTN corresponds with the boundaries of the Murrumbidgee Local Health District in the central south of New South Wales (NSW), incorporating 29 Local Government Areas. The Riverina ICTN provides leadership and direction for clinical training and acts as forum for planning and dialogue between education and health service providers. Through this project, the Riverina ICTN aimed to test an assumption that untapped capacity existed in settings not traditionally used for clinical placements. The purpose of this work was to lay the foundation to build further capacity for undergraduate clinical placements in the Riverina ICTN through expanding the scope of facilities, opportunities, and models.

Rationale
Australia is facing a significant shortfall in the health workforce due to retirement and attrition. Larger proportions of the health workforce are now in older age groups and are, on average, ageing faster than the non-health workforce. Difficulties in recruitment of a broad range of health professions have been identified and in the same time there has been an increasing demand for health care associated with an ageing population, changing patterns of disease and consumer expectations. Shortages of health professional staff are even more pronounced in rural Australia. In response to health workforce shortages, there has been an expansion in programs of education of health professionals in tertiary institutions. However, access to appropriate clinical placements has been identified as a key barrier to growth in student numbers in health professional training programs.

Clinical placements are an essential aspect of clinical education and vital in preparing students for clinical work upon graduation. Clinical placement requirements vary in length and type across disciplines and year levels and each profession has its own minimum compulsory requirements. The provision of good quality clinical placements is very complex and may be challenging to achieve. Workforce shortages will exacerbate difficulties in providing sufficient well-trained clinical supervisors.

Methods
The project sought to achieve a deep understanding of the issues through semi-structured interviews with a broad range of key stakeholders, locality-based case studies, survey methods and a review of the published and grey literature. A total of 63 people (42 health service professionals and 21 education provider professionals) were involved in 47 interviews. Interviewees included members of the Riverina ICTN Advisory Committee, representatives from Aboriginal Health Services, and Medicare Locals plus staff of health and education providers involved, or potentially involved, in clinical placements. In keeping with the exploratory nature of the project, the team explored prospects as these arose and as such, some interviews were opportunistic.
Locality-based case studies were undertaken in the communities of Berrigan and Narrandera and explored barriers and enablers to clinical placements as well as other community based supports. A selected review of the published and grey literature was undertaken using the following databases: EBSCOhost (Health), ProQuest, and CINAHL Plus with Full-Text. In addition, the Google and Google Scholar search engines were searched using the key terms (and combinations of these terms): clinical placement, innovative model, clinical school, partnership, allied health, nursing, and rural.

Qualitative data was analysed using a thematic analysis process.

Two surveys, one for education providers seeking information on barriers/challenges and enablers/solutions to clinical placements and a similar one for health service providers with an additional section on motivating factors, were made available through the web-based survey tool, SurveyMonkey©. A total of 46 quantitative questionnaires were completed. Response rates of questionnaire completion were 76% for health service professionals (n=34) and 48% for education provider professionals (n=12). Quantitative data was analysed using descriptive statistics.

Findings

The project findings grouped under the headings of limits, enablers and threats are summarised below.

Limits:
- Although there is untapped capacity in the Riverina ICTN, it is limited.
- Providing clinical supervision increases the workload for health staff who must manage competing priorities.
- Some clinicians are not ready, willing or suitable to provide supervision.
- Because of specific circumstances, some practice contexts limit the number of placements that can be offered and accepted.

Enabling factors:
- Good relationships, effective communication and collaboration are vital. Specific actions include enhanced input, support and feedback from education providers to health services.
- Improving efficiency in the current system.
- Creation of a culture of learning in practice settings.
- Utilisation of new and different sites and innovative placement and supervision models.
- Providing education and support for clinical supervisors.
- Reframing supervisors’ concepts of how placements can be structured and how they perceive students.
- Identification and utilisation of motivating factors for taking students.
- Recognising the opportunities and challenges in using the private system for placements.
- Incentives for students to go to rural areas.
- Shifting student perceptions of expanded placements.

Threats:
- Poor quality placements.
- Poor communication.
- Having to adhere to rigid regulations about how supervision is delivered.
• Charging fees for clinical placements.
• Lack of clinical supervisors.
• The process of allocating placements lacks transparency and there is a lack of forward planning.
• Lack of time and energy for innovation and problem solving.
• Prejudice and misplaced desire for only some types of placements.
• Poor organisational culture.

Exemplars of innovative and expanded capacity approaches:
The following innovative models and projects were identified for specific mention:
• Specialist Integrated Community Engagement (SpICE)
• The Whole-of-System Student Clinical Placements
• Moira Health Services Interprofessional Clinical Coordination Project
• Clinical Placements in Residential Aged Care: A Scoping Study
• Rural Model Dedicated Education Unit: A Partnership between College and Hospital
• Gribble Rosenwax Advanced Clinical Education (GRACE) Program
• The Clinical Learning Environments Evaluation Framework (CLEEF)

Case Studies
Berrigan and Narrandera case studies identified the potential of using the clinical placement capacity of small communities if barriers can be addressed. The importance of collaboration between health service providers, the contribution of other agencies, the importance of community support and the need to tailor solutions and systems to the specific community were findings from the case studies.

Utilisation of aged care facilities
The aged care sector has amongst the most serious current and projected health workforce shortages. Increasing demand due to an ageing population and a changing disease profile are contributing factors. In addition, there is a negative view towards aged care as a clinical placement or employment option. Data suggests that aged care settings are underutilised as clinical placements in the Riverina ICTN. The Teaching Nursing Home model has been successfully implemented in a number of countries including Australia, and provides the basis for linking spheres of clinical education and training, clinical care and research.

Formal partnership approach to clinical placements
Formal partnerships and clinical school approaches provide a level of certainty for both health services and education providers about the number and timing of placements as well as transparency regarding resourcing. Clinical school models generally promote centralisation and favour larger sites and may not meet the needs of smaller sites.

Opportunities for Action
The opportunities for action that are detailed in this section have been developed specifically for the Riverina area and for the health service staff and education providers who participate in placements in this area. Our ideas are framed as opportunities rather than as recommendations to highlight that there are many possible solutions to the complex problem of increasing placement capacity. Some ideas may be easily implemented and easily achievable; some suggestions require only small changes
by one individual whereas others may require the concerted effort of many contributors over a longer period of time. The opportunities we present here are clustered as opportunities at the macro-level, opportunities at the meso-level, and opportunities at the micro-level. We acknowledge that human and financial resources are required to achieve many of these proposed actions.

The macro-level opportunities are:
1. Fostering relationships, good communication, and collaborative working;
2. Being and becoming learning workplaces;
3. Taking a whole-of-community approach to problem-solving and innovation;
4. Sanctioning time for ongoing review, problem-solving, improvement, and creative development of placements;
5. Working with professional organisations to lobby for increased creativity, flexibility, and reform in conceptualising how placements can and should be structured.

The meso-level opportunities are:
1. Using new and different sites and areas of practice to source placements;
2. Experimenting with innovative models of supervision.

Micro-level opportunities are chiefly opportunities for improving efficiency within current systems of placements. These opportunities are:
1. Increasing transparency in the process of offering, allocating, and accepting placements;
2. Undertaking more collaborative planning of placements across a longer time frame;
3. Ensuring all placement experiences are high quality;
4. Providing education and support for supervisors;
5. The effective use of payments for placements that directly support and build clinical training capacity;
6. Reframing students’ and academics’ perspectives about placements that are considered to be uninteresting or unpopular;
7. Providing support for students to attend rural placements;
8. Reframing supervisors’ ideas about how placements can be structured.

Although these opportunities have been displayed as lists of activities, the items detailed do not really occur in isolation and therefore when choosing an opportunity to action it may be that change to more than one area is affected. These ideas are presented in a linear way for ease of explaining them and to focus actions that may arise as a consequence of this report. We recognise that in reality the implementation of these solutions is likely to be much more inter-dependent.

Conclusion

The project identified untapped and unused capacity within Riverina ICTN across the broad range of health services and much goodwill of interviewees towards being part of clinical placement solutions.

Identifying this additional capacity is only part of the solution; expanded capacity is available only if the systems are right. The clinical placement system is highly variable and complex, the challenges are significant and the current constraints and issues strongly influence the ability to expand clinical
placements. Systems, resources and quality must be adequate before expanding clinical placements to meet increasing demand.

Consideration and implementation of a range of the opportunities for action recommended in this final report will enhance enablers and minimise threats, increasing clinical placement capacity in the Riverina ICTN, and contributing to a sustainable rural health workforce for the future.
Introduction

Effective clinical training of health professional students is essential to meet health workforce needs and challenges to the health system over the coming decades. The Riverina Interdisciplinary Clinical Training Network (ICTN), one of eight Networks across NSW, provides leadership and direction for clinical training and acts as forum for planning and dialogue between education providers and health service providers.

Through this project, the Riverina ICTN aimed to test an assumption that untapped capacity existed in settings not traditionally used for clinical placements. The purpose of this work was to lay the foundation to build further capacity for undergraduate clinical placements in the Riverina ICTN through expanding the scope of facilities, opportunities, and models. The settings where enhanced placement capacity appeared possible included small rural health services, primary care, aged care, mental health services and the private sector. These settings face significant challenges especially around resources and infrastructure to support clinical placements. In addition, the inefficiencies and deficiencies in the current clinical placement system are constraints to the expansion into untapped or underutilised sites. A short statement made by an interview participant early in the project referring to the current clinical placement system came to define these challenges:

*It's almost like it's [a] bit broken... EP6*

The project sought to achieve a deep understanding of the issues through interviews with a broad range of key stakeholders, locality-based case studies, survey methods and the literature. The approach created rich, contextual and locally relevant information and allowed the identification of limits, enablers, threats and exemplars specific to this rural setting. Finally, the project describes opportunities for action for the Riverina ICTN to consider.
Research design and methodology

The scope of this project was both broad and complex. Overall, a collaborative action learning approach was used as the overarching framework for the project. The project team sought to actively involve and consult with Riverina ICTN members, the project’s reference group (known as the “Brains Trust”) and key stakeholders, who were health service managers and academic staff in tertiary institutions that sought to place students in the Riverina ICTN. As much as possible these key personnel were included in processes of reflection, discussion, and problem solving. As is the case for action learning, sharing feedback and discussion with stakeholders served to increase dialogue between all parties, to foster relationships, and to spark innovative ideas.

Mixed methods were used for data collection and analysis. Qualitative data was collected using semi-structured interviews, reviewing selected published and grey literature, and via locality-based case studies. This data was analysed thematically and as two case study presentations. Quantitative data was collected via two surveys; this data was analysed using descriptive statistics.

Qualitative data: semi-structured interviews

Participant recruitment

The Riverina ICTN requested that the project team consult widely with key health service and education providers. Specifically, this included as many members of the Riverina ICTN Advisory Committee as possible, Aboriginal Health Services, and Medicare Locals plus staff of health and education providers involved, or potentially involved, in clinical placements. Accordingly, all members of the Riverina ICTN advisory committee were approached for interview and encouraged to complete the online surveys. Interviews were achieved with all members or their nominated representative apart from one health service member who completed the online survey only. The project Brains Trust assisted in identifying other health service and education provider representatives for interview. In keeping with the exploratory nature of the project, the Riverina ICTN requested that the team explore prospects as these arose and as such, some interviews were opportunistic. For example, the finding that the aged care sector appears to be underutilised for clinical placements in the Riverina ICTN led to further interviews and exploration of this issue. In addition, interviews were conducted with a range of service providers and local organisations during the case studies.
**Data collection**
Interviews were conducted face-to-face and by telephone. The list of topics explored during the semi-structured interviews is available in Appendices 2 and 3. Not all topics were discussed in each interview and other issues may have been discussed also.

Prior to the interview, participants were provided with a letter of introduction, definitions and scope which informed the work, and the project information sheet. The aims of the project were also briefly outlined. Participants gave their consent to be interviewed and the interview audio-recorded. Participants were informed that the information they provided would be treated as confidential and would be presented in an aggregated and/or de-identified form.

**Data analysis**
A total of 63 people (42 health service professionals and 21 education provider professionals) were involved in 47 interviews, and an additional 12 people were approached for an interview but did not participate (7 from health services, 5 from education providers). Of the 47 interviews, 24 were conducted face-to-face and 23 by telephone. A further 8 health service professionals and 8 education provider professionals were consulted for input to the project.

Approximately half of the health service interviews (n=21) represented individuals from the public sector, with 17 from the private sector and four from other areas such as local government, community services and tourism. Interviewees from health services were mostly managers, team leaders, Chief Executive Officers (CEOs) or directors (Table 1). This poses a risk for potential bias in responses favouring experiences of those in high-level positions.

**Table 1: Interviewee roles within organisation**

<table>
<thead>
<tr>
<th>Interviewee roles (multiple responses allowed)</th>
<th>Health service interviewees</th>
<th>Education provider interviewees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager/Team Leader</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Head of Faculty/School/Department or above</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Educator</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Clinical Placement/Clinical Education Coordinator</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>CEO/Director</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Clinician</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Unit Coordinator/Team Leader</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>HR/Training</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Course Administrator</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Course Convenor</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>5</td>
</tr>
</tbody>
</table>

Education provider interviews predominantly represented Universities (16 of 21 interviewees), with four people interviewed from the Vocational Education and Training (VET) sector. Interviewees from education providers were mostly a head of faculty, school or department; or an educator or clinical education coordinator (Table 1).
The analysis of the transcripts broadly followed the process of thematic analysis described by Green et al (Green et al., 2007). There were four steps in this process: data immersion; data coding; creating categories; and identifying themes. The project team immersed themselves in the data by engaging in the interview process. Reading of interview transcripts commenced as soon as the transcript was available thus allowing team members to become familiar with the data and to use this to inform their discussions in future interviews.

The team members analysed the transcripts and developed codes for issues that were identified. Next, the codes were organised into categories, and finally into themes. The process of analysis did not occur in a linear progression, but rather team members constantly assessed and discussed new information as it became available. Each new piece of information was compared to the existing data analysis and was incorporated either into existing categories and themes or when appropriate, new categories and themes were developed. In addition, emerging categories and themes were discussed with the Brain’s Trust, thus ideas were formed and tested during these discussions. Although the transcripts of the semi-structured interviews were the primary source of data for the thematic analysis, the results of the surveys and published and grey literature were also used to inform concept development and data analysis.

Setting the scene: The Riverina ICTN

The geographic area of the Riverina ICTN corresponds with the boundaries of the Murrumbidgee Local Health District (MLHD) which covers 125,561 km² in the central south of New South Wales (NSW), incorporating 29 Local Government Areas (LGAs). Most of Riverina ICTN is considered inner regional or outer regional with only the north western LGA of Hay classified as remote (Murrumbidgee Local Health District, 2012).

The latest population estimate for the area covered by the Riverina ICTN is 277,393 (Australian Bureau of Statistics, 2011a). The district has a slower rate of growth compared to NSW overall (3.2% versus 10.1%), with the population estimated to grow to 250,437 by 2036. The majority of growth is predicted to occur in larger centres such as Wagga Wagga and Griffith, with towns such as Corowa and Young experiencing moderate growth; and a decrease in populations of smaller towns such as Jerilderie, Conargo, and Urana (NSW Health Department of Planning & Statewide Services Development Branch, 2009).

The aged population (people 75 years and older) is estimated to increase to 13% of the total population in 2031, whereas for NSW the estimated aged population is 10%. Life expectancy for a person born between 2003 and 2007 in MLHD is lower than the NSW average (80.4 years compared to 81.6 years), and age-adjusted all-cause death rate from 2006-2007 is significantly higher than expected based on NSW rates (634.4 per 100,000 population compared to 596.6 per 100,000 in NSW (Murrumbidgee Local Health District, 2012).

Within MLHD there are 23 public hospitals, 10 multi-purpose services, 2 affiliated sub-acute centres and community health centres. Although Albury Hospital provides a significant number of services to the region, it is administered by the state of Victoria through Albury Wodonga Health and therefore health practitioners from this hospital were not recruited to this project. Two large private hospitals
are found in the area: Calvary Hospital in Wagga Wagga and Albury Wodonga Private Hospital, Albury. A number of day surgery centres are also located in the Riverina ICTN. Additionally, the Riverina ICTN hosts a range of private, community, and non-government, not-for-profit health services (Murrumbidgee Local Health District, 2012). Three Medicare Locals (MLs) are contained in, or comprise part of, the Riverina ICTN: the Murrumbidgee ML; the Hume ML; and, the Loddon Mallee Murray ML.

**Qualitative data: literature review**

A selected review of the published and grey literature was undertaken during the course of the project. Government reports and scholarly journal articles that described demographic data about the Australian health workforce and innovative approaches to the expansion of clinical placements were the focus of the literature explored. The reviewed literature was used in the following ways: to develop the survey questions and the topics for the interviews; it was discussed during Riverina ICTN meetings and was used to increase dialogue and interest amongst the stakeholders; and, it was used as an additional data source during the process of thematic analysis.

The literature was sourced using databases available through the Charles Sturt University Library. Databases searched included EBSCOhost (Health), ProQuest, and CINAHL Plus with Full-Text. In addition, the Google and Google Scholar search engines were searched using the key terms (and combinations of these terms): clinical placement, innovative model, clinical school, partnership, allied health, nursing, and rural. Reference lists of found literature were also used to identify other key literature.

Reports of innovative approaches for the provision of student placements is summarised as an annotated bibliography in Appendix 1. The literature is categorised in relation to the nature of the clinical placement innovation.

**Qualitative data: locality-based case studies**

A locality-based approach was proposed to examine clinical placements at a whole-of-community level. Three communities were identified by the Riverina ICTN as worthy of special investigation and focused study: Berrigan was chosen as a representative of a small rural community; Narrandera was chosen as a representative of a medium-sized rural community; and Wagga Wagga was chosen as a representative of a large regional centre. The purpose of these locality-based case studies was to explore the influence of locality-specific and contextually-specific barriers to, and enablers for, clinical placements. Unfortunately, the project timeframe did not allow a full investigation of the Wagga Wagga case study, although the findings from participants based in Wagga Wagga are included.

Health service providers in Berrigan and Narrandera were identified from telephone and service directories and approached for interview. This included hospital and community health services, General Practice, residential aged care facilities, pharmacists and other community based services. In addition, other key community stakeholders such as Local Government, and non government
agencies were identified and approached. Some of the locality-based interviews were opportunistic in nature. All participants were encouraged to complete the relevant questionnaire survey. For Berrigan, data on local health services was collected for inclusion in a matrix of local health services.

In this report, findings about these communities are presented within two case studies: one for Narrandera and one that focuses on Berrigan but which also includes aspects of the Wagga Wagga analysis. In addition, interview and questionnaire survey data collected during these locality-based explorations is included as part of the data for the qualitative analysis: interviews and the quantitative analysis: surveys.

Quantitative data: surveys

Two surveys, one for health services and the other for education providers, were developed by project staff following reference to the literature to identify recognised barriers/challenges and enablers/solutions to clinical placements. These surveys sought the opinions of the participants about the main barriers and enablers to expanded clinical placements. Health services were also asked about their motivations for hosting students. The survey questions used a Likert scale format.

Participant sample

People who were interviewed were also asked to complete the survey. As much as possible, the participants were asked to complete the survey prior to or at the beginning of the interview. This meant that the interviewer could use the survey results to help shape the interview and explore issues that were raised while completing the survey.

Data collection

Initially, hard copy surveys were utilised and were completed either at the interview of electronically. Later, the web-based survey tool, SurveyMonkey©, was used to facilitate survey completion and collection of data. People who were identified as potential interviewees, but were unable to participate in an interview, were encouraged to complete the online survey.

Response rate

A total of 46 quantitative questionnaires were completed. Response rates of questionnaire completion were 76% for health service professionals (n=34) and 48% for education provider professionals (n=12).

Data analysis

The results of the SurveyMonkey© reports were downloaded into MS Excel© spread-sheets for use in descriptive statistical data analysis. Response frequencies for each question were collected.
Constraints and Limitations of the Project

The project presented a number of challenges for the project team. The broad scope and complex nature of the project within a relatively short timeframe were key issues. Interim reports to the Riverina ICTN committee proved useful in stimulating discussion and facilitated thinking and enthusiasm for innovative approaches to clinical placements. This process may have been enhanced had the project run over a longer period.

While interview participants were generally keen to contribute to the project, competing demands on their time meant that engaging with them proved challenging. Specific issues were that interviews involved busy senior personnel within health and education provider organisations and, for those involved with organising clinical placements, the project coincided with one of the busiest times in the academic year.

Health and education providers interviewed and surveyed were predominantly senior staff and this suggests that the views of clinicians and front line staff are underrepresented in the findings.

There was a complex array of clinical placement related activities and projects occurring at local, state and national levels. Interview respondents reported some fatigue and confusion associated with these different activities and projects.

...there are so many people definitely trying to find solutions that, you know, I think the energy that we have put into surveys and data collection. ... I truly find it hard not to give a sigh of exasperation... I mean I hang in there because it's so important and we so have to get it right. It's worthwhile keeping going and just plugging away at it, but gee whiz it's difficult isn't it? And everyone who is in this business has tried to do their very best that they possibly can, but it's very complex system and I'm with you. I don't want...to end up with going nowhere because there's no possibility of achieving what needs to be achieved. EP9

The short project timeframe did not support much collaboration with other projects.
Review of the Literature and Theoretical Framework

The provision of health services is reliant upon having a suitably prepared and qualified workforce of health service providers; that is, staff who have the necessary skills and expertise to provide health care. People become health care professionals through engaging in clinical education. Although a significant amount of health professional education is achieved through academic-based study within educational institutions, it is also important that some clinical education is undertaken in real-world contexts. Learning within workplaces provides students with an opportunity to apply knowledge and skills they have developed during their formal study (Cooper, Orell, & Bowden, 2010). Through working with actual clients, students establish an understanding of the nature of real-world work and the experience of being a health professional, Cooper in (Smith, 2013).

A broad and inconsistent range of terminology is used to refer to learning in real-world settings; the terms clinical placement, workplace learning, fieldwork, and practicum are all used to describe such experiences. In this report, the broad and inclusive term workplace learning (Smith, 2013) is used interchangeably with clinical placements when referring to educational activities in which students and staff have the opportunity to implement their developing professional roles in actual workplace settings.

Clinical placements are an essential aspect of clinical education and vital in preparing students for clinical work upon graduation, Chun-Heung & French, Edwards, Smith, Courtney, Finlayson & Chapman in (Swerissen & Rayner, 2005); and (National Health Workforce Taskforce, 2009). In health courses in Australia, clinical placements vary in length and type across disciplines and year levels and each profession has its own minimum compulsory requirements. Given their central role in assisting students to learn how to be health professionals, the ability to provide high quality clinical placements is indispensable in the education of health care students.

It is important to have good quality clinical placements in order to prepare students well for health practice; however the provision of excellent clinical placements is very complex and may be challenging to achieve. The stakeholders in the provision of clinical placements include students, health services, education providers, and professional associations. Each of these stakeholders might have different (and sometimes conflicting) needs and this tension can increase complexity when delivering student placements. Some of the principles that influence the quality of clinical placement provision are:

- Effective clinical practice;
• An organisational culture that values life-long learning;
• Effective interprofessional learning;
• A supportive relationship between health services and education providers;
• Effective communication processes;
• Appropriate resources and facilities;
• Students having an equitable high quality placement regardless of location or who organised it;
• Students receiving high quality supervision;
• A safe working environment in which patient care is not disadvantaged by the presence of students;
• Efficiency in coordination of placements;
• Meeting educational criteria and requirements of registration boards.

Though developed through studying nursing in aged care settings, (Abbey et al., 2006) a range of criteria transferable to all disciplines were identified. In the preparation and planning phase, it was critical that students were adequately prepared, a clear and realistic statement about their desired learning objectives was developed, gathered information about assessment arrangements, and had undertaken a briefing that explored expectations of roles and responsibilities of both the student and health service. Discussion of roles and responsibilities includes detailing clinical teaching roles and responsibilities, arrangements for accessing clinical teacher/academic advisor, schedules for debriefing, and gathering information relevant to the logistical organisation of the placement including, for example, transport, site orientation and introduction to site staff. Promoting the benefits for health service staff through their involvement with students and ensuring that adequate resources, including free time, are available for the supervisory/facilitation/teaching/preceptor role are necessary.

Critical inputs at the implementation and evaluative phases include timely and objective feedback on performance, structured and regular opportunities to debrief and reflect during and after the placement, and the cultivation and adoption of what constitutes a stimulating and supportive learning environment (Abbey, et al., 2006; Barnett, Abbey, & Eyre, 2011a; Health Workforce Australia, 2013a; Mason, Bowles, Osburn, Mansell Lees, & Gregory, 2012; Robinson et al., 2008; State Government Victoria, 2011; Swerissen & Rayner, 2005).

A traditional model for workplace learning is that skilled and experienced health staff structure learning opportunities for students and provide suitable support and supervision for students in the workplace. These health professionals are known as clinical supervisors (Health Workforce Australia, 2013a) or clinical facilitators. Typically, clinical supervision is not a clinical supervisor’s only, or even primary, role: in the first instance they are usually employed to provide health services to clients/patients. Health workers often take on clinical supervision in addition to the other roles and tasks they are required to perform within the health service.

Education providers need to work closely with health services and clinical supervisors in order to operationalise clinical placements. Usually a process of matching is required. That is, education providers need to match their students’ needs to the placements that are offered by the health services so that students obtain education and experience in the clinical areas in which they need to
develop skills. Although this sounds like a relatively straightforward process, when one considers the diverse range of student needs (across disciplines and year levels), the large number of students who need placements, and the pressures that health services experience (staffing issues, patient care issues, organisation policies and practices, and so on), it may be appreciated that the process is exceedingly complex.

**Problems in delivering high quality placement experiences**

Australia’s Health Workforce, Productivity Research Commission Report, December 2005 in (National Health Workforce Taskforce, 2009) highlighted a number of key problems in the current health workforce education and training approach in Australia, noting specifically complexity, poor coordination between education and health delivery, and low responsiveness to changing needs as difficulties.

Availability of appropriate clinical supervisors has been essential to enabling workplace learning. Clinical placements are threatened when there are not enough clinical supervisors to support the number of students who need to undertake placements. Health workforce changes over recent years may mean that there are insufficient clinical supervisors to provide the growing volume of placements that will be needed to prepare the next generation of health workers.

Numbers of health workers are decreasing due to retirement and attrition. Shortfall in the number and subsequent availability of health staff to provide clinical supervision will severely negatively impact the ability of health services to provide the clinical supervision that is required to prepare a future health workforce (National Health Workforce Taskforce, 2009). Larger proportions of the health workforce are now in older age groups and are, on average, ageing faster than the non-health workforce. People aged 55 or older comprised 19% of the health workforce in 2010 compared with 15% in 2005 (Australian Institute of Health & Welfare, 2012). While the average age of all Australian workers has increased by 2.8 years over the past 20 years, the average age of workers in health services has risen by 5.5 years, (Kryger & Australia Department of Parliamentary Services, 2005). Difficulties in recruitment of a broad range of health professions have been identified. At the same time there is an increasing demand for health care associated with an ageing population, changing patterns of disease and consumer expectations (Australian Institute of Health & Welfare, 2012).

High turnover rates may also decrease numbers of health staff; essentially workers may leave health jobs more quickly than they can be replaced. According to the NSW Health Annual Report 2011-12 in (New South Wales Interdisciplinary Clinical Training Networks & Health Education & Training Institute, 2013), the staff turnover rate for allied health professionals in NSW between 2011-2012 was 16%. It is estimated that there will be a highly significant shortage of 109,000 nurses and 2,700 doctors by 2025 (Health Workforce Australia, undated).

Shortages of health professional staff are even more pronounced in rural Australia. In the early 2000s there were 60% fewer allied health practitioners per 100,000 of population working in rural areas compared to those working in metropolitan areas, Australian Institute of Health and Welfare (AIHW) in (Struber, 2005); and (Australian Health Ministers’ Conference, 2004). The rural workforce is ageing...
more quickly than the metropolitan workforce (National Health Workforce Taskforce, 2009). Between 1986 and 2001, the percentage of rural general practitioners aged over 40 years rose to 20%, compared to 14% for metropolitan general practitioners. In 2001, those aged 55 years or older made up 52% of the city general practitioner workforce and 59% of the rural general practitioner workforce (National Health Workforce Taskforce, 2009). Staff turnover is also higher in rural areas compared to metropolitan areas. Queensland Health in (Struber, 2005) found a rural health workforce exit rate of 29% (compared to 19% for metropolitan workers).

Sustainability of the health service workforce may be compromised in rural areas because working conditions for rural workers are more demanding than those for metropolitan health workers. For example, health professionals in rural areas work longer hours than the national average. Remote area nurses work between five hours, to two days more than the national average for registered nurses per week. Medical practitioners work on average three more hours per week than those in metropolitan areas, AIHW 2010b; 2010c; Lenthall 2011; Health Workforce Queensland and New South Wales Rural Doctors Network 2009 in (Health Workforce Australia, 2013e).

Lack of support and a high workload may negatively impact on practitioners’ ability to supervise students and may also decrease the quality of clinical placement experiences. Lower numbers of practitioners in rural areas can create professional and social isolation for health practitioners, Mitchell 1996; National Rural Health Alliance 2002; and Pashen, undated in (Leggat, 2003), which may reduce practitioners’ feelings of confidence and may decrease their support in supervising students. Staff in rural areas might also experience adverse effects from having a complex and high workload, which coupled with isolation and lack of support, can increase rates of burnout, New South Wales (NSW) Government 2012, in (New South Wales Interdisciplinary Clinical Training Networks & Health Education & Training Institute, 2013). When a clinical supervisor is feeling stressed, unsupported, isolated, and under pressure, it can be very difficult to muster the energy to provide a student with a high quality learning experience.

In considering the preparation of students for practice, different approaches may be needed to prepare rural practitioners from those that are required to prepare practitioners for metropolitan areas (Health Workforce Australia, 2013b; Leggat, 2003). Understanding rural health and preparing students for rural practice may require a broader consideration of the characteristics of rurality than just consideration of geographical location. Bourke, 2004 in (Smith, 2013) proposed that the concept of rural included sociological, economic, cultural, and spiritual values that were different for rural residents compared to metropolitan dwellers. A predominance of metro-centric approaches within health care professional education may mean that students are not sufficiently prepared for rural health practice (Kenny & Duckett, 2003).

Reid, 2011 in (Smith, 2013) observed that issues of recruitment and retention to rural locations, access to care for rural people, and the preparation of practitioners for rural practice are “wicked problems” (p.8); that is, they are problems that resist solutions. The rural health workforce faces significant challenges regarding ageing of the workplace, high rates of staff turnover, and demanding conditions for practice, which may make rural practice less attractive to some potential workers.
Attempts to solve problems of delivering high quality student placements

One solution to the problem of shortages of trained medical staff has been to employ overseas-trained doctors. The Australian Health Workforce Productivity Report in (National Health Workforce Taskforce, 2009) states that the number of overseas-trained doctors is currently 25%, compared to 19% a decade ago. In addition, in rural areas, the proportion of internationally-trained doctors is significantly higher than in metropolitan areas. In many rural and remote areas 41% of all doctors have trained overseas and in some communities there is up to 70% internationally-trained personnel (Health Workforce Australia, 2013e).

Another response to increasing numbers of staff in the rural health workforce has been to increase the number of health professionals being trained, according to the World Health Organisation, 2010 in (Smith, 2013). However, even though growth in numbers of health workers is essential to Australia’s health workforce supply, an increased number of health professional students will create substantial pressure for education providers and health services to increase numbers of clinical placements. For example, under the Council of Australian Governments agreement of July 2006, the Commonwealth Government assumed responsibility for funding an increased number of places in medical schools (NSW Institute of Medical Education and Training, 2009). Increasing numbers of medical commencements nationally has translated into increasing numbers of medical graduates (1,660 in 2000 compared with 3,469 in 2010), Medical Deans Australia in (Health Workforce Australia, 2012a). Numbers of graduates are projected to increase by more than 50% again from the 2,380 who graduated in 2009 to reach almost 3,800 in 2015, Medical Training Review Panel Fourteenth Report as cited in (Health Workforce Australia, 2012a).

Even though increasing the numbers of medical students may provide a much needed boost to the medical workforce in rural and regional areas, this strategy has created strain on the system. A study undertaken in Victoria indicated that by 2017-2018 the demand for medical student placements in general practices will have grown by 165% (Burgell Consulting, 2008). Reportedly, universities and medical practices are extremely under-prepared and under-resourced to provide for the large numbers of medical student clinical placements identified by the estimates of demand (Burgell Consulting, 2008). The number of medical graduates in NSW (domestic and international students) nearly doubled from 2008 to 2012, requiring intern positions to increase by approximately 40% from 2008 to 2013 (NSW Institute of Medical Education and Training, 2009). This increase in medical graduates resulted in there being insufficient postgraduate medical training places for the number of graduates seeking them (Health Workforce Australia, undated).

There is a growing mismatch between supply and demand for training places, exacerbated by government, employers, colleges, universities, and professional bodies each affecting the provision of medical training positions at different stages of the training pathway. For example, the Commonwealth Government determines the number of domestic professional entry places to university and general practice training places, whereas the States and Territories largely determine the capacity for internships and vocational training (Health Workforce Australia, 2013d).
Access to appropriate clinical placements has been identified as a key barrier to growth in student numbers in health professional training programs (Health Workforce Australia, 2011a). A clinical placement mapping study by Health Workforce Australia (HWA) reported that universities planned to increase the number of health students from 93,283 equivalent full time student load (EFTSL) in 2009 to 119,784 EFTSL in 2014. This planned growth of more than 26,500 EFTSL (28.4%) is comparable to a university the size of Deakin or Western Sydney being comprised entirely of additional health profession students (Health Workforce Australia, 2011a). This planned growth is substantially higher than the projected 7.6% population growth over the same period as documented in the Australian Bureau of Statistics cat. no. 3220 in (Health Workforce Australia, 2011a).

Planned growth to numbers of health students affects different professions differently. The highest proportional differences between planned and potential placement load in an HWA mapping study are in Dietetics, Dentistry, Physiotherapy and Audiology with potential student loads between 12% and 34% higher than planned, indicating access to clinical placements is a significant problem for some professions, whereas for other professions this issue may be of a somewhat lesser concern (Health Workforce Australia, 2011a). However, the profession that is most significantly affected by planned increases is nursing, and this increase in numbers would put substantial strain on existing systems. Limits on clinical placements considerably constrain growth in this profession (Health Workforce Australia, 2011a).

Problems of access to clinical placements include competition between education providers for a limited number of placements, costs of paying for placements, and complexity in the process of locating and accessing appropriate placements (Health Workforce Australia, 2011a). For some professions, requirements of accrediting bodies regarding minimum standards of clinical experiences can constrain access to clinical placements. For example in midwifery, students must attend a prescribed minimum number of births. As student numbers rise there will be increasing competition for access to a limited number of births. Regional placements may not be able to supply sufficient opportunities for students to attend births to meet accreditation requirements. Thus, limited ability to be able to meet this requirement may cause education providers significant difficulty and almost certainly will result in limits to student numbers (Health Workforce Australia, 2011a).

A paradoxical problem: is it possible to have a sustainable increase in capacity for clinical placements?

Clearly, in order to have a sustainable health workforce for future generations, it is important to prepare large numbers of student health professionals for this future practice. Significantly, the preparation of upcoming health care practitioners is reliant upon the goodwill of practitioners to provide clinical training to healthcare students. There is a need to increase student numbers in order to meet projected shortages of staff, especially in rural areas of health service delivery. However, demographic trends in the clinical workforce mean that the supply of clinical supervisors may shrink at the same time as demand increases (NSW Institute of Medical Education and Training, 2009). In addition, it is unclear how, where, and who might provide clinical training for the proposed increased numbers of students, according to Dahlberg, 2006 in (National Health Workforce Taskforce, 2009).
A mapping study undertaken in 2012 by the Health Education and Training Institute, as cited by (New South Wales Interdisciplinary Clinical Training Networks & Health Education & Training Institute, 2013), determined that there is additional capacity for more clinical placements to be undertaken in NSW; specifically there was opportunity of 26.2% growth within medicine in the public health sector and 32.6% growth across other disciplines. However, although there is significant need for increased clinical placements and there may be some untapped capacity, it is unclear precisely where opportunities for clinical placements can be created (if at all) and how to actualise these opportunities.
Findings and Discussion: Quantitative Data

Clinical placement data for Riverina ICTN: trends and ideas for further exploration

Details of the database
Data about clinical placement activity was collected by Health Workforce Australia (HWA) via a survey of 48 higher education providers across 25 health professions; the data is known as the Clinical Placement Dataset and is available on the HWA website (Health Workforce Australia). The first survey was undertaken in 2010 and HWA intends to collect further data samples annually. Data collection tools developed in MS Excel© were used to collect 2011 and 2012 data. Each discipline within the education provider completed a separate MS Excel© file. Each institution receives a summary from HWA of the data that institution provided along with a national overview.

Results of descriptive statistical analysis
A total of 157,994 hours of clinical placements occurred within the Riverina ICTN during 2011; approximately 63% of the total clinical placement hours occurred in public facilities. Almost half of all clinical placements were in nursing and almost 70% of all nursing placement hours in the Riverina ICTN occurred in public facilities (Table 2). Additional unpublished data was provided to the project team by HWA that revealed a listing of education providers and the postcodes of placements they utilised (S. Tyson, personal communication, March 5, 2013). This data indicated that 25 education providers use the Riverina ICTN for clinical placements; however University of NSW could not be included because data for this institution was aggregated and could not be categorised according to postcode and in addition data from the VET sector was not collected by HWA and is therefore missing from the data set. The postcode-education provider data set revealed that Charles Sturt University (CSU) utilises the most clinical placements in the Riverina ICTN; CSU provided approximately 65% of all placement hours to the Riverina ICTN. LaTrobe University contributed to 8% of all placements and the Universities of Newcastle, Sydney, Western Sydney, and Wollongong each contributed about 4% of clinical placements in the Riverina ICTN. By postcode, about 42% of all Riverina ICTN clinical placements occurred in postcode 2650 (Wagga Wagga), 27% in 2640 (Albury), 7% in 2680 (Griffith), and 3% in 2705 (Leeton).
Table 2: Clinical placement hours in the Riverina ICTN by course and provider type, 2011

<table>
<thead>
<tr>
<th>Course</th>
<th>Provider</th>
<th>Private</th>
<th>Public</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td></td>
<td>23,298</td>
<td>54,077</td>
<td>77,375</td>
</tr>
<tr>
<td>Medicine</td>
<td></td>
<td>12,405</td>
<td>7,735</td>
<td>20,140</td>
</tr>
<tr>
<td>Social Work</td>
<td></td>
<td>2,875</td>
<td>12,210</td>
<td>15,085</td>
</tr>
<tr>
<td>Midwifery</td>
<td></td>
<td>1,500</td>
<td>10,715</td>
<td>12,215</td>
</tr>
<tr>
<td>Radiation Science</td>
<td></td>
<td>5,360</td>
<td>4,520</td>
<td>9,880</td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td>5,353</td>
<td>1,293</td>
<td>6,646</td>
</tr>
<tr>
<td>Physiology</td>
<td></td>
<td>1,935</td>
<td>3,444</td>
<td>5,379</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td>1,010</td>
<td>2,364</td>
<td>3,374</td>
</tr>
<tr>
<td>Dietetics</td>
<td></td>
<td>640</td>
<td>1,720</td>
<td>2,360</td>
</tr>
<tr>
<td>Speech Pathology</td>
<td></td>
<td>640</td>
<td>1,439</td>
<td>2,079</td>
</tr>
<tr>
<td>Medical Laboratory Science</td>
<td></td>
<td>664</td>
<td>379</td>
<td>1,043</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander Health Worker</td>
<td></td>
<td>770</td>
<td>70</td>
<td>840</td>
</tr>
<tr>
<td>Dentistry</td>
<td></td>
<td>630</td>
<td>0</td>
<td>630</td>
</tr>
<tr>
<td>Podiatry</td>
<td></td>
<td>428</td>
<td>0</td>
<td>428</td>
</tr>
<tr>
<td>Psychology</td>
<td></td>
<td>255</td>
<td>0</td>
<td>255</td>
</tr>
<tr>
<td>Exercise Physiology</td>
<td></td>
<td>160</td>
<td>0</td>
<td>160</td>
</tr>
<tr>
<td>Audiology</td>
<td></td>
<td>0</td>
<td>105</td>
<td>105</td>
</tr>
<tr>
<td>Chiropractic</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Optometry</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Oral Health</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Orthotics</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Orthotics and Prosthetics</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Osteopathy</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Paramedicine</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sonography</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>57,923</strong></td>
<td><strong>100,071</strong></td>
<td><strong>157,994</strong></td>
</tr>
</tbody>
</table>

Table 3 highlights the number of total clinical placement hours in Riverina ICTN compared with total clinical placement hours in other NSW ICTNs and compares that with the proportion of the estimated NSW population in that ICTN. The Riverina ICTN took 1.8% of the NSW total placements while making up about 3.3% of the NSW population suggesting that the Riverina ICTN may be underperforming as a clinical placement destination. However, these data need to be interpreted with caution. Approximately 16% of the total placement hours could not be assigned to any particular ICTN. Also this analysis does not take into account the health services and opportunities for clinical placements in the ICTNs nor the proximity and relationships between health services and education providers.
Table 3: Clinical placement hours compared with population by NSW ICTN, 2011

<table>
<thead>
<tr>
<th>ICTN</th>
<th>Clinical Placement Hours</th>
<th>% of Total Placement Hours</th>
<th>Projected Population 2011 (NSW Health)</th>
<th>% of Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro North and East</td>
<td>1,895,422</td>
<td>21.9</td>
<td>1,699,555</td>
<td>23.6</td>
</tr>
<tr>
<td>Western</td>
<td>1,776,134</td>
<td>20.5</td>
<td>1,465,612</td>
<td>20.3</td>
</tr>
<tr>
<td>Sydney</td>
<td>1,567,088</td>
<td>18.1</td>
<td>1,457,589</td>
<td>20.2</td>
</tr>
<tr>
<td>Unknown NSW</td>
<td>1,354,781</td>
<td>15.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hunter and Coast</td>
<td>1,192,117</td>
<td>13.7</td>
<td>1,402,687</td>
<td>19.5</td>
</tr>
<tr>
<td>South Coast</td>
<td>368,210</td>
<td>4.2</td>
<td>580,272</td>
<td>8.0</td>
</tr>
<tr>
<td>North Coast</td>
<td>302,825</td>
<td>3.5</td>
<td>288,307</td>
<td>4.0</td>
</tr>
<tr>
<td>Riverina</td>
<td>157,994</td>
<td>1.8</td>
<td>236,774</td>
<td>3.3</td>
</tr>
<tr>
<td>Broken Hill Region</td>
<td>55,894</td>
<td>0.6</td>
<td>31,124</td>
<td>0.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8,670,465</strong></td>
<td><strong>100.0</strong></td>
<td><strong>7,211,468</strong></td>
<td></td>
</tr>
</tbody>
</table>

Analysis of Charles Sturt University placements

Given that CSU is the major contributor to clinical placements in the Riverina ICTN, a more detailed examination of CSU data was undertaken and the following paragraphs refer to clinical placement data for CSU only. Data has been drawn from the HWA summary report for CSU for 2011 as well as from MS Excel© data collection tools used by disciplines at CSU for 2012 which were pre-populated with 2011 data.

Total CSU clinical placement hours for 2011 approached 763,000 while in 2012, about 894,000 hours are recorded. As previously stated, unpublished HWA data indicated that CSU contributed about 65% of the total clinical placement hours in the Riverina ICTN. From the perspective of CSU however, only 10-15% of the total CSU placements occurred in the Riverina ICTN. The high proportion of CSU placements that are undertaken outside the Riverina ICTN may reflect placements for distance education students and student preference for placements near home, or accreditation requirements for placements in tertiary and specialist facilities. However, it could also reflect that the availability of placements in the Riverina ICTN is proportionately less than that available in other regions. It may be appropriate to further examine reasons for this apparent low proportion of placements in the Riverina ICTN compared with other areas and to continue to explore opportunities to benchmark clinical placements within the Riverina ICTN and with other rural clinical training networks.

Most of CSU’s clinical placements occurred in the acute setting and the second most utilised placement type was primary care and community health (Table 4).
Table 4: Clinical placements for CSU by placement setting, 2011 and 2012

<table>
<thead>
<tr>
<th>Setting</th>
<th>Year</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011</td>
<td>2012</td>
<td></td>
</tr>
<tr>
<td>Acute (Medical/Surgical/Maternity/Emergency)</td>
<td>41.5%</td>
<td>35.2%</td>
<td></td>
</tr>
<tr>
<td>Primary Care and Community Health (excl. GP)</td>
<td>14.7%</td>
<td>10.2%</td>
<td></td>
</tr>
<tr>
<td>Human Services</td>
<td>10.8%</td>
<td>7.8%</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>8.4%</td>
<td>6.4%</td>
<td></td>
</tr>
<tr>
<td>Sub-Acute</td>
<td>6.9%</td>
<td>5.7%</td>
<td></td>
</tr>
<tr>
<td>Private/Professional Practice (excl. GP &amp; Diag)</td>
<td>4.8%</td>
<td>8.6%</td>
<td></td>
</tr>
<tr>
<td>Mental Health/Alcohol &amp; Other Drugs</td>
<td>4.2%</td>
<td>4.3%</td>
<td></td>
</tr>
<tr>
<td>Aged Care</td>
<td>4.0%</td>
<td>3.1%</td>
<td></td>
</tr>
<tr>
<td>Ambulatory/Outpatients</td>
<td>2.2%</td>
<td>2.5%</td>
<td></td>
</tr>
<tr>
<td>Not Identified</td>
<td>1.0%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Educational Institutions</td>
<td>0.9%</td>
<td>4.6%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0.3%</td>
<td>0.2%</td>
<td></td>
</tr>
<tr>
<td>Dental and Oral Health</td>
<td>0.2%</td>
<td>11.3%</td>
<td></td>
</tr>
<tr>
<td>General Practice</td>
<td>0.1%</td>
<td>0.2%</td>
<td></td>
</tr>
<tr>
<td>Non Government Organisation (NGO)</td>
<td>0.0%</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

For nursing within CSU, a total of 28,000 hours in 2011 and 22,920 hours in 2012 were undertaken in aged care settings (Table 5). These totals can be further divided into facilities inside and outside the Riverina ICTN. Small rural health services operated by MLHD provided about 30 to 40% of the total aged care placements for CSU nursing students. Of clinical placements for CSU Nursing in residential aged care facilities, 76% of these placements occurred outside the Riverina ICTN in 2011 and 58% in 2012. It should be noted that a number of CSU campuses are found outside the Riverina ICTN and distance education students and others may seek placements outside the ICTN. Overall, this may suggest that residential aged care facilities in the Riverina ICTN are not heavily utilised for CSU clinical placements. Further investigation is required to verify this possible finding. The analysis also suggests that opportunities exist to expand placements in aged care facilities in the Riverina ICTN.
Table 5: Clinical placement hours for CSU nursing students undertaking aged care placements by placement location and year

<table>
<thead>
<tr>
<th>Location of Placement</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hours</td>
<td>%</td>
</tr>
<tr>
<td>Residential Aged Care – not Riverina ICTN</td>
<td>12,600</td>
<td>45.0</td>
</tr>
<tr>
<td>Residential Aged Care – Riverina ICTN</td>
<td>4,060</td>
<td>14.5</td>
</tr>
<tr>
<td>MLHD health service – multipurpose services and small rural health services</td>
<td>11,340</td>
<td>40.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28,000</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**VET Sector Data**

The exclusion of the VET sector from the HWA data collection process is an important limitation when trying to examine and monitor clinical placement information, particularly in the aged care setting. Information was provided directly by Riverina TAFE for use in this project. A total of 8,332 clinical placement hours were recorded in 2011 across 6 courses. Interestingly the most frequently used area for clinical placements by Riverina TAFE was aged care (58% of all placements), whereas for universities acute care was the most frequently used area. Acute settings were the second most frequently used by Riverina TAFE (40% of all placements) and all remaining placements occurred in public and private dental services. In 2011, a total of 760 hours (or just over 9% of the total Riverina TAFE clinical placement hours) were undertaken in the Riverina ICTN and all of this occurred in private aged care settings.

**Limitations of the data set**

As this brief examination of clinical placement data has shown, there are some problems with the quality and completeness of the data collected. This is not unexpected given the size and complexity of the task and it is anticipated that data quality will improve with subsequent collections. Consideration of data confidentiality is also an important concern and HWA would not release more detailed data for individual institutions without the permission of those institutions. The Riverina ICTN committee declined to seek the permission of individual institutions for the release of detailed clinical placement data in the Riverina ICTN and therefore this data was unavailable in the preparation of this report.

**Survey data**

The results of the SurveyMonkey© questionnaires are found in Appendix 5.
Findings and Discussion: Qualitative Data

The project described in this report aimed to determine: Does untapped capacity for clinical placements exist? Where is it and can it be used? We will show that there is untapped capacity for clinical placements in the Riverina ICTN; however this capacity is not unlimited. We have not named capacity as occurring in specific locations, in part to preserve the anonymity and confidentiality of the people who generously agreed to participate in this project. However, specific details about the capacity of different organisations will be provided as a commercial in confidence list held by the Riverina ICTN Coordinator. In part, the locations of places where capacity may exist have also not been directly named since the creation of capacity was found to be complex and highly-contextualised. Instead, we suggest that capacity may be increased if the conditions are right.

There are a number of ways in which to increase capacity. If it is possible to overcome the significant list of problems that the current system faces, then capacity can be dramatically increased. In addition, it may be possible to make some small improvements to efficiency within the system of placement allocation and uptake within the Riverina ICTN that may enable capacity to be increased.

In this section of the report, we will also highlight a number of enablers and threats to placement capacity. Capacity may be increased by making use of enabling strategies and by reducing the impacts of threats to building capacity. Finally, we will present case studies of Narrandera and Berrigan and a number of creative and expanded scope placement innovations that may serve as exemplars of ways in which placement capacity may be increased. Thus, by the end of this section, a range of strategies and ideas for tapping the unused placement capacity within Riverina ICTN will have been presented.

In this presentation of findings, the project team made a commitment to being as up-beat and optimistic as possible. Rather than continuing to highlight only the problems that are faced, we aimed to focus on solutions and strategies for enabling change. However, even though our desire is to be confident and hopeful, we recognise that many of the problems are substantial, and some may be insurmountable. We encourage readers of this report to read it with hope and yet also not to feel guilty or depressed if large changes cannot be actualised immediately; it is still possible to make sizeable shifts by taking small steps.

“...I can tell you what my budget is, can tell you what we spend, that’s not actually the value we get. We get much greater value through goodwill.”
EP14

Untapped capacity for clinical placements in the Riverina ICTN
Final Report, May 2013
Overall, it appeared that there is significant untapped and unused capacity in the Riverina ICTN. In addition, many of the participants expressed willingness to support for the aims of the project and keen interest to work together to improve placement capacity.

Our capacity for students is known. It is easy to run a report in ClinConnect to look at the monthly capacity by days or hours, we prefer days. We look at the number of days requested, for example in one month [February 2013], only 38% of our capacity was requested, which leaves 62% unrequested. If we look at what happens to the requested numbers: we approved 85% of the requested placements, those we did not approve were overlap requests and beyond capacity on those days, this brings us down to 32% of total capacity. Then the education providers accept or decline the positions, in this month only 62% of those requests were accepted (this brings us down to 24% of total capacity). If we follow this through to the number of placements actually used it drops to 50% of those we approved or 30% of the requested number (this brings us down to 12% of total capacity). This 12% that is actually used is such a small amount of the total capacity. Even in peak activity months, only 25-30% of capacity is utilised. HS20

There are a multitude of reasons why capacity is unused, underutilised, and untapped. In some cases a clinical supervisor is simply never asked to take a student. In other instances, governing factors are far more complex. This exploration of where capacity may be increased and how this might be achieved begins first by identifying what are the boundaries of placement capacity in the Riverina ICTN.

Limits to placement capacity in the Riverina ICTN

Although in the previous section it was identified that there is capacity for increasing the number of clinical placements in the Riverina ICTN, this capacity is not boundless. In their survey responses, health services ranked “capacity to accept further clinical placements” as a major challenge. There is considerable goodwill on the part of health service providers to take on more students, however constraints and issues within systems, staffing, and resourcing may reduce ability to action this generosity.

And the capacity to take more, I don’t know, as I said we continually review it each year with the clinical nurse educator saying, “Do you think you could take any more?” And they will throw back 10,000 reasons why not. They would like to, but logistically it’s very difficult to do. HS24

Limit: Balancing time for all the tasks that must be completed within a working day

Clinicians are busy people. They are employed to provide a health service. Clinical supervision also takes time and effort. As there are finite hours in a working day, clinicians need to prioritise how they spend their time in the range of different activities they are required to perform. It is always challenging to make time for student supervision when already called upon to maintain a high caseload and also engage in the range of other tasks that must be accomplished, for example: administrative work, committee work, continuing professional development. Clearly, there are
physical time limits to what can be achieved, including limits to the number of students that any one clinician can take responsibility for at a certain point in time.

I think from the clinician’s perspective it’s around how you can manage your caseload and your service while also undertaking student placement supervision. How can you effectively supervise students and manage your workload at the same time? I think that would be the single most significant barrier to having clinicians take on students – “I’m far too busy”, that sort of thing. HS9

It’s a resource factor. They often have minimal staff on a shift. Given the size of the facility they might have a registered nurse and an enrolled nurse on the shift so their capacity is quite limited ... I was always conscious of other people’s workloads, that our continual trail of students, whoever they may be, is an enormous impact on the workloads of department managers and senior staff in supporting those people. That’s probably I think the biggest challenge is their existing workload. HS1

Obviously that would help being actually fully staffed, would be a help for starters. Maybe having that bit more time to be a little bit more prepared and get through the things you need to get through with your student and having that time to be able to put aside with a student would be helpful. That comes back again to the whole clinical caseload. HS22

Increasing placement numbers is likely to increase work for clinicians. Currently, the system is not at capacity and therefore it may be possible for some of this increased workload to be absorbed; however, growth in student numbers cannot continue unabated. There will be a point at which no further expansion can be achieved. One limiting factor is the obligation that health service staff have to providing health services to clients. “Increasing pressures to accommodate escalating clinical loads” was noted in the survey results as a foremost impediment to increasing placement capacity. Health services have a moral and ethical obligation to serve their communities as a matter of priority and this obligation may trump time spent supervising students.

Because it is additional work, definitely. The model with students going out with clinicians in a car, that works well in the sense the car time often provides debrief time and what not. But if there’s additional work required around documentation, around meeting their clinical objectives, that’s over and above what they normally do. Because their clinics are solidly booked ... We have KPIs [key performance indicators] around patient numbers and attendances. Well, there’s KPIs, but there’s also that moral and ethical aspect of, if a clinician’s going to that community, they need to see as many people as possible. So we wouldn’t be necessarily carving off an appointment for a diabetes educator or a dietitian in a regional community to be able to accommodate a student. So that is something that the clinicians, they do wear that, and yeah, it’s definitely an additional burden on them. That’s, I guess one of those things that limits our capacity. HS23/24

I don’t think I could take any more students just working the two days a week. I don’t think feasibly I could actually do that logistically ... that would probably be the maximum that I could actually handle. HS4
Limit: some clinicians can supervise and some cannot

Even though there are many ways of assisting clinicians to become supervisors and improve their supervision skills, there might also be some clinicians who are not ready, not willing, or not suitable to provide supervision. Thus, there are limits to the capacity of an organisation to be able to provide student placements. It is important to recognise that such limits exist; pushing people beyond their capacity is likely to result only in stress and placement experiences that are negative.

You can’t go to somebody and say, “It’s logical that you become a supervisor and educator.” That just won’t happen. If they don’t put their hand up and offer to do it, and they’re not keen to do it, you can’t make them do it ... there are lots of places, there’s lots of hospitals that could easily have [students], and they won’t go to the trouble to do it because it means that they’ve got to … quarantine some time for it, they’ve got to quarantine some time for the infrastructure, they’ve got to make sure that there is a hell of a lot more effort goes into training ... They look for somebody who is going to help them do their job, they don’t want be spending their time doing it unless they’re keen. So one of the biggest problems with getting supervisors, and you’ve got to have supervisors, you can’t look at it on a map, you can’t look at it in terms of the population, you’ve got to have individuals who will put up their hands and are dedicated to make it happen. ... And I think governments don’t sort of understand that. They see a map and they look at demographics and all sorts of things, but you know, it really is very much a personal thing and people have to put in a personal effort and dedication into making it happen. I think that that’s probably the biggest barrier of all is to identify people who would be good supervisors and then give them the infrastructure to be able to do it. EP13

Limit: some practice contexts limit the number of placements that can be offered and accepted

In some environments there are cultural, confidentiality, and sensitivity issues that reduce the capacity of the organisation to take on students. For example, Aboriginal health and medical services adhere to the cultural boundaries that affect the clients who attend these services, including that female health workers cannot provide men’s health and male health workers cannot provide women’s health.

We have a lot of problems with male doctors sitting in when it’s a female patient because it’s men’s and women’s business. So that’s an issue that we have to face as well. So if you have like a male nursing student, for example, in with a female patient, they’ll sit in with the female nurse ... and they will say to the placement, “You need to leave the room for this one, or you can stay for this one”. HS15

I actually always ask [if a student can come into a home], because sometimes we talk about really sensitive stuff. If I just gave an example, say if I had a teenage mum who’s expecting and you’ve got a student who’s 19, it’s easy to feel that judgment happening. So you have to be really careful of where you go with that. I’m not saying the students judge them at all. Sometimes the client feels like they’re being judged even though there’s not been any expression of that at all. HS4
Sometimes other specialist services such as those providing drug and alcohol rehabilitation and support in mental health have restraints about the type and number of students who can be allocated to these services.

The staff in the mental health services are worried about their confidentiality and, as you would understand, you see people at their most, most vulnerable and sometimes it’s not always, you’re not always able to send a student with mental health because they might just start to refuse. I know there are some clients who just say “no, I’m sorry, I can’t have a student”. You know and that, if that client was having a baby or was having some kind surgery, it might not even quiver, but when it’s mental health, it seems to be an issue. HS37

I guess the hardest part about coordinating here is trying to place them with staff. It’s very hard because there are certain clients that will not have students in the rooms. So it’s like our drug and alcohol, when we got placements that ask to sit with our drug and alcohol team, at times I’m very reluctant to do that because the nature of the business is they’re got drug and alcohol problems and they don’t want everyone else to know their business. HS15

Private practitioners are a potential source for increasing student placement opportunities; however, despite their apparent availability the situation is more complex than initially meets the eye. Private practitioners are in business for themselves and thus the costs of taking a student must be solely borne by them, whereas in public health, the costs of placements are indirectly subsidised by governments who provide the funding to run public services. Although there is a move to paying for placements in recognition of the costs of taking students, it is not feasible for education providers to pay the full costs to private practitioners.

The problem I have in the medical field is that physicians in private practice make a bucket full of money. I can’t mimic that, I can’t say listen I’m going to pay you [xx] an hour to do clinical teaching because that’s unsustainable, can’t do it. And yet a physician in private practice could probably quite happily make that, so that adds certain difficulties for medical student training because the workforce is a highly trained but also highly paid workforce. It’s like asking senior counsel to do all the law teaching to law undergraduates; wouldn’t work, you can’t do it. EP14

Location, size, and culture of the health service and composition of the staff within departments can place limitations on their capacity to take students.

It does relate to the size of the facility in your capacity to undertake things. I think in terms of your location. So the more rural and isolated, the more difficult it is to access the sorts of development opportunities that you need, and the more difficult it is to actually provide learning opportunities out there. So I think there’s a range of factors in there that talk about the culture and leadership of that particular unit: its location, its size, and its resourcing. HS19

Overseas trained professionals make an important contribution to health care in rural areas. This group of people also have needs for support in adjusting to Australian culture and Australian health
care systems, which means the energy of their colleagues and managers are often directed towards helping them to assimilate, which may leave little energy for assisting and supervising students.

“We’ve also got a number of international staff down here from overseas which also creates extra stress on the ward that they couldn’t have X number of students and that also creates a bit of a barrier because recently we have had quite a large influx of overseas registered nurses which has caused a little bit more pressure on the wards so that has then changed the way we think about where we put students and we wouldn’t want to do things too differently or new or innovative because we’ve got our problems to start with. We don’t want anything extra, that sort of thing.” EP12

Enablers of capacity-building

In this section a number of strategies that may enhance capacity for increased student placements will be presented. In some cases these enabling situations are already occurring and if more sites can adopt these helpful strategies then the overall capacity for student placements in the Riverina ICTN may be increased. In some situations, stakeholders who were interviewed proposed interesting ideas for increasing placements and if these ideas can be adopted then placement capacity may be augmented.

Enabler: good relationships, communication, and working collaboratively

As there are many stakeholders and the issues affecting the provision of clinical placements are complex, addressing these challenges cannot be achieved in isolation (Health Workforce Australia, 2013e). The National Health Workforce Taskforce, 2009, in (Barnett, et al., 2011a) stated that given the shared responsibility for clinical education across the health and training sectors, mechanisms for effective engagement between the sectors are critical success factors. Effective clinical education for students ought not to be seen as a task for any one agency; rather all stakeholders need to collaborate, joined by a well-nurtured and constantly developing commitment to a partnership that aims to deliver tangible benefits to all parties, Abbey et al. 2006 in (Barnett, et al., 2011a). Such collaboration may foster even more collaboration, co-operation, and coordination that may serve to increase the development of clinical placements.

The development of partnerships takes time. Professor Jan Patterson in O’Keefe in (Aged and Community Care Victoria, 2011) asserted that effective partnerships take about three years to develop. Time is needed so that health services and education providers can become familiar and comfortable with the needs of each other’s organisation, and for health service staff to become used to having students on site, Abbey et al.
New opportunities for clinical placements may be created by developing open communication. Frank and honest communication can facilitate the development of trusting relationships and collaborative working towards common goals, including the goal of increasing clinical placements. Both health services and education providers ranked the development of genuine partnerships, and better coordination and communication between education providers and health services as the most important option for improving issues with clinical placements in the surveys. The issue of communication and relationships was also discussed in the interviews as being vital to solving longstanding problems with clinical placements.

Once again, it comes back to relationships – we just have to constantly work on those relationships and make sure that our students are getting what they need and that our preceptors are getting what they need without them being too much of a negative effect on their workflow and their service delivery. And so how do you work on the relationships, and who does that? Well it’s everybody. Everybody plays a part in that...we all work towards...building on relationships and strengthening them. EP10

Education providers may be more comfortable knowing that placement experiences are of high quality when they remain in close contact and communication with health services. Knowing that placements are of exemplary quality may increase the confidence of education providers to place students with health services.

We also have an obligation to ensure the quality of the experience our students have, that we know the quality if someone’s making decisions about our students, what those decisions actually are. We need to have some sense of that, the idea of not just tossing a student out with somebody who we never contact and we never hear from until the student comes back or not following up and ensuring the quality of what the students are actually experiencing is actually a problem for us in terms of the quality of courses that we’re delivering. I think increasing what will be the environment is that we’ll be asked to account for that more and more about how we’re managing that process. EP4-7

**Actions education providers could take to improve relationships with health services**

It appears that health services would value more input, support and feedback from education providers and that receiving these would improve the relationship between health services and education providers.

At the last minute, the Friday before the Monday placement... the placements [have] been coming through. And I think the earlier the better we get that type of information, because there’s nothing worse than a student getting to the end of a placement, and going, “Oh, by the way I didn’t met my objectives” because we didn’t have time to properly situate that student within the organisation. HS 23/24
When you talk about something like a partnership, I suppose there’s that notion of it is two ways. So at the moment we’re supplying the placement, and asking our clinicians to kind of go above and beyond. And we’re doing that, and we’re doing it willingly, but we don’t get anything ... as an organisation we don’t get anything extra. So if a true partnership, if there was that opportunity for planning, opportunity for up-skilling of our clinicians, I think things could be so much further enhanced. HS23/24

A very practical example of something education providers could give to health services to enhance relationships is to provide them with feedback and debriefing about the placement after it is completed. This would seem to be a low-cost and low-effort solution for education providers and may pay off dividends in terms of higher quality placements and increased goodwill from health services.

Having some evaluation from both the student’s perspective and the supervisor’s perspective, I think is important for knowing how we can do placements better...And I think it would actually be worthwhile to be getting some information back around these, the reported experiences of the students, and this what worked well, and this is what didn’t work well. The site...to that side, and then that would actually enable us to look at where we’ve got to target our energies to improve the experience and the opportunity. So there may be individual feedback going back to individual...but it might be good for us to think on higher levels, so that we know where is it working? Where’s it not working? We might need a bit more education and training to be able to provide appropriate supervision. And what are the good and bad experiences that students have out of that. But equally I think, in terms of then, the sites and the supervisors similarly doing a feedback at a collective level. We can say this is what worked well in us getting a student, and this is what didn’t work well. And to think about the sort of quality improvement side of that, and to have that, and to have those feedback mechanisms there at more than just individual feedback to the individual supervisor or individual student, but at a more organisational level, for both the university and for us. HS19

The intervention of conducting the project has resulted in increased communication, reflection and action amongst stakeholders. In interviews and consultations, the discussions enabled some new thinking around how to effect change in their organisations.

**Enabler: improving efficiency in the current system may increase capacity**

Within the current system of implementing clinical placements there are a number of problems and inefficiencies. Although it may be challenging to overcome these difficulties, finding solutions to the challenges would certainly serve to increase capacity for placements. For example, it can be more efficient to negotiate one placement for eight students rather than four placements for two students. In addition, it is more efficient if larger groups of students can be placed at one site with one supervisor. This model may be more suitable for larger sites however.

But definitely it’s sometimes numbers so if you can only place two students with a community mental health nurse, the negotiation is the same as the negotiation is for the next two, the next two the next two, so you’re making your negotiation for a placement four
times when you can just place one group of eight. So the time it takes to develop that relationship and to then do all that work and then you can place only two students for two weeks. So there are economies of scale. EP9

Some health services proposed that knowing more about the individual needs of a student could assist them to provide a better quality placement for the student. By having a more in-depth understanding of each particular student’s learning needs, the health services considered that they could tailor the placement to meet these needs.

Have some sort of almost individual report before a student comes in that says, “This is where they’re currently sitting in terms of their cohort. These are the areas that this student actually might benefit from, in terms of the focus around their placement. We’d like to see them as part of this placement actually develop better skills in this area, or that area.” I think that would actually, as far as I know that doesn’t currently happen, almost an individual plan. That you know, yes, as part of a placement this has to cover these things, but I think it would be useful to know what skill level an individual is coming at, and where might they need the most support… if they’re coming out the end of the placement, if there’s one thing almost that they really need help with, what would that be? And I think that might give a good experience for both understanding for the organisation that they’re coming into, around what the skill level is of the person and what they may or may not be able to do, and how they can best support them through there. HS19

Some education providers wanted to engage in more planning with health services so that there could be more certainty about the types of placements that would be available. In addition, having a longer term timeframe for planning (ten years as opposed to one year) would mean that education providers could be clearer about where gaps and overflow occurred in the system and potentially they would have more time in which to engage in problem solving to overcome these challenges.

Ideally it should be a workforce planning model that the education providers respond to…it needs to be underpinned by a model where the health providers are saying we need more whatever and they have a plan that it’s not just a wish list but a plan that spells out, well, over ten years and what the projected demands are and the changing needs are and their retiring workforce and all of these things. I mean that’d be great, if we had that to work on as education providers we’d be in a wonderful position. EP3

If extra support can be provided to deal with the administration requirements of placements then the health service could take more students.

I’ll take five first year nursing students and they can go and then work with the nurses out on the ward. I would take more, but it’s far too big a job for the people [to] complete all their workbooks for them, sign all that off. And I’ve spoken to [EP placement coordinator] and said, “If there’s any way that you can bring a clinical co-ordinator into the facility and pay that person to do all that supervision and all that paperwork, then I’ll take as many as you like, but I cannot do it unless there’s somebody to come and do it. HS 7,16,17
**Enabler: being a learning workplace**

Creating a culture of learning in practice settings is a way in which capacity for clinical placements may be increased. That is, learning and teaching in the practice setting become commonplace expected activities for all levels of workers, including students and experienced clinicians. This culture is already supported and expected by professional organisations. However, it is unknown how well known and adopted this standard is.

It’s actually in the Australian Nursing Midwifery Professional Registration Competency Standards… So it is an expectation. It’s in the job description that everyone participates in that orientation or supervision because there are always learners in the facility; whether it’s a new staff member, a new grad, a new EN [enrolled nurse], a work experience student, a student or somebody who hasn’t learnt that skill before who doesn’t have that knowledge. There are always learners in the environment; we all should be participating in that. **HS20**

Conceptualising learning and teaching as an accepted aspect of everyday practice may increase student placements. In medicine this concept is known as *vertical integration* (New South Wales Interdisciplinary Clinical Training Networks & Health Education & Training Institute, 2013; NSW Institute of Medical Education and Training, 2009) and it occurs through an accepted system of trainee and junior doctors receiving mentoring from their more senior colleagues. Viewing practice settings as learning workplaces changes the question from “Can you take a student?” to “How can I best structure the work and workplace to support a learning opportunity for a student?”

You can’t really opt in for students, you should be, it’s a given that you’ll take a student…resistance to students tends to be indicative of other cultural things… I think reinforcing that taking a student is part of your job is really important, rather than capitulating to centres that whinge. **HS21**

It is important that all levels of workers make a commitment to taking students and that supporting students’ learning becomes a priority policy for health services. By making such a commitment, capacity to take students no longer rests with individuals.

*Regarding capacity, we always make sure that we have the senior management buy-in. So for example, our regional nurse manager came to us recently and said that in our bigger [health service] we could be taking two students at once. And what that means is that, when staff say, “Oh, I couldn’t possibly take a student,” we can say, “Well this is what’s been decided by management.”* **HS21**

In addition, clinical supervisors who want to take students, but who feel unsupported by their managers, can also be assured that creating placements is an organisational goal and therefore it is valid to be asking to have student placements.

*I see it when I have students in my care that I value the placement, but I don’t know if the health service do.* **HS4**
Enabler: utilisation of new and different sites and innovative placement and supervision models

One of the key challenges in the future of healthcare is that hospitals have traditionally been viewed as the basic building block of health care services and subsequently that it is imperative that students receive workplace education in acute care. While access to hospital care is fundamental to the health needs of a community, there is an increasing focus on health promotion, long-term care, and innovative services before and after hospitalisation as being equally important models of health service delivery to that of hospitalisation (National Rural Health Alliance & Australian Health Ministers’ Advisory Council’s National Rural Health Policy Sub-committee, 2002). There may be opportunities for increasing placement capacity by looking for placements outside of acute care. For example, increasing aged care, community care, and private practice clinical placements.

A lot of our capacity is in aged care or sub-acute. We have very limited capacity insofar as surgery because there are only so many sites. We have limited capacity in how many we take in midwifery because there’s only so many sites to do midwifery. We have community health capacity. So we can actually look at the capacity and getting those reports, it’s far more easier to actually work that out now....open maybe some dialogue and actually start to think about where people can actually utilise clinical placements....So, for example, if they only want aged care or subacute they shouldn’t be in Wagga or Griffith, they need to be elsewhere....A smaller site...where that can be met and leaving that more acute stuff for those placements that need that acute. HS20

Utilising placement sites other than acute care may be particularly important given that health service delivery trends show a steady shift towards other settings of care, such as community health and general practice, which are increasingly managing complex long term and chronic conditions (National Health Workforce Taskforce, 2009). Placement capacity can be increased by utilising a wide range of public, private, community and local government sites in each community for aged care, mental health, and sub-acute care; the use of larger sites as exclusive centres for learning about acute care may also streamline placement experiences.

Some smaller sites have historically not offered clinical placements. With the right preparation and support it is possible that these smaller types of health services could assist in increasing capacity for placements by offering to take students. In order to make this strategy work, these places will require assistance with preparing for students and make a commitment to becoming learning organisations. It is vitally important that all placement experiences provide excellent learning opportunities for students so that students might be attracted to work at these types of sites in the future.

Some participants recognised that there were strategies that could be used as alternative means of providing supervision and support. For example, alternative models for placement and supervision may encompass the use of technology, interdisciplinary supervision, and having shared placement arrangements at more than one site within the same town.

Because there’s no reason why we couldn’t do webinars and chat rooms and all that sort of stuff to look at either staff with the experience here if it fits into their workload or paying somebody who can actually liaise with lots of these students and start some discussion.
groups going with them so that they have this regular tutorial from an [allied health staff]. There’s efficiencies in doing that via that means rather than, what I have done in the past: “Is there an [allied health staff] locally who can spare me a couple of hours a week?” EP4-7

Some of the work that’s being done through nursing midwifery, or our nursing staff around what they call “nursing grand-rounds” by video conference. It’s almost something you could replicate with your students out on placement. For them to actually present, you know, a case that they’ve been involved with and what’s happened with that, and you could actually do that on a, sort of, peer almost tutorial. HS19

There may be shortages of particular discipline staff in a health organisation for a number of reasons; however use of an interdisciplinary supervisor circumvents the need for a particular discipline supervisor. Such a strategy is not without its challenges: there may be both pragmatic and conceptual difficulties. In addition, such forms of interdisciplinary supervision would still need to meet each discipline’s accreditation requirements.

I think allied health assistants, your personal care assistants, your physios, your podiatrists, there’s a whole array of health professionals, medical imaging, that really could be supported in those environments and probably aren’t supported that much and I think that the facilitators, they could be a facilitator for any type of student ... for any discipline, I think. You just need to understand the differences between the disciplines and there’s certain things that they can and can’t do. HS1

The potential to increase clinical placements and provide students with more interdisciplinary experience may be possible with interdisciplinary supervision in appropriate settings.

Where we’ve got any sort of education we try to put them together wherever possible if there are any crossovers between the disciplines. Now, the thing that they would share is that any of these places that we have found are good places to put medical students or junior doctors, would probably be exactly the same places that could support a nurse, or an allied health position, who is an undergraduate, but in general practice, not in the hospital setting. So I think that the same sort of places that we would find suitable for doctors, almost certainly, with the right sort of support, would be in a position to do it and they would do it really well. EP13

HWA supports utilising interdisciplinary supervision (Health Workforce Australia, 2013e). Once infrastructure is created then there are efficiencies in capitalising on that infrastructure.

A high usage of part-time staffing may mean that a supervisor is not always available and the organisation may have reduced ability to provide a full-time student placement. It may be possible to tap into this unused capacity by creating opportunities for shared placements. For example, one health service may auspice a student and provide primary supervision, however the student may also perform clinical tasks in another organisation during times that the primary supervisor is unavailable. This model may also have added benefits of increasing a student’s exposure to a broader range of
services and disciplines, thus enabling a student to have a more holistic understanding of a health care service.

*If someone is working part time they don’t feel like they can put their hand up to take on students because they’re not there the whole week. There’s probably willingness there from a lot of part-timers because that’s where a lot of our senior staff are too... so creating opportunities for student placements where there’s joint supervision arrangements would also be helpful.* HS9

*Maybe if someone else actually had the student so they were being, you know, actually primarily managed from say medical centre and then could come out for two days a week, one day we share somewhere or something. I could see we could work to a plan if we felt like we could manage that rather than have full responsibility for someone and maybe the student would get more out it if they weren’t just here.* HS2,13,14

Providing funding to health services for taking students has been an important issue. However, it may be that rather than providing each practitioner who supervises a student with some funding, or absorbing payments into the general funding for a health service, these funds may be used to employ a specific clinical supervisor who provides supervision and support to more than one student.

*One of the things we could do is actually secure some better arrangements where we might be able to fund that person to help with the coordination of placements and the allocation of placements. Not just in health but also in other centres and stuff like that. We are having to pay the placements eventually anyway but there’s different ways in which you can.* EPS

The placement of students is often based around education providers’ timetables which results in peaks and troughs for health service placement requests. Spreading the load of clinical placements across a calendar year and into shifts that extend across a 24 hour day and seven day a week timeframe (where appropriate) would be likely to increase placement opportunities.

*The problem is... that they’re all wanting it at the same time... There’s a whole month here where we could take ten students... So I have three months where I don’t have students where I could potentially have lots.* HS18

*We have is absolutely saturation pretty much over four months of the year. So if we look at it April, May, probably into early June, probably mid-May through to mid-June that’s probably a peak, and again August, September and maybe a little bit into October, but those are really high traffic months.* HS20

For some professions and sites, the provision of 24 hour a day care is a practice reality and therefore having a placement experience that mimics this reality may assist in better preparing the students for the actual experience of working life. Thus, there are additional advantages to considering providing placements across the entire spectrum of the working day and week, in addition to increasing capacity for placements.
It's one of those industries where it's not Monday to Friday, it's not regular hours. Like we had 47 grads start recently and only two of them had ever done a night duty and only about six had ever done an afternoon shift out of that many. So what they're experiencing on clinical placements ... is not reality. So their clinical placements currently are not preparing them for the workplace, and when they were told they were going to be doing afternoons like almost immediately, some of them I think nearly thought that I had two heads! The fact that they would be doing night duty after four weeks, they thought they'd get six months without nights a lot of them. So I think that making it real. We don't protect them like they are protected within an education facility.

The model is the student is tied to the registered nurse, and they get rostered on for the same shifts as that registered nurse for their placement. So whether it's weekends, whether it's evenings, they work the same sort of shift pattern as a registered nurse. Which is also not a bad way for them to see what it's like to work nightshift, and that kind of thing.

Expanded scope placements and innovative clinical placement models may be important strategies for increasing student placements. Successful innovative and expanded scope clinical placement models must be sustainable, high quality, and respond to changes in health service, educational, and workforce needs (State Government of Victoria, 2007b). A review of expanded scope and innovative clinical placement model literature was undertaken (Appendix 1) in order to identify and learn from successful implementation of innovative models, and discern the role of these models in meeting the objectives of this project, the education providers, health services, and students.

Examples of innovative and expanded scope clinical placement models include:
- Re-structuring placements to extend across the academic year (Healthcare Management Advisors Pty Ltd, 2007; Rosenwax, et al., 2010) and utilising weekends or 24 hour shift rostering for placements where appropriate (Healthcare Management Advisors Pty Ltd, 2007; Hume Clinical Placement Network Moira Project, 2012; State Government of Victoria, 2007a; Turner, 2001);
- Supporting supervisors by establishing networks with other supervisors (Mason, et al., 2012), providing academic resources from education providers (Rosenwax, et al., 2010), or providing incentives such as formal supervisor recognition or qualifications (Aged and Community Care Victoria, 2011; Mason, et al., 2012; Victorian Healthcare Association, 2011);
- Developing new and innovative sites such as Teaching Nursing Homes (TNH) (Barnett, et al., 2011a) or expanded utilisation of other facilities including aged care (Turner, 2001);
- Improving partnerships between health services and education providers (Rosenwax, et al., 2010).

**Enabler: providing education, support and incentives**

Clinicians may struggle to supervise because they are unsure how to help others learn. In a study by Community Services & Health Industry Skills Council the need for greater emphasis on the development of supervision skills for workplace supervisors was highlighted by 40% of respondents in a 2013 environmental scan, Community Services & Health Industry Skills Council, 2013, in (New South Wales Interdisciplinary Clinical Training Networks & Health Education & Training Institute, 2013). Reticence to supervise due to lack of confidence and knowledge may translate to clinicians not
offering to take students. Therefore, if supervisors could become more confident and knowledgeable and feel more supported in supervising, they may be more willing to take on students.

_We do offer clinical supervision workshops ... supervisors come along to those workshops in droves really and they seem so appreciative for anything you can tell them, because this the other thing that I find really interesting is that for any of our disciplines, our supervisors have no educational qualifications ... they're professionals in their discipline and then we send them students and say “Look after them.” So they have no qualifications [in teaching students] and I think they really appreciate anything that we can give them to support them, some ideas about how do you supervise ... EP4-7_

There were suggestions about what kind of education about supervision is most helpful, and what some of the barriers to participating in such education were. It appears that education that occurs at the health service site is the easiest location for clinicians to attend. Health service managers could also support the development of clinicians’ ability to supervise by providing them with permission and leave to engage in education about supervision.

_[Education providers] do hold some workshops, they’re generally off-site though so it depends again on someone’s capacity to get to those workshops and be supported by their line managers to attend those workshops and that’s another tension. When it comes to anything around what might be seen as either professional development opportunities and/or things like clinical supervision which are not necessarily part of your brief as a clinician, to get permission to go off-site and do those things is sometimes a barrier. HS9_

Giving clinicians ideas about how to approach supervision and giving them positive feedback about their supervision are ways in which clinicians can be supported.

_I think also it helps if you actually either walk them through the options that they could have, so you listen to what they do and then you flip it and say “Well this could actually be done this way and you could be doing this” ... so you actually create a vision for them of what a placement could look like and that’s often the first step to them thinking “I can do it.” They get locked in the minutia of just doing work, sometimes it’s hard for them to step out, you walk down the road with them about how this placement could look and you map it out for them and give them lots of options. EP4-7_

Regional training has also highlighted the importance of providing clinicians with support for learning how to supervise. Evaluations of the Master Class Clinical Supervision Training, offered by Health Education and Training Institute (HETI) NSW held in Wagga Wagga in May 2013 indicated that locally relevant training enabled clinicians to immediately apply their learning from this workshop into their workplaces (Health Education and Training Institute, 2012). For example, one of the attending clinicians commented that “topics and approaches were extremely relevant to my current needs. You know it has been a worthwhile experience when it continues to dominate conversations across all areas of daily work” (Health Education and Training Institute, 2012).
Valuing staff through acknowledgement, expressions of appreciation, financial incentives, and other rewards may provide motivation for student placement coordinators to find new placement opportunities and for clinical supervisors to take more students. Cuss’s recruitment and retention study of the allied health workforce in rural Victoria found that practitioners wanted to feel valued for the work they produced. In particular they desired feedback, respect and understanding (Cuss, 2005). In the current system, clinical supervisors report feeling undervalued (New South Wales Interdisciplinary Clinical Training Networks & Health Education & Training Institute, 2013). There needs to be more incentive for health professionals to embrace clinical supervision as a key part of workforce development (New South Wales Interdisciplinary Clinical Training Networks & Health Education & Training Institute, 2013).

The successful GRACE model (Rosenwax, et al., 2010) rewarded the efforts of each health service Clinical Education Coordinator with an appointment as an associate of the university. Associate status provided the worker with access to library facilities, academic staff, and the Occupational Therapy Assessment and Measurement Resources Learning Centre. In the Riverina, only one practice was found to pay their supervisors a proportion of the income from the placement to compensate for the workload. However, the value of these incentives in increasing clinical placements is unknown.

*We pass on a bit of the payment to the nurses, so I think they get a proportion of it. We get $57 a day or something like this and we give the nurses each who look after them that day $10 out of that. With the nurses it’s not so much an income issue, but I think it’s more it does, it just creates a bit more stress in their work environment, just having students with you all the time it is a bit more stressful, it’s a recognition of that.* HS30

There was a sense of irony that placement coordinators were now so much in the spotlight.

*I think it’s really interesting that a lot of people who are student placement co-ordinators have been saying that they were just quietly doing their jobs for years, and then all of a sudden there’s been an explosion in interest because of Health Workforce Australia was giving money... They were saying suddenly they’re being invited to Dean’s meetings and executive meetings and stuff ... [laughs] to talk about student placements, because it’s suddenly the hot issue.... Yeah, they’ve been doing it for years. And they go, “Oh, all of a sudden everyone’s interested in what I do”. HS21*

**Enabler: reframing supervisors’ concepts of how placements can be structured and how they perceive students**

Giving students increased responsibility and allowing them to do more than just follow and watch may be useful for increasing both an organisation’s capacity to take on more students and also to enhance students’ experiences of placements as valuable and satisfying. Sometimes it is staff members who need to rethink how they structure students’ experiences; it may be possible to allow students to be more active and take on more duties than they originally thought possible. In addition, if staff change the way they supervise students they may be able to take on more students. Students can receive supervision and planning in a group, but then be allowed to implement their plans on their own, without a staff member’s constant supervision.
We couldn’t take extra students because we couldn’t have two on the morning and two on the afternoon. I try to double the capacity at our local hospital and they weren’t really happy about taking more because they thought that they wouldn’t be able to cope with students. I think one of the biggest things is that a lot of our sites don’t know how to use the students to their best. The students aren’t there as an extra pair of hands, but for goodness sake students hate watching and just following people around feeling like they’re a puppy dog. They actually want to get in and work and look after patients. That’s what they want. They want to belong to the site. They want to feel like they are there. They want to feel like they’re learning. They want to feel like they’re actually contributing whilst they’re on placement and that’s where we need to get the staff that they’re currently working with to then think how can I utilise this student that I’ve got to the best I can? And if that means that I give them their own patients, which that’s what we’re trying to get them to do, the student has a much better placement, the RN [registered nurse] or the staff that they’re working with actually feel like they’ve got a bit of time freed up to teach the students and it works really well both ways; the student learns and the RN actually enjoys having the students and we also increase our capacities so you know a lot of the staff on the ward need to know how that they can best use students because they feel like, you know, they’re there to: “Yeah, she can make the beds and you can do all the showers,” but students can do lots and lots of things. EP12

A supervisor’s perception about the kind of learning tasks that a student can be assigned might either enhance or constrain capacity to take on more students. A supervisor can reframe his or her vision of a student from being a burden to being someone who can provide help. Students certainly need structured tasks to complete, however they may not need continual oversight when performing these structured tasks and therefore the supervisor can be freed to complete other tasks while the student is completing (and learning how to do) the assigned task.

But from a positive point of view I now also have a little helper too, because I actually see that yes, [my] clinical load has slightly increased but if I can go and get an undergrad to go and do some observations and then feed that back to me that enables me to go and do something, I can still be in the room supervising but I can be doing something with my other patients. So there certainly are positives, but people shouldn’t just see it as extra workload, they should actually see it on a positive light in that now I’ve got another pair of hands. HS24

By framing students as useful to the practice environment, for example as assisting practitioners to keep their skills up-to-date, clinicians may be more encouraged to take students.

...if I had to sell it to a GP ... I’d be selling it from the point that [it] ... keeps their practice nurse on their toes, doesn’t let them get too out dated, it helps them understand what people are being trained in today....And it’s about engaging some of them in building that workforce, I mean especially in rural areas. We have some doctors here who are quite outspoken, expressing their concerns about workforce and the workloads that are associated with medical services in rural and regional areas so I think there’d be many to whom we could appeal on the basis of its investing in our workforce, it’s building our capacity, it’s building our capability and it’s providing opportunities for future health professionals to undertake training in a different environment or to experience a different environment, may
well be the future employee that they have...but it would require a marketing campaign around that. EP 16/17

I think at the moment the flow, it’s only one way. It’s just the universities contact us, we say, “Righty-oh, here’s our person.” And it goes ahead. But I’m just thinking moving forward, if we had a “go-to person” maybe there are opportunities that would arise where we’d say, “Oh hang on a minute, let’s contact the go-to person at the university for some nursing students to help us out with a particular project that they might be able to link in. HS 23/24

Utilising students to their best may increase capacity by having them as active members of the health care team within their capabilities, rather than just another body shadowing the supervisor. In such a model, students benefit through becoming active agents of their own learning and development. They may also become more accountable and responsible for their professional behaviour during their placements (Rosenwax, et al., 2010). Adult learning principles include that students benefit by becoming engaged as active learning agents in their own development (Burns, 1995).

**Enabler: identification and utilisation of motivating factors for taking students**

Identifying and appealing to the factors that motivate health services and individual supervisors to take students could increase placement uptake. Wanting to foster recruitment to rural practice, existing relationships and historical partnerships, succession planning, being an alumni, seeking revenue opportunities, and personal preferences are all factors that impact on whether placements are offered.

Another strong motivating factor for GPs [general practitioners] is that they see that as a form of succession planning, of filling future workforce needs, because historically it’s been very hard to attract young doctors to rural areas, especially the GP population and especially in rural areas is ageing, and often they wonder where they’re going to find someone to replace them when they decide to move on or retire, and I think a lot of them see this as a valuable form of successive planning. If they give students and registrars a positive experience in their practice, then they’re going to make decisions about coming back to that practice or to another practice like it in the future. EP10

A supportive organisational culture and a positive clinical placement experience may be important factors in supporting recruitment.

...a lot of our students have said when they’ve come back on posts, they’ve applied for post grad placements with us after being students. They’ve said the reason we have come back here is because you guys looked after us so well, we felt so valued and we really enjoyed our time and so we wanted to come back and work for you and to get a grad placement with you. That’s how we’ve retained a lot of our younger staff or drawn them in. HS1

Helping health services to see that providing supervision might enable them to prepare students for rural practice in the way that they think these students should be best prepared, may motivate them to take more students.
In the public sector particularly, and maybe the not-for-profits as well, actually. That whole concept that the students might actually be their future workforce, and not only that, a future loyal workforce that actually embodies their values and core principles of quality, because you’re actually trained them. Straight off the apple tree, like, before they’ve been socialised by their health professional peers. … I don’t think health providers have got it, because they’re focused on the budget this year, or the profit margin this year … and the whole ICTN opportunities that the health providers and the education providers sitting down at a table and starting to work together … and for the Riverina the opportunity is that out of that you’ll actually get a region that creates a training interface, and that subsequently becomes a workforce interface. I think it’s a huge opportunity that’s really exciting. EP2

When health services receive payment for students undertaking clinical placement, this may increase their sense of responsibility and commitment to taking students. In addition, helping to pay for some of the costs associated with taking students on clinical placement may assist a health service to take on more students.

I think an approach to charging isn’t a bad idea, because I think it actually establishes a relationship, you know? And the university, if it’s paying, can expect certain stuff. And the hospital if it’s getting paid, has to provide certain stuff, and I think it creates a relationship, you know? Otherwise what starts as a favour ends as a chore. So you might as well get it commercially set up from the start, I think. And I think it gets everyone focused on the issue. Yeah. So I think it will happen. I think there’ll be charging. And if in the new placements you approach people and they say, “Well, we can’t take students, but…” Maybe they could if there was a charge associated with it. Well, maybe we ought to consider that…To open up new placements. I think that’d be all right. EP2

Hosting students is a way that some health services can dispel myths, improve public relations, and assist students to better understand the needs of vulnerable people, including Aboriginal and Torres Strait Islander communities, aged and disability clients, and people who are in the justice system.

Some staff realise that welcoming students into such facilities can help them overcome their prejudices and fear of working with certain groups of people. By assisting staff to see the many benefits that can be reaped by offering student placements, they may be encouraged to offer more.

In dealing with the kind of prejudices around our patient group, means that a lot our staff do know that it’s important to get students in. That students are our future, and also for every student that comes and spends time with us, they then go out, they tell their friends, “I went into [Health Service] … people do good work there, patients are really unwell, they need a lot of help.”…And we hear students saying this. We hear them saying that their minds are just completely blown by coming here. And it unearths so many prejudices. I’ve had medical students saying, “I read in textbooks… that being illiterate will affect your health, but wow! Now I can actually see that.” Because, you know, they’ll deal with people who have had sad, very, very impoverished lives. And I think that’s the thing. I think most people who work here do have a bit of a social conscience, and they realise that taking students is a way of sharing the unique insight that we have, with the rest of the world… And I think that’s where our best
successes are from; people who want to promote their service are the ones who are very enthusiastic about students. HS21

Hosting students may provide clinical supervisors with opportunities for ongoing professional development and therefore providing placements may be seen as providing benefit to health services. Benefits such as this may increase health service staff’s motivation to offer clinical placements, thus increasing capacity.

And it’s also good for our staff. It’s good to have students ask embarrassing questions. That’s what they’re there for. We have people that have never been to university, and we also have people that have not been to university in a very long time, and the students are hearing the most, the latest knowledge, the latest research. It’s very helpful for students to go, “Oh, well we were taught this way. Oh really? Oh.” And students ask, “Why do you do it that way? Why do we still use this medication?” so it makes our staff more on the ball, it keeps them on their toes. They behave better when they’ve got an audience. So it’s not just workforce recruitment and PR [public relations], it actually makes our staff smarter as well, and makes them more reflective and more engaged. HS21

These motivations for hosting students were also reflected in the survey results. Clinical supervisors valued placements as a means to facilitate intellectual stimulation and contributing to the development of staff’s clinical knowledge base, academic thinking, and examination of their practices; such benefits were reported as being prime motivators for hosting students.

**Enabler: there are opportunities and challenges in using the private system for placements**

Public providers, especially public hospitals, are the most dominant type of clinical training placement provider – especially in the larger professions such as nursing and medicine, where they provide 71% and 72% of all clinical placement days respectively (Health Workforce Australia, 2011b). Thus, the use of the private system to increase capacity for placements is a significant untapped market.

The world that I think is untapped is the GP world, the practice nurse environment. I think we’re missing a huge...75% of GP practices would have some sort of practice nurse associated with them... that’s definitely, absolutely, it’s definitely an untapped world. EP 16/17

Although there appears to be substantial untapped capacity in the private sector, accessing this capacity may be problematic for a variety of reasons.

Sure, there’s capacity in private practice and there’s a lot of it. There are 80 specialists in Wagga but you have to set up a way of providing students what they need in a private practice setting and I’m not sure that’s easy to do. EP14

One option was: can we go to expanded settings? Like go to private hospitals, go to general practice, and all that sort of thing. Well, when we looked at it, it’s all very easy to say, “Yeah that’s great,” but heck, the barriers are incredible, and the barriers are particularly around the facilities and the ability for people to supervise. I mean they might be keen to supervise but
they’ve also got to be the only doctor who’s on call and they’ve got to do this and do that, and I’m sure that the same thing would apply to allied health. EP13

We do use private practice, mainly for third and fourth years...I haven’t sort of had a look at the second or first years. Our private practices seem to be really good in allowing the students to have a lot of involvement with the clients. I’m sure there’s more capacity to take on more private practice, you know, but again, it’s the time, it’s the time to go and build that relationship and then to, you know, come up with it, you know, an incentive for that private practice to, you know, to take on more students. EP22-25

I would imagine that for-profit private hospitals... they will see students as being a slow down of their throughput and a real cost. So unless they can tie it to their workforce strategy, or unless they’re going to do it to please a clinician, or there’s some pay off for them, it’s going to be more problematic. But, you know, at the end of the day, if we want to expand capacity, we’ve got to look at the privates. EP2

Opportunities that target private health services need to recognise their operation in a competitive market and private providers may not be able to accommodate placement growth without also receiving funding to support these placements, Health Workforce Australia 2011 in (New South Wales Interdisciplinary Clinical Training Networks & Health Education & Training Institute, 2013).

I think private practice training is quite good but private practice comes with private practice so the provider is generally trying to make a living and they make a living by seeing patients; they don’t make a living by teaching and supervising. That balance has to be thought through ... after all what it’s about is seeing clients and charging those clients a fee for being seen so they can’t take twice as long over what they do. You need to structure that into an overall educational experience. EP14

The private system appears to be greatly underutilised for student placements. However, there are a number of challenges that private allied health practitioners face when offering placements and these problems need to be addressed before it is possible to tap the capacity within this area of practice.

They’re very reluctant to take students, we find that in the private health system and particularly private physiotherapist working in private practice very reluctant to take students and when they do take students because of the nature of the fee for service students often don’t get any hands-on experience. The students are all keen to go to a private clinic because that’s what they think they’re going to do when they finish work, they’re going to open their own practice so they want private health experience but when they get there, probably 90% of the students who go are disappointed. Private hospitals are a bit better ... It’s the private practices which are problematic, 10% would offer a really fantastic experience the other 90% [do not have a good experience] ... The private practitioners complain that our graduates aren’t ready for private practice....But they can’t get the private practice experience... well to us the solutions quite simple: give them a good experience and take more students. They often need a lot of hand holding and we have to try to explain to them how you might be able to have a student in private practice. They have, obviously the issues
of not being able to charge clients if students have been treating them ... It’s amazing how some of them seem to get around it. I just don’t understand. Some of them it’s not an issue, it’s doesn’t matter. Others it’s their little mantra, their flag waving... I guess you have to understand that’s the way they make their money so they have to make their living but I think ... if we could crack that nut of private practice taking our students, that’s a lot of untapped capacity. EP4-7

The private health sector has traditionally not offered a lot of student placements however there might be a number of reasons why these services might consider taking students. There may be benefits to private organisations for offering student placements. Private health services may fear that their paying clients do not want to be troubled by students; however, this may be a misperception. Some participants considered that private patients would welcome students.

But there’s two things about students in private hospitals that people don’t realise. The first is that it’s good for the hospital. It’s good for the hospital to have students. It’s better for their quality. Students generate a questioning attitude amongst clinicians that is very, very powerful. Okay? And the second thing is patients really like them...And private patients don’t get the opportunity to have students normally. EP2

For instance, I wanted to put some trainees over at [name of health service] in the private hospital. I had a lot of objection from quite a few of the specialists, the VMOs [Visiting Medical Officers], who said, “But my patients don’t want to have medical students here, and they don’t want to have trainees here, because they’ve gone into a private hospital because they want me to look after them.” But, when you go to the patients, they say, “I would be delighted to have a medical student here,” and, “I would be delighted to have a trainee here.” But consultants use it as an argument against that, and I don’t know why it is. ... So I mean, for instance, if you were a GP and you don’t want to have somebody else in the room, and you just want to deal with your patients that are there, it’s all private and it’s all confidence and they can’t possibly deal with it with students there. There are people who have those attitudes, and that’s a barrier to those places being used as an expanded setting of training, and increasing the clinical placement options. EP13

**Enabler: incentives for students to go to rural areas**

It may be possible to increase uptake of placements in the Riverina ICTN by offering students incentives to attend placements in this area. There is considerable cost involved for students completing a rural placement away from their usual place of residence. Expenses include travel to and from the placement, accommodation costs in the placement town (and possibly also in the home town), and sustenance costs when living in temporary accommodation (which may be higher than in one’s home). Students may also be carers for children or ageing parents, and may need to pay other care-givers in their absence. In addition to these costs, some educational institutions may require students to pay increased fees in the future to access compulsory placements. There is recognition that these types of costs may be unavoidable. In order to counter-balance costs associated with students undertaking rural placements, some incentives may be needed to attract more students to the Riverina ICTN for their clinical placements.
Now ... they [governments] basically say, “Well, here’s HECS and you owe us money. When you can earn the money to pay us back”, and now you say, “Okay, well you need to have a clinical placement and we’ve run out of clinical placements in the major places. I’m sorry, you’ve got to go out to [name of town], and this is where you’re going for your clinical placement because there is nowhere else for you to go. It’s going to cost you, this, this and this, and we’ll add that to your HECS fee.” That’s the sort of approach that they would take.

Now if they are really “fair dinkum” about doing anything about workforce, they would see that that was something to do with incentives that they could actually do, that might encourage people to go to these places that are a bit on the nose that nobody wants. It’s the mal-distribution; it’s not just rural, it’s a question of where do people want to go versus not want to go. So you’ve got to provide some incentives, rather than sticks. You’ve got to have some carrots to get them to these places and I think they’ve got the potential for doing this. So, I think identifying those costs, making it transparent, would go a long way to help HWA [Health Workforce Australia] decide, and the Federal Government to decide how they’re going to actually spend their dollars. EP13

I mean the accommodation here in [name of town] is crap, it’s terrible; you wouldn’t let your child live there and that’s what’s provided, it’s just so embarrassing, ... but to me, that would have been the one thing that would have increased our clinical placements for allied health dramatically because we would have had somewhere nice for them to stay, and they would be happy and they would come, and they would come for short term rotations etcetera, so I think having accommodation is really important. EP13

Billeting students may increase capacity because this helps to decrease the costs students have to bear when attending placements in rural areas. It can also decrease loneliness and sense of isolation for students, and their hosts can assist with orienting them to the social life of the new community. In addition, there may also be benefits to the hosts.

You could see how that could happen quite nicely because students often live with other people when they’re here. I’ve known a lot of students who live with older people whose children are off at uni [university] or they’ve left. Hospitals often do that, I know in Melbourne there’s a lot of houses around Austin where you can stay at these people’s homes who go if you’ve got family in the hospital you go and stay there and it’s really cheap. ... Billeting is quite common ... That’s a nice thought to give back isn’t it? EP4-7

If you can socially support that person, which is what you can do with students, barbecues, take them out, give them a good time, all those things, they remember those good times and even if they don’t go back, they’ll tell people and then they may be inclined to go back or go somewhere else because they have such a good time there. HS1

Take the time to make the students feel very valued ... get them together and just do a bit of a rah, rah and have really interesting clinical networking days and tutorials or education days or different things and so they make it into a really enticing package and they’re wanting students to say “I want to choose that place to go for my placement”. HS1
**Enabler: shifting student perceptions of expanded placements**

Assisting students to understand the benefits of learning generic and interdisciplinary skills may increase their uptake of placements that are in non-acute, expanded setting, or innovative model contexts. Thus, changing students’ perceptions of what constitutes a great learning environment may increase placement capacity.

*I still think we look at what their [students’] needs are, but we can’t be as accommodating as once upon a time we used to be because we don’t have the placements anymore. Basically we tell them now “you’re lucky if you get a placement, let alone, you know, wanting to get your dream one”, so, and the other thing is we try to get them to think outside the square. A lot of them think, oh well, Westmead Hospital sounds so much better than Parkes Community Health, but I say to them, you know, Westmead Hospital has all the policies, procedures, it’s a lot bigger hospital, you might only see one type of patient, you might not even get to touch that patient. Whereas Parkes Community Health because they are desperate for staffing and they work as an interdisciplinary team, you’ll probably get to work with whole number of people, have your own clients, you’ll actually probably get much more out of that placement. So it’s trying to get students to think differently about the types of placements that they get and I guess this is the issue with some of the non-traditional type placements when I allocate a student like an occupational rehab [rehabilitation] placement or a schools project, that they all go, “Ewww! I don’t want to do that because where am I getting my [discipline-specific] skills from?” So they just think I’ve got to be in a [discipline-specific] environment with a [discipline-specific] supervisor and I need to get [discipline-specific] skills. They don’t think “oh, I also need to have project management skills, I need to have, you know, planning skills. I need all these other different skills that I can get on a different type of placement. I need communication skills, I can get that anywhere”. So it’s trying to get the students to actually think a little bit differently about their placement as well because they all think, “oh I need hospital acute experience and I need this and I need that” when in fact, they don’t. So as long as they get a couple of [discipline-specific] placements, that’s fine, but the rest of them don’t necessarily need to be in that way. EP22-25

**Threats to capacity-building**

**Threat: poor quality placements**

Placement experiences that are poorly executed and result in students having substandard experiences are likely to result in erosion of placement capacity over time. Poor quality placements can have longstanding detrimental effects: students are dissatisfied and may avoid looking for work in similar types of organisations or areas of health service in the future; clients may be disadvantaged and receive inferior health care, which is not only potentially disastrous on a personal level but they may also denigrate the health service to other clients (thus causing a crisis of confidence in the community) or complain and engage in litigation with the health service; and, staff may become stressed and dispirited by the experience and its consequences.
I think that’s a real risk, I don’t want to get into a lot of politics but I think if we overrun health services with students who are not getting a quality experience, who are not getting good supervision and for whom there is not the clinical capacity then we run the risk of providing a poor educational experience and of upsetting the hospitals or the health districts and of upsetting our consumers who are, at the end of the day, the patients. That’s the real risk.

EP14

It may be that it is worse to offer a poor quality placement rather than not being able to offer any placement.

Although there may be considerable unused opportunities for increasing placements, a commitment to providing high quality placements still needs to be a higher priority than increasing the number of placements, regardless of the quality of these placements.

We have our students go to private practice settings but if the view is “Boy, there’s so much capacity in private practice for teaching” you’ve got to look at the product and what I said earlier is there are certain things that students get out of private practice education that are great and there’s stuff they’re not going to learn there. What I think is the wrong approach is to say “There are a lot of doctors in a lot of offices with a lot of patients who don’t have students with them. Let’s use their capacity.” That’s one way of looking at it, the other way of looking at it is to say “We have to provide students with a very good educational product. Can we do that in private practice?” We’ve got to look at it from the other approach. If the answer is yes, then do it. If the answer’s no, then either you don’t do it or you say “Right we’ve got to make a product” but just sticking a student in a room with a doctor doesn’t educate them. EP14

If numbers of placements are increased, but those placements do not provide superb experiences, then they may be worse than a waste of time; they may also destroy goodwill and result in lack of motivation to engage in future placements.

You’ve got to look at that from either side, you’ve got to say “Okay, we can’t just keep providing a quality product for an insatiable demand” because that isn’t going to work. At the end of the day you’ve got to say “Okay what numbers can we properly educate given if you like the current way we educate them?” My personal view is I’m at that capacity now, I don’t think I can increase clinical placements. ... I personally believe that’s pretty much capacity to give people a really good experience. Sure, we could double that we could go to [X number] and they’d be falling over themselves and they’ll be telling us, I believe, that their experience is poor because that’s what has happened in a number of metropolitan centres. You go to Saint Vincent’s Hospital, there are students falling over themselves. I think then we give people a poor product. Sure, they’ll graduate because they’re smart kids but they won’t come back. So I think the product’s really important. EP14

Clearly, providing placements is an expensive and time consuming endeavour. It is however important to allocate sufficient resources to this endeavour so that a high quality product is achieved.
Our clinical placement here is really well-resourced. We’ve got a systems academic, we’ve got a team leader in that unit, we’ve got staff of five who look after and the cost to the university is quite high already. Without even then going into the cost of a placement where students don’t show up or the cost when we have to have an agency. There are agency facilitators now and they cost more than facilitators that we might employ for example. So it’s a big staffing cost. EP9

**Threat: poor communication**

Communication problems can result in lost opportunities for placements. For example, one education provider noted that sometimes placements that had been booked did not actually occur but rather than letting other education providers know that there were last minute placement opportunities, these placements were simply cancelled. The net result was that no students utilised the placement opportunities.

The other thing that I do find hard to deal with is - and nothing against the university system - but you find that they tend to book up all of the places, and I can imagine why, but then the last minute they don’t want them. So they ring up and say, “We’re going to cancel those places”, and we don’t get that feedback. It would be lovely if we had some type of communications somehow between the education providers I think. EP11

**Threat: having to adhere to rigid regulations about how supervision is delivered**

Sometimes education providers had an innovative idea about how to increase placement opportunities however these innovations were foiled by regulation requirements. It is clearly important to ensure that placements are appropriately supervised by well-prepared, expert staff but if there is no ability for flexibility or creativity to capitalise on localised opportunities then these opportunities cannot be actualised and are lost.

We’re unfortunately deemed by the board that we have to have RNs supervising students which actually causes us to be a bit of an issue that it may not make some of our placements as interesting or not make other sites come up. I was talking to the Head of School this week and we were thinking about primary health care placements for first years and we use all our GP practices which are great, but you know, should we be using things like child care centres? Once again, no registered nurse often in those so we’ve got to think a little bit outside the square and, all right, we could use that, but how if we had child care centres, how could we use them? ... How can we accommodate the requirements of the board and the requirements of the subjects so that the student gets the best out of the placement but it also keeps the board happy? That’s probably one of the hard things I have is to keep everybody happy in the sense that we’re right and we’re okay with the nurses board, that we’re doing everything right and we’re also giving the student a good quality placement with places that we’ve not potentially used before. You know we’ve got a whole fantastic disability service down here [but] there’s no registered nurses in it, but it is fantastic ... to send students into those locations for primary health care ... That’s probably my biggest issue that I have is with untapped capacity is how can I utilise this to ensure that we’re meeting the requirements of the board? EP12
There can also be regulations about the conditions that must be met in order for a placement to be officially recognised as contributing to the number of placement hours for a student.

“When I ring up and say, “Have you got placements?” they’ve got the capacity but the capacity is in places where they won’t meet the clinical requirement of students. So there’s always capacity at those smaller facilities, but when it comes time to do an elective placement or an placement they don’t meet the requirements because the rules are ... general practice can be done anywhere, but acute medical placement in the hospital must have six patients that are acute every day while that student is on placement. So a lot of the multipurpose services, they have an acute side and an aged care side, but they might have days when they’ve only got one or two acute patients there. So that doesn’t meet the requirements of what we’ve been told. So it’s no good even looking at sending them to those places simply because we know that on average they’re not going to have the number of patients required. It’s a shame because they’ve got the capacity to take them but they don’t have the patient load that we need.” EP11

In this excerpt, the education provider recognises the potential for placements but cannot implement these placements because they fall short of the requirements for placement as set out by the professional registration organisation.

Sometimes, although staff members may perform similar duties, there are some staff who are prohibited from providing supervision to students by the professional organisation.

“So there are certain things that the EENs [Endorsed Enrolled Nurse] can’t do and one is precept a third year RN to give out medications and things like that. So I can only take enough third year students to cover the RNs that are working here. HS 7,16,17

**Threat: charging fees for clinical placements**

Many education providers expressed concern that paying for placements would ultimately result in reducing the number of placements that occurred. Although health services would still have the capacity to offer placements, education providers may be unable to accept placement offers because they cannot afford to pay for them.

“I know that cost is something that we don’t like to talk too much about, but financial issues is also another factor that we deal with because a lot of our institutions are charging and they’re becoming more expensive and some sites we actually have to say “no” to when the
cost has actually come, you know nearly double what we’re paying for some sites. So those things go into you know, apart from availability. EP12

In the survey, education providers ranked the request for payment from health services as the biggest potential challenge or barrier to clinical placements.

Currently, education providers only pay for some clinical placements, and in particular they pay for placements in many public health services. However, if more private health services start to ask for payment, the cost of paying for placements might become prohibitive.

We pay $59.00 per day per student to the health facility and we get bulk billed if you will on that. At the end of a three month period we receive the bill for all of the placements that have been undertaken in a health facility for that previous three months and at this stage that’s coming in at a roundabout 30 to 35 thousand dollars per three month period. We expect it to go up a little bit because the last two three month periods have sort of been across holidays and whatever and so we haven’t had as many people in placement and we were also, we were only discussing this yesterday, we are also hearing on the grapevine that private facilities hearing that we are paying health facilities for that clinical placement are considering levying a charge as well. Well it’s going to start having a fairly significant impact soon. We have been managing that cost by taking the money out of our delivery dollars, we’re only funded for delivery; we don’t receive any supplementary funding for work placement. So we’ve had to take that funding, reduce our delivery cost if you will and channel that funding into paying for this clinical placement but we can only do that for so long. So we now have to implement a cost recovery process for that fee. EP16/17

As was seen in the previous excerpt, some education providers consider that they will have to deal with the high cost of paying for clinical placements by asking students to pay increased fees. However, charging students for placements may well mean that students cannot afford to undertake the health courses they want to do and this may ultimately end in reduced numbers of graduates entering the workforce. Fewer numbers of graduates may contribute to health workforce shortages, which are already apparent, particularly in rural areas.

The challenge will arise where we will have a student that our teachers believe is just eminently suitable for this career, is so well suited to a career in nursing it’s almost like they’re made for the role, however, financial constraints might meant that that student can’t pay that work placement fee, that clinical placement fee. So the dilemma is do we put that person into a clinical placement anyway and we support them and if we support them why don’t we support the other one, or, do we say “you haven’t paid your clinical placement fee, therefore, I’m sorry but you can’t go on clinical placement, therefore, you can’t complete your course, therefore, you have to find another career”. EP16/17

Passing on costs for placements may further disadvantage an already disadvantaged group of students. If only students who are wealthy can afford to enter and graduate from health courses, this can create a socially unjust and inequitable situation that affects the whole community.
Enrolled nurses are required to do 400 hours clinical placement at $59.00 a day actually 50 days at $59.00 is $2,950.00 so just shy of $3,000.00 per enrolled nursing student and a health assistant nurse or an assistant in nursing’s required to do it five days minimum and that would be an extra $300.00 for that person on top of other fees. And those courses traditionally have, and this is with our lower socio-economic population and non-English speaking background, Aboriginal communities, so they tend to be groups that $300.00 for may be a concern, there’s levels of disadvantage. And I mean people sometimes make choices to go into the VET sector because it is for them a cheaper alternative than a RN sector. … I mean we look at five days as the minimum but we try to provide our students with more because we want them to be as job ready as they need to be to walk straight into employment the moment they course complete. So in some cases we will try to arrange ten days of clinical placement for health services assistants for example or aged care, so that now becomes $600.00 as opposed to $300.00. So if we asked a student to pay a $600.00 fee on top of their course costs we are almost doubling the costs that they would incur and what we then have to look at is whether or not that student would choose to go down that course and if we don’t offer the two weeks of clinical placement then it’s going to impact on their job readiness, you know, it’s a no win whichever way we look at it. EP16/17

Funding received by health services for placements may end up in consolidated revenue rather than received by the department that supervised the students. This may result in a lack of motivation to take students if the supervisors feel they put in the extra effort and workload but receive no reward in return.

They were griping about it. You know, they were saying, “oh we’re expected to take extra students but we hear that there’s a rumour that they actually get money”, but they are not told anything … I would say that they don’t know where that money [goes], they just think … it just goes into the big black hole, to put it bluntly. HS37

**Threat: lack of clinical supervisors**

Clinical placements are dependent upon the presence of workers in health services who can provide tasks for students to complete and the supervision that is needed to support the students in their learning. The capacity of a health service to take students is dependent upon being able to rely on supervisors still being employed by the health service when students arrive (some months after a promise of a placement is arranged).

We were offered quite a few placements up in [health district] and they got HWA funding to take students. So we were offered quite a few placements there only because they were offered, they had that funding, so, but it actually fell through because their staff left. A couple of the staff members left, so we were kind of left high and dry because they said, well we can’t actually offer them anymore and they had to, I think, give the money back because they couldn’t commit on their side as well. So it was pretty dire straits there for a while. EP 22-25

We’ve got two sites that can’t take students; they haven’t taken students this semester and won’t be taking them next semester because we just don’t have the staff there. They’ve got
half the staff that they need just to run the service, let alone taking students. So getting adequate staff would be a big influence and it’s not something you can just spirit out of the sky. HS37

Having expertise in their clinical area does not mean the practitioner has the skills necessary to offer quality clinical education.

...some of it’s just they fall into that position; they become a senior on the ward and they have a couple of students and that’s it, they’re the preceptor/facilitator, but they have very little to no teaching, have never learnt to teach, never learned any of those skills and it’s been sort of a bit of a flying by the seat of their pants just to get through. EP12

Lack of staff was frequently mentioned as being a reason why placements could not be offered. Clearly, not having full staffing, not having sufficiently experienced staff to supervise, and not having staff who are familiar with the organisation are major impediments to being able to provide clinical placements.

We haven’t got the staff to be able to supervise them which is a real shame because we’ve got a magnificent maternity unit. We still provide antenatal and postnatal care but we don’t have deliveries so that’s been a barrier from our perspective. HS5

Staffing, I mean they’re under the pump, they’ve got a lot of agency staff, so agency staff don’t want the responsibility of students, they’re small rural facilities often they’ve got high turnover of staff, so the managers are very conscious that the students get there and the staff really don’t know themselves what the policies and procedures are, therefore, they feel the students aren’t getting the best clinical placements they could. EP 16/17

Sometimes there is a lack of staff who have sufficient experience in order to provide supervision. Even though a health service might be fully staffed, if these staff are not the appropriate staff to supervise students then placements cannot proceed.

They may have got a number of new grads on the wards or new graduates that come there or it might be a rotation where the new grads are changing from ward to the other so therefore the skill mix isn’t as appropriate that would be good for students to go on clinical placement that they didn’t have enough senior staff. EP12

It’s probably not so much for the first year students, but the third year students there’s a big workload making sure you’ve got the RNs and stuff. And a lot of our RNs at the moment are sort of junior themselves, like they’re still learning and finding their feet, let alone having to mentor someone else. HS 7/16/17

...there are some instances where there may be a registered nurse involved but that registered nurse may be relatively inexperienced. So sometimes the day-to-day practice ... depending on the focus of the clinical, it may be an enrolled nurse, depending on what the requirements are with a registered nurse overseeing that, but ... that might be the only
registered nurse on duty and you’ve got an enrolled nurse with 20 plus years of experience. Sometimes the enrolled nurse is the one with the greatest learning potential for that student. Some of our facilities only have two staff on so sometimes there’s not a lot of choice. HS20

Staff shortages are predicted in the near future as the workforce of health providers become older and approach retirement age. This loss of experienced supervisors is likely to have substantial effects upon the ability of health services to provide enough, and appropriately experienced, supervisors.

And if you look at a lot of the research and the papers that have been done addressing the amount of nursing staff that are going to be leaving the institution within the next five years, and I suppose the global financial crisis has kept a lot of people working because now their superannuation is worth nothing. But the mass exodus of the baby boomers who are going to be walking out is phenomenal and I don’t know, I know there’s been a lot of discussion and working parties and this is an international problem it’s not just addressed to Australia, I don’t know that they’ve fully addressed it. HS42

**Threat: the process of allocating placements lacks transparency and there is a lack of forward planning**

While health workforce education and training has been evolving in response to Australia’s changing requirements, the complexity of the current arrangements and the many players involved means that coordination problems abound. There are weaknesses within the current system of clinical placements which have a major influence on the ability to expand numbers or settings.

Since we’ve had the physio that is in charge here ... since she’s been here for about the last five years, we’re inundated with people who want to send physio students here, and we can’t take them because they all want to come at the same time, we don’t have any facilities for short term placement for them for a bed and that sort of thing, and there’s a whole lot of barriers that turns them off. EP13

There is a view amongst some placement sites that the process of allocating placements lacks transparency and does not adequately take into account the needs of health services. For example one health service received a lot of nursing students and although they wanted to also host other types of students, these other discipline students were not offered to them. They felt pressured to take nursing students and showed goodwill by hosting many nursing students however they did not feel their generosity was reciprocated because they were not offered the other discipline students that they wanted.

Another health service felt that their point of view was disregarded. This service received inappropriate placements even though they considered they had sufficiently communicated to the education provider the nature of the placements they could offer.

Universities insisting on sending mental health placements, even when we’ve said, “No, no, this would really be a better community or primary care placement.” We advertise them on purpose. They just seem to send whatever they want to send, without really being sensitive to how we’ve advertised our placements. HS21
**Threat: lack of time and energy for innovation and problem solving**

Dealing with the current system in all its complexity may mean that supervisors, managers, and education providers have little or no time or energy for thinking about solving problems. Coordinating clinical placements is labour intensive and lack of resourcing and support leads to workload stress. The sheer volume of student numbers, the multiple variables in placement needs, and well-habituated patterns of thinking can stifle innovation. Resources and time are necessary for sustainability of the placement coordination system and rural health workforce.

...what we've found is that the placement coordinators are so overwhelmed by the everyday nature of trying to juggle numbers and places and students, it's really difficult for them to step back and try to be innovative. EP9

And I know like there's been people in the past that have had great ideas and it's been knocked on the head by the school because of funding or whatever and so I guess some of them find it then very hard to jump on board with other ideas ... So, it's very hard because some people do have to go out on a limb...and it's like they're on their lonesome and they have to just keep pushing through and it takes ages for the school to finally come on board and go "okay, we'll help you with this or support you by giving you the hours or the funding or whatever in relation to it." So ... there's probably ideas that may have been just docked before it's gotten any further because it was too hard. EP22-25

Innovation can be costly in its development and coordination, and with a system and staff feeling overstretched, there can be a sense that it is too hard to be inventive. At these times it is especially important that the staff who are working to achieve change feel well-supported in order for the change to be achieved. Support that is practical, such as providing necessary funding, and also support of ideas and a willingness to embrace change are important.

I think one of the problems with some of the innovative stuff, I think in this school we have tried over the years to be innovative, I think there still is a push but it all costs money. Innovation, it costs money and if you want it to be sustainable there needs to be a lot more planning that is involved if you want this to continue...So we do try these innovative things but I guess the backing is not there and eventually you've got to ask yourself "Is this sustainable? What do you need to make this keep on ticking over?" EP4-7

**Threat: prejudice and misplaced desire for only some types of placements**

Some aspects of health practice can be considered fashionable and highly desirable, whereas other areas may be considered to be uninteresting and undesirable. Such trends can cause problems for increasing placement capacity because placements cannot be created in only the popular areas of practice. In order to increase opportunities for placements less well-liked areas of practice will need to be utilised.

So a lot comes back to if you look at what are the glamour roles, and I always call them the sexy roles. It's anything that goes "beep" and you can push buttons, and what is on the television. Now if you look at it, and I've been working in education and across hospitals for a long time. I've seen a real propensity for this escalation towards wanting ED
[Emergency Department] as a speciality, but you also have to look at that proliferation of television programmes around ED. You’ve had ER [the television program “Emergency Room”], and all these other... RPA [the television program “Royal Prince Alfred” Hospital] and all these other sorts of things that promote this in a positive way. So like if you look at our new grads, we had twenty two start at [name of town]. Fourteen of those identified they wanted ED and there’s only one placement for the four rotations. So that means there’s a lot of people going to miss out and that’s only the first preference let alone going down further [on their list of preferences]. So a lot of people are going to miss out on that because that’s what they’ve identified. They find that far more attractive, but if you actually ask them what an ED nurse does, they actually can’t articulate that. So it’s this notion, it’s this idea that we’ve publicised it through these other mediums that I think is actually having a huge impact because it used to be ICU [intensive care unit] that used to be one of the most popular, but I’m finding now that my personal experience, ED has become more popular than ICU. You think of some of the big culture changes - it’s television. HS20

The media, peers, the general public, and academic staff all play a part in shaping the perceptions of students’ attitudes towards health professions and placements. The ideas that the general public and students have about health careers are often represented by stereotypes, Obrien et al., in (Gillespie & McLaren, 2010). For example, health care is repeatedly portrayed as dramatic, brief, and frequent emergencies of acute instances of care, Spouse, in (Gillespie & McLaren, 2010). These formulaic portrayals of health care can seriously undermine the placement process.

Misperceptions about what is the real work of a particular profession can negatively affect both student placement capacity and also the future workforce. If students perceive certain areas of practice as uninteresting or unglamorous, opportunities for placements may exist (such as in aged care) however they are not realised, because students shun taking up these opportunities. Limited exposure to practice environments other than acute care may shape perceptions of these settings as very unattractive, Attracting health professionals into primary care: strategies for recruitment, APHCRI, November 2007 in (National Health Workforce Taskforce, 2009). As perceptions about work are very influential on a person’s career choices, lack of experience in these settings may result in new graduates avoiding jobs in these areas.

I have people say to me all the time, “I don’t want to work with old people”, and there’s a misconception. If we look at the average age of the patient in the hospital they’ve over 70 anyway, they are aged. So they say they won’t work with old people. Well they’re in the wrong job because most of our hospitalised patients are aged. HS20

You’ll often find, even with the first year students that we get, after about two days of working with the AINs [Assistants in Nursing] wiping bottoms, making beds, they’ve had enough. They come to me, they want to be put with an RN. “I want to follow the RN around. I don’t want to know about wiping bottoms and showering.” And I say, “No. This is part of nursing. You have to do it.” They become impatient with it. They just want to move on. They don’t want to do that. It’s beneath them. HS 7,16,17
Misperception and bias that acute practice is the only truly valid area in which students can learn and professionals can practice may destroy opportunities for building capacity. In addition, such malaligned beliefs create chaos and discouragement throughout the health service system.

“We students are very locked into that traditional vision...I’ve heard it said a number of times "It’s a nice placement but it wasn’t a real one," there’s a real concern that something’s a bit out of the square... [students say] “Can I have a real one next time?” EP4-7

There’s a lot of prejudice around the work we do, because we’re not in the acute setting. So there’s a lot of snobbery around the fact that we do a lot of clinic care. A lot of mental health nurses get told that if they spend their transition year in mental health they’ll never ever, ever get a job ever again in the acute setting, which is nonsense. So we deal with a lot of prejudice around the work we do, and a lot of people are thinking that what we do is low-status work, because it’s not like we have a visiting cardiologist. HS21

It can be challenging to change perceptions; however this is vital for assisting students to have the experiences they need to ensure that they are well-rounded and accomplished professionals. It is also essential for creating opportunities for more placements.

That’s some of the pushback that we’ve had so they’ve said half the class go to a paediatric hospital like Westmead Children’s and the other half go to a childcare centre down the road, they absolutely feel the difference. So we’ve got to manage that expectation of students as well and we have to talk to them about the fact that these are the reasons you’re going on placement. That in fact you will see more about child development in some of the childcare centres than you will with sick children where parents are providing a lot of the care and are being protective, understandably. There is an image that of nursing that happens in acute care so the students find that difficult. That’s challenging. Definitely. EP9

**Threat: poor organisational culture**

The organisational culture within a health service has an important bearing on the student experience. While student placements can contribute to an environment of questioning and learning, an existing poor organisational culture can be counterproductive.
...this idea that students are going to go out and change culture in small rural health services, what you might end up doing of course is completely destroying the clinical placement experience for the student in the process of going to a place where they’re not welcome and the culture’s not there... What happens, as an example here, in I think nursing one of the local hospitals where what happened was the new graduates just assimilated into the existing culture. Because they are not in a position to change well entrenched cultures within their organisations. EP4

...if we’re going to explore those options, we have to support the students, and we have to be cognisant of the culture that exists there, and we have to be... we have to prepare and skill up the clinicians to accept students, and I think that won’t be... I think we have to be careful, because we can send students in and they can have a terrible experience.....we have an expanded placement and it’s ... a disaster. EP2

So it is a challenge, I guess, when we’re talking about expanding clinical placement opportunities and perhaps moving into facilities, or smaller facilities which may not have had a lot of clinical placement before, that we need to do some work to prepare that site for clinical placement ... And I think that’s also where you need, either the clinical supervisor, or the, you know, somebody like a nurse educator that’s not involved in the day-to-day clinical care of that particular site. That is almost a safe place for students to go to query, “Oh well, we were taught this was how we should do it here, but when I come here it was like is being done. I’m a bit confused.” Then becomes a point of escalation, but a safe place of escalation ... and a learning opportunity for all of us”HS19

**Challenges and barriers within the current system that need to be fixed if capacity is to be increased**

There has long been a concern that rural and regional services could become increasingly hesitant to offer placements due to pressures in organisations to be more efficient in an economic rationalist climate. The literature supports these fears, Mason 2006 and Bocage et al., in (Mason, et al., 2012; Washington, 2004) which also centre around workplace culture, the availability of skilled staff for student supervision, concerns about risks to clients, a preference for more capable students and less capacity to accept students facing challenges, alongside increased competition for placements due to the growing number of education providers and students, which also places stress on health services.

Other challenges to health services commonly cited in the literature (Swerissen & Rayner, 2005); Northern Territory Government in (Smedts, Campbell, & Sweet, 2013) could be categorised as organisational, clinical and supervisory, physical infrastructure, and links with education providers. Known organisational and physical barriers are:

- Costs both in-kind and budgetary;
- Complexity and resource intensiveness of the clinical placement process;
- Lack of clarity around student and curricula requirements;
- Lack of accommodation, travel, information technology and physical space for students;
Clinical placement requests that do not match the service’s needs (Health Workforce Australia, 2011b, 2013e; Turner & Lane in (New South Wales Interdisciplinary Clinical Training Networks & Health Education & Training Institute, 2013).

Clinical and supervisory challenges include:
- Balancing clinical caseloads, administration and student supervision;
- Lack of time, training and confidence to supervise;
- Supervisory role being significantly undervalued;
- Mix or throughput of cases (Health Education & Training Institute; Health Workforce Australia, 2013e; ZEST Health Strategies, 2012).

Lack of support and communication with the tertiary institutions are noted (Aged and Community Care Victoria, 2011), as is fluctuation in demand and the timing of placements throughout the year, HETI 2012 in (New South Wales Interdisciplinary Clinical Training Networks & Health Education & Training Institute, 2013).

Education providers face challenges (Swerissen & Rayner, 2005) such as the clinical placement component of the curriculum not being directly funded, competition from so many other providers for finite places, student perceptions of what are ‘good’ placements (Gillespie & McLaren, 2010), meeting the requirements of the professional associations and logistical and time difficulties in identifying and securing suitable placements. The placement of undergraduates is based around the university curriculum and semester timetable, HETI 2012 in (New South Wales Interdisciplinary Clinical Training Networks & Health Education & Training Institute, 2013), which results in ‘lumpy’ spells for health services receiving placement requests. As evidenced in ClinConnect, in May 2013, nursing and midwifery requests were at 145% of the total placement capacity, NSW Health 2012 in (New South Wales Interdisciplinary Clinical Training Networks & Health Education & Training Institute, 2013).

Organisational cultures do not always support supervising students, including a lack of management support for increasing placement capacity, HWA 2011 in (New South Wales Interdisciplinary Clinical Training Networks & Health Education & Training Institute, 2013). Perceived lack of sufficient benefits to offset the additional workload, balancing service delivery and supervisory expectations, and managing relationships and issues with education providers are also issues, HETI 2012 in (New South Wales Interdisciplinary Clinical Training Networks & Health Education & Training Institute, 2013). Supervision is not seen as part of some health workers’ responsibilities, and the burden and complexity of the processes of coordinating clinical placements are noted barriers (New South Wales Interdisciplinary Clinical Training Networks & Health Education & Training Institute, 2013).

Exemplars of innovative and expanded capacity approaches

Expanded scope and innovative placement models are key factors in addressing the increasing demand for student placements. Successful innovative and expanded scope clinical placement models must be sustainable, high quality, and respond to changes in health service, educational and workforce needs (State Government of Victoria, 2007b).
Examples of traditional placement models include one educator-to-one student supervision; one educator to multiple students; multiple educators to multiple students; designated clinical educators; designated facilities; supported distance education and inter-professional placements (Healthcare Management Advisors Pty Ltd, 2007). Innovative models may suggest changes in supervisor roles or overall organisation of placements, for example, enabling appropriate clinical placements to take place on weekends and shift work (Healthcare Management Advisors Pty Ltd, 2007; State Government of Victoria, 2007a).

During the course of the project, the team became aware of some innovative clinical placement models. In addition, a review of expanded and innovative clinical placement model literature was undertaken to identify relevant innovative placement models, and discern the role of innovative models in meeting the clinical placement objectives. Projects and models describing clinical placement innovation in rural areas were of specific interest. Information on innovative models identified during the project is contained in an annotated bibliography (Appendix 1) which is coded according to factors addressed in the project/model.

A number of innovative approaches have been selected for that list, with some specifically relevant to rural settings, and are described here in more detail.
SpICE (Specialist Integrated Community Engagement)

The SpICE approach to placements derived from the ‘Schools Project’ (Beecham & Denton, 2010; Denton & Parents Early Childhood Primary Learning Assistants Community). The Schools Project represented a ten year long, cost-neutral placement and capacity-building partnership between Charles Sturt University (CSU) speech pathology, Albury Community Health, and the Riverina Department of Education and Communities (DEC). Teams of 2<sup>nd</sup> and 4<sup>th</sup> year speech students entered up to 10 Riverina schools a year, engaged in a collaborative needs analysis, then developed resources and education packages around communication and literacy issues of concern to that specific school. The success of this partnership arose from the intersection of three needs: the schools’ need for support in gaining better learning outcomes, the need for the health service to promote better communication outcomes for school-age children, and the need for CSU students to explore different ways of delivering services.

The SpICE model (Denton, Clarke, Clark, & McCormack, 2012) extends the Schools Project into a whole-of-community approach, inviting all organisations and groups within a community to host students from a variety of CSU programs. SpICE has now developed into a community capacity-building strategy that offers placements for students from a range of vocational and professional degree programs. Students work with local community leaders in a broad range of settings including schools, welfare and disability services, NGOs, public health, and Aboriginal healing, health and welfare organisations.

In addition to the wide number of hosting organisations within specific communities, and apart from CSU, the key partners in the SpICE placement model are:
- The Commonwealth Department of Families and Housing, Community Services and Indigenous Affairs - specifically the Indigenous Coordination Centre
- The NSW Department of Education and Communities, particularly the Riverina Regional Office; and
- NSW Health; particularly the Murrumbidgee Local Health District.

For 2013, SpICE offers placements in Parkes, Forbes, Griffith, Coleambally, Corowa, Henty, Jindera, Wagga Wagga and Lockhart. These sites will be expanded in 2014 and beyond. Students currently represent 3 CSU faculties, and include those from disciplines of physiotherapy, speech pathology, dentistry, oral health, medical imaging, nutrition and dietetics, nursing and social work.

By using a strengths-based approach, SpICE engages parents, teachers and other services in a community of learners aimed at improving child, family and community wellbeing. Rather than a focus on a specialist identification of impairment, the community of learners is shaped by the self-identified needs of the families in collaboration with service organisations. The learning outcomes for students closely align with the graduate attributes of CSU, as well as with many professional and vocational competencies.

The overall aim of SpICE is to explore different ways of delivering services while creatively building the capacity of regional, rural, remote and Aboriginal Australians. At the same time, SpICE placements significantly reduce the impact of traditional placements on the health sector, while increasing the capacity of generalist supervisors in rural locations. Further information can be obtained from CSU SpICE Coordinator, Dr Ruth Beecham rbeecham@csu.edu.au.
The Whole of System Student Clinical Placements for Undergraduate Medical, Nursing and Allied Health Students

This project aimed to increase the capacity of rural health services and rural communities to support student clinical placements. The project was based on the concept that clinical placements in small health services provide unique opportunities for students to learn from a range of health professionals under innovative supervision models and to experience different levels of the health system. Also that placement in a small community allows students to gain a deeper understanding of primary health care and facilitates and promotes inter-professional education and practice. A whole-of-system approach was adopted in this project which completed the pilot phase in one Victorian community in late 2012 (Health Workforce Australia, 2012c). A key learning of the first phase has been the recognition that whole-of-system approaches need to be tailored for individual communities. The project is moving into the next phase which will see the development of an implementation module including tools and templates to assist in the assessment of needs and issues for communities hosting clinical placements and in developing a whole-of-system approach to suit that community (N. Radomski, personal communication, May 27, 2013). The outcomes of this second phase may be useful in guiding efforts of the Riverina ICTN to build capacity for clinical placements using a whole of system approach in small communities.

Moira Health Services Interprofessional Clinical Placement Coordination Project

This project aimed to utilise untapped clinical placement capacity in the Small Rural Health Services (SRHS) of the Moira Region of Victoria. A forum for identified stakeholders held early in the project served to identify barriers to clinical placements and to generate discussion, foster relationships and assisted in embedding clinical placements as core business within the health services. The project led to improved coordination of clinical placements across the sites, identification of student accommodation, instigation of 7-day week placements and expanded clinical placement opportunities across aged care services. A 65% increase in clinical placements was reported. Having a project officer was identified was a key success factor (Hume Clinical Placement Network Moira Project, 2012). This project highlights the potential of small rural health services to be involved in clinical placement if all stakeholders are engaged and locally specific solutions are identified.

Clinical Placements in Residential Aged Care: A Scoping Study

This project aimed to explore barriers to, and opportunities for, expanded clinical placement in the aged care sector. Aged care providers were found to be highly supportive of student placements to support clinical improvement, overcome the negative stereotypes of aged care as a profession and contribute to workforce recruitment and retention. While the aged care providers believed that student experiences in aged care were valuable, they face barriers including lack of support for clinical supervision of students and key infrastructure. The project recommends linking to teaching nursing homes, creating partnerships with education providers and focussing on multidisciplinary approaches. The use of aged care clinical teaching specialists in designing objectives and learning outcomes for students is recommended (Aged and Community Care Victoria, 2011).
Rural Model Dedicated Education Unit: Partnership between College and Hospital

This project, from a rural area of the United States, aimed to address the difficulties that rural based students faced in undertaking clinical placements in major centres and students’ lack of confidence regarding their clinical proficiency in larger hospitals. The Dedicated Education Unit (DEU) model involved pairing student nurses with specific staff nurses in rural hospitals for the final year of the course. The student-to-nurse pairing occurred for 24 hours per week over a large part of the academic year, facilitating and consolidating the relationship. Some nurse-student pairings worked night shifts and weekends. The results of the DEU model are described as helping to prepare student nurses for rural nurse generalist roles while also facilitating the recruitment and retention of competent rural nurses (Harmon, 2013).

Gribble and Rosenwax Advanced Clinical Education (GRACE) program

Gribble and Rosenwax’s successful approach to reforming Occupational Therapy (OT) clinical education, GRACE, was achieved by changing perceptions of potential host sites as offering the school a service by hosting students to one of regarding each host site as integral and valued partners in the clinical education process. The innovative model has been described as drawn from the concept of relationship marketing with a touch of blue sky thinking, requiring key stakeholders to embrace radical change, cementing enriched relationships with shared values and a sense of loyalty between industry and the university. There is now an oversupply of OT placements and less stress on placement staff allowing more time for research, teaching and learning (Rosenwax, Gribble, & Margaria, 2010).

The Clinical Learning Environments Evaluation Framework (CLEEF)

A HWA project examining the elements of clinical placements in rural and remote primary health care settings which support sustainability as well as transferability to other primary care settings led to the development of the CLEEF. The CLEEF builds on the Best Practice Clinical Learning Environments within health services for Undergraduate and Early Graduate Learners- the BPCLE framework, developed for use in Victoria. Nine key elements contributing to an effective clinical learning environment are described in the CLEEF (Health Workforce Australia, 2013a). Applying the CLEEF to potential placement sites may assist in identifying issues to be addressed to support effective clinical placements. The GRACE model for clinical placements has been assessed against the CLEEF. Foundations of quality learning environments are described in this report as an example (Table 6).
Table 6: Vignette: The innovative GRACE model (Rosenwax, et al., 2010) put to the litmus test against the foundations of a quality workplace learning environment and CLEEF (Health Workforce Australia, 2013a).

<table>
<thead>
<tr>
<th>Theoretical construct</th>
<th>Relationship marketing theory, key guiding principles with a touch of blue sky thinking.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catalyst for innovation/change</td>
<td>Increased student numbers, undersupply of clinical placements, poor relationships with sites, inadequate preparation time for students and supervisors, bottleneck of clinical placements required at the same time.</td>
</tr>
<tr>
<td>Primary goal</td>
<td>The cultivation and enrichment of long term relationships that would be of maximum benefits to stakeholders and create a set of guiding principles regarding clinical education.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Foundations of a quality workplace based learning environment</th>
<th>Does the GRACE innovative model meet these criteria?</th>
</tr>
</thead>
<tbody>
<tr>
<td>An organisational culture that values life-long learning</td>
<td>Aim is to enhance student learning, encourage professional behaviour and support student accountability and responsibility for placements.</td>
</tr>
<tr>
<td>A supportive relationship between health services and education providers</td>
<td>Cultural change of one where sites offered a service by hosting students to one where each host site as a partner in clinical education.</td>
</tr>
<tr>
<td>Effective communication processes</td>
<td>Annual contractual arrangements (AUD$500 per student in 2009)</td>
</tr>
<tr>
<td>Appropriate resources and facilities</td>
<td>Specific to occupational therapy. Transferrable approach.</td>
</tr>
<tr>
<td>Effective interdisciplinary learning</td>
<td>Students are allocated to sites for an entire year; delivering service to consumers instead of sporadic provision of occupational therapy services as per the previous clinical education calendar. This works particularly well in aged care facilities, paediatric units, rehabilitation units, mental health, health promotion, research and community rehabilitation sites.</td>
</tr>
<tr>
<td>Effective clinical practice and a safe working environment</td>
<td>Clinical education consecutively 42 weeks a year rather than intermittently, ensuring continuity for consumers and supervision of students.</td>
</tr>
<tr>
<td>Efficiency in coordination of placements</td>
<td>Appointment of a Clinical Education Coordinator (CEC) at each host site within allocated budget, reduction in staff stress and workload allowing for more time for academic activities.</td>
</tr>
<tr>
<td>Fits with educational criteria and meets the requirements of registration boards</td>
<td>Yes</td>
</tr>
<tr>
<td>Adequate preparation of students</td>
<td>Student learning experiences are enhanced through cultivation and enrichment of key relationships with host placements.</td>
</tr>
<tr>
<td>Fits with educational criteria and meets the requirements of registration boards</td>
<td>Yes</td>
</tr>
<tr>
<td>Foundations of a quality workplace based learning environment</td>
<td>Does the GRACE innovative model meet these criteria?</td>
</tr>
<tr>
<td>------------------------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Adequate preparation of students</td>
<td>Student learning experiences are enhanced through cultivation and enrichment of key relationships with host placements.</td>
</tr>
<tr>
<td>A clear and realistic statement about the desired learning objectives together with information about assessment arrangements and a briefing that explores expectations of roles and responsibilities of both the student and health service</td>
<td>Each CEC must plan and conduct the clinical orientation for the students at the host site; contact supervisory therapists to review the student progress; assist supervisory therapists who are new to supervision; meet with students before and during the placement; set preparation readings and tasks for students; coordinate tutorial sessions on relevant topics pertinent to the students learning; observe and evaluate student performance; pursue formal discussions with the school’s director of clinical education with regard to any problems or issues; review the overall placement experience for the students and the supervisory therapists; and implement any necessary changes to enhance the next planned placement experience.</td>
</tr>
<tr>
<td>Information relevant to the logistical organisation of the placement</td>
<td>Mutually beneficial relationships achieved by offering three drivers: economic incentives, interpersonal relationships and access to resources not offered by competitors.</td>
</tr>
<tr>
<td>Ensuring that adequate resources, including free time, are available for quality of the supervisory/facilitation/teaching/preceptor role</td>
<td>Any issues and/or performance problems with the student and/or the supervisory therapist are directed to the CEC. Access to academic fieldwork experts within 24 hours for students identified with performance issues.</td>
</tr>
<tr>
<td>Promoting an understanding of the benefits for health service staff from their involvement with the students and the education provider</td>
<td>On completion of each of the six blocks, students participate in debriefing tutorials facilitated by School academic staff.</td>
</tr>
<tr>
<td>Timely and objective feedback on performance</td>
<td>Shared responsibility for the clinical education of students between the School of Occupational Therapy and Social Work and key stakeholders – i.e. university and School management, academic staff, fieldwork site supervisors and employers.</td>
</tr>
<tr>
<td>Structured and regular opportunities to debrief and reflect during and after the placement</td>
<td>Other benefits of the GRACE model</td>
</tr>
<tr>
<td>The cultivation of an understanding and adoption of what constitutes a stimulating and supportive learning environment</td>
<td>The clinical placement calendar can be planned years in advance allowing students to organise work commitments. Enhanced preparedness for host sites and supervisory therapists.</td>
</tr>
<tr>
<td>Other benefits of the GRACE model</td>
<td>Number of students and remuneration defined and contracted.</td>
</tr>
<tr>
<td></td>
<td>92% reduction in placement sites, allowing enhanced quality control and streamlined placement processes.</td>
</tr>
</tbody>
</table>
Case studies
Rural health service models need to be based on integrated care that is specific to a rural location, and consider demographics of the residents, the health profile of the community, level of geographic isolation of the location, existing service infrastructure and the available workforce and their specific skill sets. Planning to meet community needs requires an understanding of not only the size, demographic and epidemiological profile of communities, but also the many determinants of health status, health system performance, and community expectations and preferences. The literature suggests that there are benefits to developing planning models that include the workforce across all sectors of the community, and stronger linkages with public, private and NGO health and aged care services, government and tourism (Health Workforce Australia, 2013e).

Consideration of these community and socio-demographic determinants influenced the project methodology and led to the decision to conduct case studies of small (Berrigan) and medium-sized (Narrandera) rural communities. Time constraints of the project did not allow a similar whole of community approach to Wagga Wagga as a regional centre example.

In both Berrigan and Narrandera, a broad range of people were consulted in keeping with a whole-of-community approach. The findings from the case studies are specific to the localities studied and cannot be directly transferred to others although there may be similarities in issues and models for clinical placements. A key issue arising from the case studies and the literature is the need to tailor models to suit each community.

Narrandera case study
The community of Narrandera was chosen as the medium-sized locality case study for this project. Two project officers surveyed local health service providers across two days; 12 interviews were conducted with 9 face-to-face and 3 by telephone.

Located on the Murrumbidgee River, Narrandera acts as a centre for the farming industry including parts of the Murrumbidgee Irrigation Area (Narrandera Shire Council). Narrandera Local Government Area (LGA) has a population of almost six thousand people (Table 7), though this number has been predicted to decrease by 20 percent in the next 25 years, the fifth largest prediction of population decline amongst 29 Murrumbidgee LGAs in this period (NSW Health Department of Planning & Statewide Services Development Branch, 2009). Narrandera LGA has higher proportions of residents aged over 55 years compared to NSW as a whole (33% compared to 26%) and Aboriginal and Torres Strait Islander people (10% of population compared to 2.5% across the state) (Table 7). The Index of Relative Socio-economic Disadvantage (IRSD), which provides information on areas with higher proportions of disadvantaged households, has found that Narrandera LGA is one of the most disadvantaged communities in the Murrumbidgee LHD (Murrumbidgee Local Health District, 2012).

Narrandera, approximately 100km from both Wagga Wagga (to the South East) and Griffith (to the North West) (Narrandera Shire Council), hosts important health services such as Narrandera District Hospital, Narrandera Community Health, medical and aged care centres, as well as various community services. The town relies on some specialist health services being provided from larger localities such as Wagga Wagga and Griffith.
Speaking with community members and local health providers regarding the potential to expand student clinical placements in Narrandera, an enormous amount of optimism and goodwill was found. In particular, some interviewees were positive towards a shared supervision model of clinical placements between health services, and some community organisations and health service staff were willing to hold events to welcome students to the town and were already in the practice of inviting new students to dinner as part of including them in staff social events.

There appeared to be communication channels between and amongst local government, health services and other community organisations, though perhaps a strengthening of relationships with education providers could benefit the coordination of clinical placements. Potential underutilised accommodation facilities were discovered and these have been listed in the unused/untapped capacity list which will be held with the Riverina ICTN.

A whole-of-community approach could be a strategy to support students and increase the clinical placement capacity of small rural health services and rural communities such as Narrandera. Placement in small communities allows students to gain a deeper understanding of primary health care and facilitates and promotes interdisciplinary education and practice.

**Enabler: coordinate a whole-of-community approach**

Thwaites in (Schoo, Stagnitti, Mercer, & Dunbar, 2005) suggests that active and dynamic communities reach better outcomes in areas such as health, education and economic development. There is considerable merit in a community development approach to workforce issues and rural recruitment and retention, with collaboration between communities, health services and educational providers to address the critical shortage of health care professionals (Francis et al., 2003; McDonald, Bibby, & Carroll, 2002; Shannon, 2003; Veitch, 2003; Veitch, Harte, Hays, Pashen, & Clark, 1999; Wallis).

In smaller rural locales, there may be strong whole of community support for clinical placements if the experience of the project’s first case study in Narrandera applies to other localities. Interviews with local government, health providers and other agencies in the study community suggested that it may be possible to overcome some of the well known barriers in small communities such as lack of accommodation and assisting students to feel welcome and make contributions to the community if a whole of community approach was adopted. The opportunity for shared clinical placements across a number of sites such as GP surgery, aged care, hospital and community health services could provide a broad and worthwhile experience for students. Innovative approaches to supervision in these sites and flexible approaches would need to be identified.
Table 7: Demographics of Berrigan, Narrandera, Wagga Wagga and NSW (Australian Bureau of Statistics, 2011b)

<table>
<thead>
<tr>
<th></th>
<th>Berrigan UCL†</th>
<th>LGA‡</th>
<th>Narrandera UCL†</th>
<th>LGA‡</th>
<th>Wagga Wagga UCL†</th>
<th>LGA‡</th>
<th>NSW State</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total population</td>
<td>922</td>
<td>8066</td>
<td>3871</td>
<td>5902</td>
<td>46,913</td>
<td>59,458</td>
<td>6,917,658</td>
</tr>
<tr>
<td>Aboriginal and Torres Strait Islander people</td>
<td>3.3%</td>
<td>2.1%</td>
<td>13.1%</td>
<td>10.0%</td>
<td>5.2%</td>
<td>4.6%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Australian born</td>
<td>90.2%</td>
<td>87.2%</td>
<td>86.1%</td>
<td>87.4%</td>
<td>87.4%</td>
<td>87.8%</td>
<td>68.6%</td>
</tr>
<tr>
<td>Aged 55 and over</td>
<td>44.2%</td>
<td>41%</td>
<td>34.5%</td>
<td>33.4%</td>
<td>24.7%</td>
<td>24.2%</td>
<td>26.4%</td>
</tr>
<tr>
<td><strong>Education and Employment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher education in technical or further education; university or tertiary institution; or other</td>
<td>8.2%</td>
<td>13.1%</td>
<td>13.6%</td>
<td>13.2%</td>
<td>27.2%</td>
<td>29.5%</td>
<td>24.5%</td>
</tr>
<tr>
<td>Employment: Community and personal service workers</td>
<td>Not stated</td>
<td>10.8%</td>
<td>11.8%</td>
<td>9.8%</td>
<td>11.3%</td>
<td>11.2%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Employment: residential care services</td>
<td>6.6%</td>
<td>Not stated</td>
<td>4.5%</td>
<td>3.1%</td>
<td>Hospitals: 3.9%</td>
<td></td>
<td>2%</td>
</tr>
</tbody>
</table>

† Urban Centre/Locality
‡ Local Government Area

**Berrigan case study**

Berrigan was chosen as the small rural community of the case studies. A total of 9 interviews/consultations were conducted either on site with local health care providers in Berrigan and nearby Finley and telephone interviews were conducted to follow up on initial discussions.

In some respects Berrigan township, population 922 (Table 7) is well serviced by healthcare providers, although it became apparent that to consider the whole of community case study with the town in isolation was not appropriate, as it receives many of its services outreached from Finley Community Health, Jerilderie Community and through services which visit Berrigan. The latter include visiting public and private health professionals from regional centres such as Deniliquin, Albury, Walla Walla (a two hour drive) and Melbourne.

The township of Berrigan is situated within the Berrigan Shire LGA which covers 2067km² with a population of 8066 (Table 7) in the southern Riverina region of NSW. The Shire is adjacent to the
major transport routes of the Newell and Riverina Highways. The Shire is mainly an agricultural region, with dairying, cattle raising, wool growing and cropping the main activities. Much of the Shire is irrigated land. Towns in the shire are: Berrigan, where the Council office is based, Finley, Tocumwal and Barooga. Tourism is concentrated on the river towns of Tocumwal and Barooga.

The linkages within the communities and health services remain strong amongst the ‘triangle’ of Jerilderie, Berrigan, Finley and Tocumwal and in fact, an interviewee stated Jerilderie advocated to be aligned with the Hume Medicare Local (ML), rather than the originally designated boundaries of Murrumbidgee ML for this reason. The service delivery is a complex web of models, as identified in the Berrigan Health Services Matrix (Table 8).

The health services face significant staffing challenges. The difficulties of recruiting to part-time and maternity leave positions, sole practitioners required to deliver services to four towns in a few days per week, the stresses of solo GP practices and the ageing nurse workforce are some of the major health workforce challenges in this community. In one instance, as a part-time allied health maternity leave position was unable to be filled, another service was required to contract private allied health services from a considerable distance away, at a significant impost to their budget, to fulfil its services to clients, resulting in significant ‘cost shifting’ and delays in services.
### Table 8: Berrigan Case Study Health Services Matrix

<table>
<thead>
<tr>
<th>Service type or Discipline</th>
<th>Parent Agency</th>
<th>Serviced from</th>
<th>FTE, beds, etc</th>
<th>Private or Public</th>
<th>Currently takes Clinical Placements?</th>
<th>Identified Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aged Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low care</td>
<td>Berrigan Aged Care Assoc Inc</td>
<td>Berrigan</td>
<td>23 beds</td>
<td>Privately run not for profit community service</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Independent Living Units</td>
<td>Amaroo</td>
<td></td>
<td>18 units, 23 beds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Podiatry</td>
<td>Aged Foot Care</td>
<td>Melbourne</td>
<td>Once every 6 weeks</td>
<td>MPS aged patients (pts) only</td>
<td>Private</td>
<td></td>
</tr>
<tr>
<td>High Care</td>
<td>Berrigan MPS</td>
<td>Berrigan</td>
<td>10 beds</td>
<td>Public</td>
<td>No, nil clinicians employed</td>
<td></td>
</tr>
<tr>
<td>Retirement Village</td>
<td>Noonameena Berrigan Retirement Village Association</td>
<td>Berrigan</td>
<td>12 units</td>
<td>Not for profit community based</td>
<td>No, nil clinicians employed</td>
<td></td>
</tr>
<tr>
<td>Geriatrician</td>
<td>Dr Dennis Wong</td>
<td>Melbourne</td>
<td></td>
<td>Private</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Acute</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multi-purpose service</td>
<td>Berrigan MPS</td>
<td>Berrigan</td>
<td>4 beds inc 1 palliative care</td>
<td>Public</td>
<td>yes</td>
<td>Closes 10pm; move to make 24/7, presently no overnight services</td>
</tr>
<tr>
<td>Mental Health Videoconference</td>
<td>Albury Hospital Psychiatrist</td>
<td>Albury</td>
<td>As needs basis</td>
<td>Public</td>
<td></td>
<td>No Physio services locally; Berrigan community members can travel to Finley, referral required</td>
</tr>
<tr>
<td><strong>Community Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Finley Community Health</td>
<td>Finley</td>
<td></td>
<td>some AH</td>
<td></td>
<td>No service locally; can ring for advice to Deniliquin or Wagga Wagga</td>
</tr>
<tr>
<td>Generalist Counsellor</td>
<td></td>
<td></td>
<td>Outreach to Berrigan weekly if required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continence Nurse</td>
<td></td>
<td></td>
<td>Nil service to Berrigan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Education</td>
<td></td>
<td></td>
<td>One day/month in Berrigan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wound Care</td>
<td></td>
<td></td>
<td>Nil service to Berrigan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OT</td>
<td></td>
<td></td>
<td>Nil at present</td>
<td></td>
<td></td>
<td>Wound Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>On maternity leave</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service type or Discipline</td>
<td>Parent Agency</td>
<td>Serviced from</td>
<td>FTE, beds, etc</td>
<td>Private or Public</td>
<td>Currently takes Clinical Placements?</td>
<td>Identified Gaps</td>
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</tr>
<tr>
<td>Dietitian</td>
<td>Hume ML</td>
<td></td>
<td>1 day/month</td>
<td></td>
<td></td>
<td>Finley CH Dietitian On maternity leave, usually 1 day/month Presently getting Hume ML to service</td>
</tr>
<tr>
<td>Community Health Nurse</td>
<td>Jerilderie Community Health</td>
<td>Outreach from Jerilderie</td>
<td>Daily as needed</td>
<td>HACC funded</td>
<td>yes</td>
<td></td>
</tr>
<tr>
<td>Dentist</td>
<td>Oral Health Service Branch MLHD</td>
<td>Outreach Dental Therapist to Berrigan; eligible adults could travel to Albury or Deniliquin for free service</td>
<td>1 day/week</td>
<td>Public Children &amp; health care card holders birth to 18 years</td>
<td>Ad hoc basis in Deniliquin clinic, open to host more</td>
<td>Pt demand for 2 days/week but short staffed one Dental Therapist Currently no Dentist available in this service to Berrigan</td>
</tr>
<tr>
<td>Dentist</td>
<td>Deniliquin Dental Clinic</td>
<td>Deniliquin outreach to Berrigan</td>
<td>1 day/month</td>
<td>Private</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietetics</td>
<td>Dietitian</td>
<td>Hume ML</td>
<td>Outreach to Berrigan</td>
<td>monthly</td>
<td>Private</td>
<td></td>
</tr>
<tr>
<td>Early Childhood Intervention Service</td>
<td>Nurse Diversional Therapist Team approach to families</td>
<td>Berrigan Shire Council</td>
<td>Finley</td>
<td>As needs basis outreach to Berrigan</td>
<td>Public</td>
<td>Generally TAFE welfare students Families caught between service/shire boundaries Berrigan/Urana/ Jerilderie/ Corowa Respite for families</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Podiatrist</td>
<td>Footsteps Griffith</td>
<td>GP rooms Berrigan</td>
<td>Once every month</td>
<td>Amaroo pts &amp; private clients</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Pharmacist who also reviews medications for the aged in home(HMR) and in residential facilities (RMMR)</td>
<td>Berrigan Pharmacy</td>
<td>Berrigan</td>
<td>1 FTE</td>
<td>Private</td>
<td>Yes, available to take placements</td>
</tr>
<tr>
<td>Service type or Discipline</td>
<td>Parent Agency</td>
<td>Serviced from</td>
<td>FTE, beds, etc</td>
<td>Private or Public</td>
<td>Currently takes Clinical Placements?</td>
<td>Identified Gaps</td>
</tr>
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</tr>
<tr>
<td>Berrigan Shire Council HACC Multi Service Outlet</td>
<td>Berrigan Shire</td>
<td>Coordinated from Finley with volunteers in Berrigan</td>
<td>Accessible 7 days/week</td>
<td>Public for HACC eligible (65 years or over) clients or people under 65 with a disability</td>
<td>No</td>
<td>Funding for Health Related Transport (HRT)</td>
</tr>
<tr>
<td>Community Transport</td>
<td></td>
<td>Frozen meal service from Finley (purchased from Wagga)</td>
<td>Available 5 days/week on as needs basis</td>
<td></td>
<td></td>
<td>Local OT on maternity leave; Contracts private OT from Walla Walla to do assessments</td>
</tr>
<tr>
<td>Home Modifications and Maintenance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Volunteers</td>
</tr>
<tr>
<td>Meals on Wheels</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bush Bursary</td>
<td>NSW Rural Doctor's Network</td>
<td>Berrigan</td>
<td>Coordinated towards an understanding of a social model of health with a view that they will return to service rural communities</td>
<td></td>
<td>Yes, one per year for 2 weeks and over a weekend</td>
<td></td>
</tr>
<tr>
<td>Medical Student</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP Clinic</td>
<td>Berrigan Medical Practice</td>
<td>Berrigan</td>
<td>Principal GP 4 days/week + 1 GP 1 day/week</td>
<td>Private</td>
<td>Yes, medical students</td>
<td>Locum relief</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Practice Nurses 1.2FTE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative Care Service</td>
<td>MOU with Mercy Health Finley Community Health Service</td>
<td>Albury</td>
<td>1 day/week servicing 4 towns</td>
<td></td>
<td>No nursing students</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Trained to deliver palliative care within CHN role</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon</td>
<td>Albury</td>
<td></td>
<td>1 day/fortnight</td>
<td>Private</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma Educator</td>
<td>Hume ML</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>Available from Finley Community Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist Educator</td>
<td>Hume ML</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</table>
Regionally known endearingly as the ‘gray capital’ of NSW, people aged 55 and over make up 44.2% of the total Berrigan town population, compared to 26.4% in NSW. This is reflected in Berrigan’s 6.6% employment in residential care facilities, contrasted with only 2% throughout NSW (Australian Bureau of Statistics, 2011b). With an ageing population of local retirees, people making lifestyle choices to retire along the Murray River particularly into Tocumwal, and younger people leaving the district, a need for increased aged care services, palliative care and retirement and aged care accommodation has been recognised. Berrigan Shire has recently approved development of Barooga Retirement Village and in Finley an application is currently with Council for development of further medical facilities which tie in with the aged care facility already in place allowing for further short term accommodation and palliative care, focused on catering to the ever increasingly ageing population. Consideration of development of a retirement village in Finley is still possibly five years away (S. Escott, personal communication, 24 April and 2 May, 2013).

The important role of health care and other service providers in this small community serving older people highlights an opportunity to develop this location as a placement site where students could experience a broad range of residential aged care and community based services. Possible approaches include developing specific aged care clinical training arrangements in Berrigan or linking via a hub and spoke model to a regionally based aged care clinical training facility as described in the focus on aged care section in this report.

**Utilisation of aged care facilities**

The significant increase of older people as a proportion of the population indicates that there will be considerable demand for aged care services in the future. To cope with this increased demand, service provision will also need to increase over the next 40 years. However, concern has been raised about the ability of the health workforce across all regions, and specifically in rural areas, to meet this demand, Productivity Commission 2011 in (Health Workforce Australia, 2013e).

The Health Workforce Australia report entitled, *Health Workforce 2025; Volume 2* (Health Workforce Australia, 2012b) describes a substantial shortfall in the nursing workforce in the aged care sector over the next decade. The projected workforce gap in 2025 for aged care registered nurses is 11,511. This represents close to 41% of the estimated necessary aged care RN workforce. While there are projected gaps in the acute sector (22.5% of estimated demand in 2025) and the critical care and emergency sector (17.5% of estimated demand in 2025), the workforce gap in aged care is of particular concern. The various scenarios tested by HWA in this report suggest that an improvement in workforce retention and increasing numbers of graduates entering aged care offer the best opportunities for reducing the gap.

For enrolled nurses the projected gap in the aged care EN workforce is 41% of the estimated demand compared with 38.5% in the acute sector and 34% in the critical care and emergency sector. Similar to RNs, the modelling suggests that workforce retention provides the best opportunity to reduce the workforce gap. There was no evidence that increasing numbers of enrolled nurses will be entering the workforce and this scenario was not tested by HWA.
Clinical placements in aged care

Clinical placement data suggests that residential aged care facilities are underutilised in the Riverina ICTN. Interviews with stakeholders during the course of the project identified challenges to clinical placements in aged care which align with findings in the literature, including a negative view by students and perhaps some educators of aged care as a clinical placement option or longer term employment option, negative views of ageing in general, lack of infrastructure in aged care facilities to support clinical placements and a shortage of clinical supervisors and teachers in aged care. The relatively low proportion of RNs compared to ENs and other VET sector trained staff in aged care facilities limits the capacity of facilities to have RNs supervising nursing students.

See you can’t buddy up a third year registered nurse student with an EEN. Now our EENs work and are paid first year RN rate. They do exactly the same work as an RN. They’re not allowed to write up a care plan, even though they’ve learnt that at TAFE. They’re not allowed to do that. The commonwealth says a registered nurse must do that. So there are certain things that the EENs can’t do and one is precept a third year RN to give out medications and things like that. So I can only take enough third year students to cover the RNs that are working here. HS7, 16, 17

The use of agency nursing staff in aged care facilities also limits supervision capacity. Clinical placements for allied health students in particular in residential aged care facilities in the Riverina ICTN are limited because of the lack of appropriate supervisors.

Interviews suggest that a high level of goodwill exists in aged care facilities towards supporting clinical placements with key aims to recruit staff and to increase the scope of services available in the facility. Interviewees indicated that while they were keen to take clinical placements and there was a commitment to clinical education, the placement system did not always meet their needs or provide the level of support they required. To some extent, there was a view that aged care facilities took what they were given when it came to clinical placements and there was a lack of transparency in regard to payment by education providers for placements. For the VET sector, increasing pressure for payment for aged care placements may see the costs passed onto students who are already paying a full course fee.

Aged care settings offering a more diverse and complex level of care are more attractive for clinical placements than residential aged care facilities offering less complex services. For the aged care facilities, more service complexity and a broader scope of services attracts higher Commonwealth funding through the Aged Care Funding Instrument.

The Teaching Nursing Home Initiative

In 2011, the Australian Institute of Social Research prepared a discussion paper as part of the Teaching Nursing Home (TNH) Initiative. This paper identifies that, apart from the system-level issues, resource, coordination and communication concerns, a key barrier to increasing clinical placements in aged care settings is a negative student attitude towards aged care as a placement and/or profession. Further, the paper suggests that a lack of encouragement by university educators for aged care exacerbates this ageist attitude (Barnett, et al., 2011a). Positive clinical placement
experiences in aged care settings enhance the profile of the sector and support workforce recruitment and retention.

The TNH model has been used successfully in a number of countries such as the Netherlands, Norway and America, and has been examined in Australia through the Teaching Nursing Home Initiative. The development of partnerships between aged care providers and education providers plus other services forms the basis for linking spheres of clinical education and training, clinical care and research (Barnett, et al., 2011a).

The drivers for the application of TNH model in Australia were identified as:
- Workforce issues and challenges in aged care;
- The need to enhance clinical training, research and placements in aged care;
- The need to improve the quality of care for older people (Barnett, Abbey, & Eyre, 2011b).

The approach is not designed as a “one size fits all” but one which will vary according to local circumstances, the organisations involved and the needs of the residents and students. Ideally, the scope of services would include high level care with a link to acute services, outreach and home based services, residential aged care services and incorporating preventative health and health promotion. A TNH may also act as a service hub supporting outreach services. The aim is to provide students with a variety of clinical experiences, working with older people across a spectrum of settings and employing an interdisciplinary approach.

The results of Australian based case studies are documented in the Final Report of the TNH Initiative (Barnett, et al., 2011b). Along with the Final Report, the Discussion Paper for the TNH Initiative act as valuable resource documents for improving quality of care and clinical placements in aged care as well as for guiding the establishment of a TNH. The criteria for selecting a site as a TNH were identified as:
- Sufficient preceptors and supervisors who can provide clinical education;
- Sufficient trained registered nurses;
- Staff who are receptive to student participation in care planning and delivery;
- An interdisciplinary team willing to teach and collaborate with an education provider;
- A robust quality assurance program;
- Compliance with industry accreditation and regulation standards;
- Having in place or access to a research ethics committee;
- A learning workplace culture and good reputation;
- A critical mass and diversity of services (Barnett, et al., 2011a).

Helping Hand new aged care
Helping Hand (HH) is a South Australian based not-for profit organisation providing residential and home based aged care services. HH has been active in developing interprofessional clinical placements in aged care and their project involving a partnership with the University of South Australia is a useful example of how this can be achieved. The project aimed to:
- Improve the quality of student learning and student supervision;
- Increase the number of placements in aged care;
- Value-add to current services;
• Create new services, and;
• Influence attitudes to placement and employment in aged care.

Megan Corlis, Director of Research and Development for HH is keen to provide information and advice to others aiming to improve clinical placements and services in aged care (M. Corlis, personal communication, April 3, 2013).

Bethanie ‘Beyond the Teaching Nursing Home – Community partnership of learning and care’

The Western Australian model Bethanie ‘Beyond the Teaching Nursing Home – Community partnership of learning and care’ (The University of Western Australia Faculty of Medicine, 2012) may contribute learnings to Riverina ICTN’s exploration of possible synergies in aged care education, research and clinical care. The unoccupied space of Bethanie Joondanna Nursing Home was refurbished to create a clinical learning environment to facilitate health workforce education and training, co-located with two residential aged care hostels and independent living units.

A feature of this project is the contribution of older adults to health professional education. This community of learning and care provides the opportunity for podiatric, nursing, medicine and other health professional students’ engagement with older people to understand their specific health needs. Students participate in a range of clinical and simulated activities with clients and residents, both in the aged care facility and clinical learning environment.

The aim is to prepare students with sound evidence based practice in aged care. This community of learning and care endeavours to provide positive clinical experience in aged care and contribute to the future care of Australia’s ageing population.

Formal partnership approach to clinical placements

Formal partnership approaches may increase capacity for placements. Formal clinical placement partnerships between education providers and health service providers are demonstrated in a broad range of models and are sometimes referred to as clinical schools. Considerable variation in models occurs with the main characteristic being that the health service and education provider have agreed to partner in the delivery of clinical education. Formal partnerships can provide a level of certainty for health services and education providers about the numbers of placements and timing of student placements. Such partnerships enable planning and transparency to be achieved; a more formal relationship means that all aspects of the contract can be negotiated overtly and upfront.

These partnerships may have a range of significant benefits for both parties. The partnership supports a culture of learning and education in the health service and provides an environment where students, clinicians, and education providers work together. A formal ongoing partnership provides stability and continuity for students, which is an influential success factor for rural students (Harmon, 2013). The partnership supports clinicians to be involved in, and recognised for, their role in education and provides opportunities for collaborative research involving clinicians and academics. The nexus of clinical care, education, and research is recognised as a key feature underpinning the teaching nursing home concept (Barnett, et al., 2011b).
The clinical placement partnership may involve an education provider and a single, usually large, facility, or multiple facilities/health services or perhaps a community. The partnership can involve a single discipline or have a multidisciplinary approach. The following examples of partnership and clinical school models are aimed to generate discussion on appropriate models for the Riverina ICTN.

Two Australian regionally-based nursing clinical schools are briefly described. The University of New England’s nursing clinical school has a staff of a Clinical Placement Manager and a Clinical Coordinator-Academic. The Clinical School provides training and support to Clinical Partners located in partnering health services. In addition, a Clinical Facilitator/Teacher may be employed by the University at the request of the health service (University of New England School of Health, 2010). Bendigo Health, in partnership with LaTrobe University, established a nursing clinical school on the health service campus. The benefits of the clinical school are described as enhanced teaching and opportunities for research and supporting the development of the nursing workforce (Bendigo Health).

The GRACE program, established by an occupational therapy school, involves an innovative change to the curriculum to facilitate an improved clinical placement system. The innovation was that all full time clinical placements were shifted to the final year of the course. Participating health service sites receive remuneration based on an agreed number of students to be hosted and use the funding to appoint a Clinical Education Coordinator who plans and oversees student placements. The placements occur in consistent blocks throughout 42 weeks of the year providing continuity of service and the ability to hand over caseloads and project activities to following student groups. The education provider and the health service sites have increased certainty facilitating better organisation and forward planning. The clinical placement experience supports a transition for the student from education to a working environment (Rosenwax, et al., 2010).

The Whole-of-System Clinical Placement project, undertaken by the School of Rural Health, Bendigo (Monash University) piloted an interprofessional clinical placement model in a rural primary health care system with a focus on supporting a range of clinical placement disciplines within a defined locality. This whole-of-system approach contributes to improved understanding by students of the multiple providers delivering comprehensive primary health care and supports integrated approaches. The next phase will involve the creation of tools and templates for assessment of clinical placement needs and capacity in small communities (Health Workforce Australia, 2012c).

Partnerships models have a number of limitations. Rosenwax and colleagues report that the GRACE model does exclude some sites which are unable to meet the requirement of providing two placement periods per block. The authors suggest that these sites may be disenfranchised and that their needs must addressed in other ways (Rosenwax, et al., 2010). Interviews during the course of the project reinforced this concern and suggested clinical school approaches, while potentially improving efficiency, promoted centralisation and generally involved larger sites. Smaller sites often lacked the capacity to take part in clinical schools and this may serve to reinforce a perception of “real”
placements versus placements in small rural services and communities. Community focused and whole-of-system approaches potentially offer positive alternatives for rural and regional areas.

Formal partnerships and clinical school models contribute to more efficient use of clinical placement resources and should be considered in an overall clinical placement system especially where these can incorporate small rural health services and community based approaches.

**ClinConnect**

Because many of the people interviewed spoke about ClinConnect as a either an enabler or a barrier to clinical placements, the project team has included findings about ClinConnect in Appendix 4.
Opportunities for action

As has been already presented, we have argued that there is some untapped capacity for clinical placements in the Riverina ICTN if certain conditions can be met. How much capacity can be increased is dependent upon the extent to which existing problems in the process of implementing placements can be solved; whether efficiency in the system can be increased; whether threats can be removed or lessened; and whether new innovations and small improvements can be actioned. These are not insignificant challenges to meet however the motivation for tackling these issues is that it is vital to increase capacity for clinical placements in the Riverina ICTN if a sustainable rural health workforce for the future is to be achieved.

The opportunities for action that are detailed in this section have been developed specifically for the Riverina area and for the health service staff and education providers who participate in placements in this area. Our ideas are framed as opportunities rather than as recommendations to highlight that there are many possible solutions to the complex problem of increasing placement capacity. Some ideas may be easily implemented and easily achievable; some suggestions require only small changes by one individual whereas others may require the concerted effort of many contributors over a longer period of time. The opportunities we present here are clustered as opportunities at the macro-level, opportunities at the meso-level, and opportunities at the micro-level. We acknowledge that human and financial resources are required to achieve many of these proposed actions.

The macro-level opportunities are:
1. Fostering relationships, good communication, and collaborative working;
2. Being and becoming learning workplaces;
3. Taking a whole-of-community approach to problem-solving and innovation;
4. Sanctioning time for ongoing review, problem-solving, improvement, and creative development of placements;
5. Working with professional organisations to lobby for increased creativity, flexibility, and reform in conceptualising how placements can and should be structured.

The meso-level opportunities are:
1. Using new and different sites and areas of practice to source placements;
2. Experimenting with innovative models of supervision.

Micro-level opportunities are chiefly opportunities for improving efficiency within current systems of placements. These opportunities are:
1. Increasing transparency in the process of offering, allocating, and accepting placements;
2. Undertaking more collaborative planning of placements across a longer time frame;
3. Ensuring all placement experiences are high quality;
4. Providing education and support for supervisors;
5. The effective use of payments for placements that directly support and build clinical training capacity;
6. Reframing students’ and academics’ perspectives about placements that are considered to be uninteresting or unpopular;
7. Providing support for students to attend rural placements;
8. Reframing supervisors’ ideas about how placements can be structured.

Although these opportunities have been displayed as lists of activities, the items detailed do not really occur in isolation and therefore when choosing an opportunity to action it may be that change to more than one area is affected. These ideas will be presented in a linear way for ease of explaining them and to focus actions that may arise as a consequence of this report. We recognise that in reality the implementation of these solutions is likely to be much more inter-dependent.

**Macro-level opportunities**

The Riverina ICTN has a crucial role to establish a vision and strategic direction and facilitate a collaborative, interdisciplinary approach to clinical training.

The opportunity for the Advisory Committee is to create a vision for the Riverina ICTN to be a workforce development region of choice through a long term strategic and whole-of-community approach to workforce development and quality clinical education.

**Fostering relationships, good communication, and collaborative working**

The placement system relies upon clear and effective communication between education providers and health service staff. Each organisation has its own goals and agendas; however, unless staff from these different institutions work together, placements will not be effective.

The participants who were health services workers appeared to experience some dissatisfaction about their relationships with education providers; in particular they perceived there was some lack of communication from education providers and inequality in the relationships between health services and education providers. The placement system currently appeared to be more about the needs of education providers for placing students, rather than the ways in which students could work in with health services for the mutual benefit of both groups of people. Therefore there is an opportunity here for education providers to engage in more listening to the needs of health services, more seeking of health services’ perspectives, and more asking about ideas that health services have for improving placements; that is, considering health services as equal partners in the creation and management of placements.

Each health service could consider creating a “Preferred Placement Profile”. This profile would specify the disciplines that site could offer placements in and the types of activities that students could expect to engage in during these placements. The profile might also include minimum and maximum
numbers of students that could be accommodated, the timing of placements and what kinds of support from education providers the placement site would need. It would be useful if these profiles could be projected over one, two and five years, as this would assist education providers with forward planning.

There could also be opportunities in health service managers preparing these Preferred Placement Profiles in collaboration with education providers. Shared discussions may spark creativity and ideas for placements that had not previously been considered. Part of the value of relationship-building is learning in more depth about the conditions, interests, challenges, and values that the “other party” has; novel solutions can sometimes be easier to see when a person is less immersed in the culture and intricacies of an organisation.

More detailed information communicated to health services about the specific learning needs of individual students should be provided alongside their learning objectives for the placement. Another practical action that education providers could take to enhance relationships with health services is to provide them with feedback and debriefing about placements after each placement is completed. Health service providers indicated that they would greatly value such feedback as it would assist them to learn from their experiences and to improve the quality of placements. These two strategies would seem to be low-cost and low-effort solutions for education providers and may pay off dividends in terms of higher quality placements and increased goodwill from health services.

Any and all opportunities that encourage and facilitate health service workers and education providers to collaborate are likely to improve communication and relationship-building. For example, the Riverina ICTN may choose to host a series of interactive forums in which education providers and health services can discuss ways to solve some of the problems that have been identified, ways to increase efficiency within systems, and ways to implement innovative ideas. Some items that we recommend for immediate attention include:

- Specifically in the discipline of nursing, discuss utilising twenty four hour a day and seven days a week shift system and spreading requests throughout the majority of the year;
- Consider opportunities for support of supervision overall and interdisciplinary supervision;
- Plan placement activities for the area of aged care.

The advantages of collaborative planning were demonstrated during a Riverina ICTN Advisory Committee meeting when members discussed the benefits of learning objectives, for each discipline and year level placement, being defined by education providers. Health service providers could then identify which of the learning objectives they could meet. By comparing these, gaps would be identified and strategies to address the gaps identified, such as shared placement models. This approach also supports the identification of student placements and arrangements which best suit the health service. This discussion formed the basis of a useful draft mapping tool by the project team (Appendix 6).

**Being and becoming learning workplaces**

Developing a culture in which everyone within an organisation considers that learning is a normal and everyday aspect of that organisation’s work provides another opportunity for increasing placement capacity. When an organisation describes itself as “a learning workplace”, it gives recognition and
overt approval for its staff to engage in learning activities. Clearly, placements are learning activities that might constitute one of a suite of learning activities that learning workplaces might undertake.

The benefit of having an explicit learning culture is that providing placements becomes a taken-for-granted activity. It is not something that is specially offered or additional to one’s workload; it becomes a normal and everyday part of everyone’s workload. However, although placements may become routine parts of health service practice, this need not mean that everyone is expected to be a clinical supervisor, even though everyone can contribute in part to students’ learning. Plainly, some people are better suited and better qualified to be supervisors but other staff who are not supervisors can still contribute to learning activities by working with and alongside students, answering questions, and providing instruction and encouragement. For those clinicians who do supervise, it is necessary they receive appropriate resources and support to provide effective student supervision.

Another benefit of being a learning workplace is that quality of placements and of the health service provided may increase. When everyone focuses on learning, continuing professional development is also prioritised. Indeed, there may be efficiencies of learning by engaging in learning activities that include both student learning and staff learning. For example, case study discussions, journal club discussions, and research activities in which staff and students (and potentially also education providers) collaborate for mutual learning and sharing of information and experience.

The community of practice model may be an appropriate tool to use for advancing learning actions. A community of practice is constituted from people who share a common practice and who come together, formally or informally, to assist each other to learn (Wenger, McDermott, & Snyder, 2002). A strength of communities of practice is that each person brings different skills, knowledge, and experiences to the group and through sharing these various perspectives, everyone develops their practice knowledge (Wenger, et al., 2002). Communities of practice have been advocated as valuable for assisting occupational therapists with ongoing professional development and learning (Wilding, Curtin, & Whiteford, 2012) and we contend that they are also useful for other health professions.

**Taking a whole-of-community approach to problem solving and innovation**

Locality specific planning is recommended as a way forward for designing clinical placements in health services, individual health facilities and small communities. The project revealed that there is untapped or underutilised clinical placement capacity across the Riverina ICTN and that barriers and failings of the system inhibited easy uptake of this capacity. Attention to the specific circumstances in facilities and communities is required to overcome barriers and to meet the needs of these placement sites. Some health providers reported that clinical placements did not match their service needs and there was a sense that they had to take what they were given.

The case studies in Berrigan and Narrandera identified a high level of goodwill and interest in supporting clinical placements in the communities although the specific circumstances of the two communities differed. The emerging literature is describing the importance of tailoring clinical placement arrangements for communities using whole-of-system approaches (N. Radomski, personal communication, May 27, 2013). For rural communities, linking the full range of health service providers and agencies such as Local Government, NGOs and service clubs into the planning of clinical placements is valuable in overcoming or lessening the impact of current barriers.
Lack of accommodation has been identified as a key barrier to students undertaking rural placements. Conducting audits of available accommodation in communities, such as nurse’s quarters, billeting students in community members’ homes and housing provided for other disciplines could be conducted in association with local government, tourism and other community agencies.

**Sanctioning time for ongoing review, problem-solving, improvement, and creative development of placements**

In the literature review, we highlighted that preparation of practitioners for rural practice was a problem that resisted solutions, Reid, 2011 in (Smith, 2013). Therefore, we acknowledge that many of the opportunities for taking action to improve placement capacity are not necessarily easily implemented. These ideas are easy to say but hard to do. Nevertheless, if the situation is to be improved then action must be taken. If energy is not to be wasted and the right actions are to be taken then there must be time for thinking, planning, discussing, and strategising.

All participants acknowledged that preparing for and implementing placements takes time and energy. Thus, health services and education providers are already expending considerable time and energy on placements. In order to ensure that this investment is not squandered, it is also important to spend some additional time engaging in continuing review, improvement, and development of the placement system.

**Working with professional organisations to lobby for increased creativity, flexibility, and reform in conceptualising how placements can and should be structured**

Having to adhere to professional organisations’ rigid regulations regarding how placements are implemented was found to be a threat to increasing capacity. Lack of flexibility of some accreditation bodies, professional and industrial groups, and educational programs has also been reported elsewhere as a common barrier to rural health workforce development (Health Workforce Australia, 2013e). Professional accreditation standards dictate many factors that must be met during placements, however as accrediting authorities are charged with ensuring public safety, they are not primarily concerned with addressing the costs of training or the logistics of providing placements (Health Workforce Australia, 2011a). Therefore, there is a disconnection between placement requirements and structuring placements to be innovative and make full use of localised contexts within rural health service settings.

The issue of control by professional and accreditation organisations is another for which there are no easy solutions. Even though professional organisations may see the value in finding solutions for increasing placement capacity, this is not necessarily a goal that is of interest to accrediting organisations. As a starting point, it would be good for education providers and health services to invite dialogue about the issues with professional and accrediting bodies. The first step to finding a solution can often be ensuring that all parties are aware that a problem exists.

As a small but hopefully achievable step towards increasing flexibility in the way that placements are structured, national professional boards could be asked to consider changing supervision requirements so that there is the possibility of interdisciplinary supervision. Even if this action could be
agreed upon for at least the early years (first and second years) of placements, it might go some way towards increasing placement capacity.

Meso-level opportunities

*Using new and different sites and areas of practice to source placements*

Participants taking part in semi-structured interviews for this project were advised that all discussions would be confidential and any findings reported would be de-identified. Untapped, unused and under-utilised capacity was identified during the project, and is captured in a separate document. At this stage, approval has not been sought from these interviewees to release this confidential information, therefore until this is obtained, this document must be held confidentially within the Riverina ICTN coordination unit. The next step here would be to seek approval from the interviewees, start to overcome any noted barriers and use this untapped capacity.

There is untapped/unused capacity if the systems are right. The constraints and issues in the current clinical placement system strongly influence the ability to expand clinical placements. The same constraints apply to establishing clinical placements in new or non-traditional settings. Establishment of effective systems and attention to specific circumstances in placement settings will support clinical placements such as in justice health, the private sector, Aboriginal health services, mental health and community based services.

There are a number of innovative models that have been discussed in this report and more information is contained in the annotated bibliography in Appendix 1. It may be useful for a health services and education providers to copy or modify one of these models as a locally-suitable solution. In particular, the SpICE model is commended as it is a successful innovation that was developed for use within rural and regional NSW. A SpICE-type model may be useful within a medium-sized community, such as Narrandera.

Formal partnership approaches detailed in this report provide a level of certainty and transparency for education providers and health services. While these partnership approaches have advantages and disadvantages as described in the report, these are an important part of an overall clinical placement system, alongside whole of community approaches and other initiatives.

There are numerous opportunities for increasing placement capacity by creating and taking up more placements within aged care. The development of effective partnerships between education providers, aged care services, acute services and supporting agencies along with the appropriate preparation of students and supervisory and mentoring arrangements appear to be essential success factors. Experience and learning from the Helping Hand project and the Teaching Nursing Home Initiative mentioned in this report would be valuable in informing the development of aged care clinical placement projects in the Riverina ICTN.

During the course of the project a specific opportunity was identified, although not extensively considered, involving the aged and extended care team of the MLHD, the Forrest Centre, Wagga Wagga and possibly other services and agencies. The aged and extended care team operates the
transitional care program at the Forrest Centre as well as the aged care assessment team and a range of general and specialised aged care services. The Forrest Centre includes the Mary Potter Nursing Home, the Loretta Home of Compassion and the Forrest Community Services with outreach services in Turnut, Griffith and Wagga. Together, these services, along with linkages to the acute sector and community based services, provide the spectrum of aged care services that could lend itself to a collaborative, interdisciplinary clinical training facility in aged care. Given the shortage of supervisory capacity in the residential aged care sector consideration of this aspect will be vital to the success of a project.

As an extension of the above model, linkage with other residential aged care services in a hub and spoke model may be appropriate. The case study undertaken in Berrigan revealed a much higher than state average proportion of residents aged over 55 years, a plethora of aged care facilities in the Berrigan Shire and broad community support for clinical placements. This would involve links with services and facilities in regional centres.

The potential advantages of focussing on aged care include:

- Identifying the needs of the residential aged care sector to enable expansion of clinical placements;
- Contributing to changing perceptions of aged care placements among students and education providers;
- Building partnerships between education providers and between education providers and aged care;
- Creating opportunities for interdisciplinary training;
- Enhancing the aged care sector as an employment option and recruitment enabler;
- Improving quality of aged care and reducing hospitalisation;
- Research of locally contextual aged care issues.

Discussions with an HWA representative during the course of the project indicated a high level of interest by HWA in projects that could support the enhancement of the aged care workforce (G. Beltchev, personal communication, April 3, 2013).

**Experimenting with innovative models of supervision**

There is a need for more incentives for health services staff to involve themselves in clinical supervision, to change the culture in health services towards clinical supervision and put mechanisms in place to ensure greater value is placed on supervision. Providing appropriate acknowledgement and support for supervisors that recognises their expertise and extra workload is necessary, and can be achieved by legitimising clinical supervision and strengthening job descriptions around clinical education. The National Clinical Supervision Competency Resource, which documents the core competencies of clinical supervisors, may be used to guide the development of current and future clinical supervisors (Health Workforce Australia, 2013c).

A Nursing Rural Generalist program is currently being developed locally. In alignment with the national competency standards for registered nurses (Australian Nursing & Midwifery Council, 2006), it is recommended that a module on clinical supervision be included as a core nursing skill.
In addition to the existing supervisory arrangements, the following alternative models are suggested:

- use of a ‘supervisor for hire’ model where ‘freelance’ clinicians provide supervision, development and implementation of interdisciplinary supervision options, pooling of resources by multiple education and health service providers to jointly support a supervision role to overcome the problems of part-time or temporary supervisors and insufficient student numbers to sustain a full time supervisor funded by one organisation.

**Micro-level opportunities**

This report has documented key limits, enablers and threats and described how these factors manifest positively and negatively in the clinical placement system. The following micro-level activities aimed at capitalising on enablers and overcoming limits and threats will improve efficiency within current systems of placements.

- Increasing transparency in the process of offering, allocating, and accepting placements;
- Undertaking more collaborative planning of placements across a longer time frame;
- Ensuring all placement experiences are high quality;
- Providing education and support for supervisors;
- The effective use of payments for placements that directly support and build clinical training capacity;
- Reframing students’ and academics’ perspectives about placements that are considered to be uninteresting or unpopular;
- Providing support for students to attend rural placements;
- Reframing supervisors’ ideas about how placements can be structured.

The clinical placement system is highly variable and complex. While change can be difficult, stakeholders working together making incremental change and locally focussed efforts will effect sustainable, robust improvements to rural workforce development.
Conclusion

The project considered the question: untapped capacity for clinical placements in the Riverina ICTN: does it exist? where is it? and can it be used? It has been demonstrated there is untapped and unused capacity within Riverina ICTN across the broad range of health services and much goodwill of interviewees towards being part of clinical placement solutions.

Identifying this additional capacity is only part of the solution; expanded capacity is available only if the systems are right. The clinical placement system is highly variable and complex, and the challenges are significant and the current constraints and issues strongly influence the ability to expand clinical placements. Systems, resources and quality must to be adequate before expanding clinical placements to meet increasing demand.

Consideration and implementation of a range of the opportunities for action recommended in this final report will enhance enablers and minimise threats, increasing clinical placement capacity in the Riverina ICTN, contributing to a sustainable rural health workforce for the future.
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Wilding, C., Curtin, M., & Whiteford, G. (2012). Enhancing occupational therapists' confidence and
professional development through a community of practice scholars. Australian occupational

ZEST Health Strategies. (2012). NSW Clinical Supervision Support Project Part A: Mapping Study -
Final Report.
### Appendix 1: Annotated Bibliography of innovative clinical placement models

**Endnote database smartgroup coding:**
- ctc = clinical training centres
- ns = new settings
- pp = placement partnerships
- sd = self directed
- fs = fund supervision
- tn = teaching nursing home
- sd = self directed
- it = informal training
- pp = placement partnerships
- ctc = clinical training centres
- sf = student focused
- fs = fund supervision
- pp = placement partnerships

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<th>Reference</th>
<th>Project description</th>
<th>Recommended/implemented innovative strategies/models for clinical placements</th>
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| (Healthcare Management Advisors Pty Ltd, 2007) | “Systematic, comprehensive assessment of current and projected undergraduate and postgraduate allied health clinical placement arrangements for occupational therapy, physiotherapy, podiatry, social work and speech pathology *(p.2)* | Recommendations included:  
1. Extended academic year  
2. Early and durable clinical placements (e.g. rostered shifts)  
3. Various clinical placement types operating at once  
4. Network of training placements or integrated clinical placement environment  
5. Clinical placement entity funded and operated for professional disciplines by academic institutions  
6. Funding as an incentive for students and payment to health services for providing placements for students  
7. Recognise the role of supervision  
8. Seek out new & innovative placement sites  
9. Optimise use of IT  
10. Establish and fund new initiatives  
11. Establishment of exclusive units to foster r’ships between facilities and TIs  
12. Pilot & evaluate innovative alternatives to clinical training  
13. Support clinical supervisors *(p.26)* | “Multi-dimensional problems require multi-dimensional solutions.” *(p.27)* Initiatives include:  
- Improved funding  
- Across allied health  
- Recognition of gap  
- Support for rural  
- Flexible approaches  
- Innovative approaches  
- Support for supervisors *(p.27)* |

| (State Government of Victoria, 2007) | Collection of innovative projects all aimed at increasing undergraduate clinical training capacity *(p.1)* | Innovative approaches used by projects included:  
- Supervisor education  
- Alternate shifts – nights, weekends  
- Alternate learning resources/programs  
- Alternative settings  
- Simulation/telemedicine/videoconferencing | Themes emerging from projects:  
- Foundations for a coordinated and effective clinical placement system  
- Improving the effectiveness and quality of clinical placements  
- Increasing clinical placement |
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| fs        |                     | • Creation of specialist resourcing role  
• Alternative blocks  
• Alternative clinical placement management booking tools/shared skills list & assessment  
• Alternative supervision model (e.g. different ratios, paid student employment, peer review, supervision by supervisor from different discipline) | capacity (p.9-14) |
| (Hume Clinical Placement Network Moira Project, 2012) | Main objective to increase clinical capacity and identify barriers and enablers to placement opportunities in a small rural health setting. | Implemented:  
• Instigating placements across 7 day weeks (as opposed to weekdays only)  
• Building of accommodation in Yarrawonga to house 14 students at a time  
• Accessing previously untapped aged care placements (in low level care and dementia specific care)  
• Utilising dialysis placements at some sites | • Identified clinical student placement as core business  
• Reviewed supervision models  
• Engaged stakeholders  
• Supervision workshops (no page numbers) |
| (Victorian Healthcare Association, 2011) | “[A]ims to support effective clinical placements within community health and small rural health services.” (p.4) | Implemented:  
• Djerriwarrh Health Service: support of six nursing staff to undertake a Certificate IV in Training and Assessment in order to enable student supervisors to gain a better understanding of the requirements of clinical supervision.  
• Sunraysia Community Health – Dental Clinic – Student teaching: The facility includes a four chair student teaching clinic with one designated dentist as supervisor. The service can take 8 dental students at a time (two students work together; one assists and the other works directly with the client). Teaching clinic has glass walls so the supervising dentist can watch.  
• Interprofessional Placements: medical, nursing and AH disciplines work together to plan and deliver care for clients. Three examples of interprofessional placements have been in a community health setting, a small rural health service and a metropolitan health service. (p.9) | Recommendations  
• Minimum standard of broadband access to students on placement  
• Agreement between universities and health services needs further consideration  
• Universities and health services market to tertiary institutes (p.12-13) |
| (Holland, 2011) | Project “was established to support effective student placements within community managed | Recommendations included:  
• Support culture change in student placements  
• Establish standards of practice  
• Build evidence base for impact of placements | Outcomes:  
• Emphasise diversity of the sector.  
• Need for structures for student placements. |
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| (Aged and Community Care Victoria, 2011) Coded: tnh                      | Aimed to “undertake a scoping of the current capacity of residential aged care to provide viable and valuable clinical placement opportunities” (p.4) identify barriers and “potential new clinical placement models for residential aged care, and to support education and training partnerships | • Improve coordination of placements  
• Increase capacity  
• Enhance quality  
• Develop systems for placement data  
• Improve understanding among stakeholders of the role of sector (p.27) | • Need for evidence base for benefits of student placement to the sector.  
• Need for promotion and partnerships limit development of student placements. (p.28) |
|                                                                          | Key findings:  
1. Lack of clinical support and supervision provided by RTO  
2. Formal orientation programs offered could be improved  
3. Lack of internal resources and do not receive funding for placements  
4. Accept students because they believe placements offer valuable clinical experience and may be a vehicle for future recruitment of staff but there are negative stereotypes  
5. Placements should occur in the middle of a course rather than at the beginning  
6. Need for genuine partnerships between universities and RTO  
7. Implementation of best practice  
8. Promotion of teaching nursing homes  
9. Lack of understanding of what a quality clinical placement is. | Innovative models  
• New model of supervision using ‘specialists’ available to the whole residential aged care sector.  
• Alignment of facilities geographically with educators.  
• ‘Upskilling’ courses.  
• Two tiered system of degree/diploma students versus certificate level students offered placements at different facilities.  
• Teaching nursing homes ‘learning on the job’. |
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<td>(Mason, et al., 2012)</td>
<td>Qualitative study of social work student clinical placements in rural Australia. “It aimed to examine what strategies and processes organisations use when they host successful direct practice placements in regional and rural Australia”. (p.131)</td>
<td>Themes:  - Commitment to supervision and professional development  - Importance of theory  - Preparation for placement  - Understanding student learning  - Value of placements  - Measuring success  - University role</td>
<td>Findings:  - Organisational commitment to ongoing professional development and supervision.  - Supervisors actively demonstrate learning principles and benefits.  - Supervisors enjoy supervising and engaging with students.  - Formalise recognition of competent educators and encourage mentorship to early career supervisors.  - Open and distance learning networks for isolated supervisors.  - Encourage positive placement experiences as retention solution.  - Further research to build on identifying successful placement components. (p.149-150)</td>
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<tr>
<td>(Rosenwax, et al., 2010)</td>
<td>Gribble Rosenwax Advanced Clinical Education (GRACE) program. Innovative approach to reforming occupational therapy clinical</td>
<td>Innovations implemented:  - Clinical education sites and key staff were viewed as integral and valued partners in the clinical education process (rather than traditional view of seeing them as offering the University a service) (p. 12)  - Mutually beneficial relationships achieved by three ‘drivers’: economic incentives; interpersonal relationships; access to resources not offered by competitors (p. 12)</td>
<td>Outcomes  - Mean length of clinical placements increased from 5.3 weeks to 7 weeks  - Clinical placement calendar can be planned 2-10 months in advance (allows students to organise work)</td>
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| placements using relational marketing theory. Primary goal was to cultivate and enrich long term relationships (between University and facilities) that would be of maximum benefit to stakeholders. Complete overhaul of clinical education program from Uni perspective, and required stakeholders to embrace radical change that affected organisation, planning, delivery and supervision of clinical placements. (p.11) | • Change in OT course structure from the University end – all full time clinical placements were moved to the final year of curriculum (p. 12)  
• Placement year spans 42 weeks from mid-Jan to mid-Dec, with 6 placement blocks of 7 weeks each across the year (1 week break between blocks)  
• Negotiation of annual contractual agreements with host sites (Clinical Education Coordinator – CEC) sites. Remuneration for hosting students $500 per student in 2009. CEC sites are remunerated for hosting ≥2 students in each of the 6 blocks (p. 13)  
• CEC person is selected by each host site to work in collaboration with the University’s clinical education team. CEC plans and runs orientation at host site; liaises with supervisory OTs including giving assistance for new supervisors; meet with students before and during placement; set readings and tasks for students; coordinate tutorial lessons for students on clinical placements; observe and evaluate students; liaise with Uni regarding any issues; review clinical placement experience for students and supervisors; implement changes to enhance next planned clinical placements. (p. 13)  
• Students allocated to sites for an entire year (p. 13)  
• Debriefing tutorials run by Uni staff for students at end of clinical placements (p. 13)  
• Students perform handover of caseload, project/s and physical orientation to students about to commence clinical placements at same site (p. 13) (done @ Uni)  
• Uni makes the final decision on whether a student fails a placement or not (p. 14)  
• CECs are appointed as University Associates – gives access to library facilities, academic staff and OT Ax and measurement resource learning centre (p. 14)  
• CECs and supervisors have access to University personnel at all times – partnership model (p. 14) | • Reduction from 123 to 64 sites utilised – less running around for University and greater quality control.  
• Students allowed some choice in host site  
• Final year is pseudo-internship year – enhances work-readiness of graduates  
• Part-time clinical placements are available  
• Smoother pathway for students who fail a clinical placement  
• All clinical placements are supervised  
• Now an oversupply of placements!  
• All students completed placements on time  
• Stress on Uni staff to find placements reduced  
• Number of academic staff allocated to clinical education program reduced from 3.4FTE to ≤1FTE (money can be used to hire CECs)  
• Early ID of students at risk of failing |
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<td>(Smedts, et al., 2013)</td>
<td>Survey of allied health professionals in NT. Findings showed the AHP workforce in NT is mostly female, non-Indigenous, trained outside NT. 62% provided student supervision, and this accounted for ~9% of workload; 20% of existing supervisors and 33% of non-supervisors were interested in greater supervisory responsibilities (p.1)</td>
<td>Models of supervisor recruitment and support should focus on professionals not currently teaching, complemented with strategies to overturn the perception that supervision equates to workload overburdening, and methods to develop supportive networks that encourage retention (p.11) Greater support for supervision in workplaces from directors and senior managers, to ensure student supervision is incorporated into core business and strategic planning (p.11)</td>
<td>Findings: Need for increased professional development for supervisors. Reduce workload of supervisors. Recognition and remuneration for supervision of students. Focus on encouraging retention of supervisors. (p11)</td>
</tr>
<tr>
<td>(Clinical Education and Training)</td>
<td>Strategies for managing increased numbers of</td>
<td>Enablers: Prevocational General Practice Placements Program provides a viable funding</td>
<td>Recommendations: General</td>
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<td>Institute, 2010</td>
<td>medical graduates in expanded settings of training, alternate training models and investment in supervision. Change in focus – hospital based to community preventive equals opportunities for training. Prevocational exposure = scope to develop in new need areas – general pract. Expand into private sector. Expanded Settings Strategy Group recommendations to NSW Health are discussed and further recommendations made relating to general practice, community based, private hospitals, and innovative specialist based training for prevocational medical trainees. (p.3)</td>
<td>stream for terms in general practice. The PGPPP could be improved by simplifying the administrative arrangements, and by guaranteeing greater continuity of funding to participating practices. General Practice recommendations: • Seek an expansion of prevocational training in general practice. • Incentive to participation – identifying practices that are accredited and successful in managing trainees. • Develop accreditation procedures for general practices to streamline process. • General practice term should not be an alternative to the core emergency medicine term. • Prevocational training networks should be encouraged to form cooperative relationships with general practices so every trainee who wishes to have an experience of one gp training term in their training contract. • Network should take responsibility for ensuring that trainees in gp have access to educational sessions (either in the gp attending hospital, or by using communications technology to provide remote education). • Document a model approach to public hospital/gp training partnerships based on best practice. (p.23)</td>
<td>• GP &amp; Community • Private hospitals • Innovative • Supervisors</td>
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Community settings. Reduce the demand for hospital services and provide alternate pathways for care of people with chronic illnesses. May be more practical to combine community health training with gp terms or hospital based terms. There is no identified public funding for prevocational training in community settings NGO. Recommended: • Innovative development of training in community health by networks to coordinate expressions of interest from CH facilities in hosting trainees with interested trainees. • Flexible and supportive approach to accreditation of CH.
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|           | Active co-operation of training networks to ensure that trainees at CH continue to receive access to ed sessions and support services at their home hospital. (p.24) | Private hospitals Can provide valuable learning experiences not available in public hospitals – different case mix and practices. Desirable features – reputation for clinical excellence, consultant staff members perm based, proximity to public hospital, willingness to develop training program for prevocational trainees. MOU between public and private hospital. Recommended:  
- Negotiate at high level – Health and owners of private hospitals.  
- Negotiate with consultants before assuming their goodwill to new responsibility.  
- Incentive to participate – ID accredited and successful managers of trainees.  
- Alternative would be part time following accredited supervisors from work in public hospitals to work in private sector. (p.25) | |
|           | Specialist rooms and other private practices Those that are most likely to engage with prevocational trainees are those that anticipate an increasing shortage of entrants to their discipline. Recommended:  
- Engage with colleges to explore training in private specialist practices.  
- Create alternatives – half terms in private specialist practices to introduce discipline.  
- Create concept of accredited supervisor – trainee follows supervisor from public to private work. (p.26) | | |
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| (Health Workforce Australia, 2011a) Coded: pp tnh ctc | Part of the Mapping Clinical Placements project this report identifies barriers and enablers to clinical placements in relation to need & student population. Identifies opportunity for growth by new practice settings. National study on clinical placements 25 professions & 69 tertiary ed institutions. Identified population density and placement activity relationship. 1% of providers deliver 42% of clinical placements. Public hospitals dominate clinical placement = underutilisation of alternatives. (p.4) | Barriers:  
- Infrastructure problems  
- Supervision  
- Existing arrangements between ed institutions & providers limits access  
- Funding  
- Clinical workload limits expansion  
- Culture that clinical placements are burdensome (p.3)  

Enablers:  
- Expanding university-led partnerships outside hospitals  
- Use existing resources for various shifts (day, night, weekend)  
- Providing administrative support, student readiness, work readiness(p.42)  

Identified opportunities for growth by innovative approaches:  
1. Expand clinical placements with aged care providers. Key opportunities – connect universities & providers, reduce admin burden, provide staff management skills.  
2. Develop university-provider partnerships around a centre of excellence. Key market differentiating focus –specialised curricula to particular setting.  
3. Involve smaller providers in a community setting. Partnering of regional universities and networks of providers around professions.  
4. Develop on-site clinical schools to deliver clinical education. Expand these schools with external funding.  
5. Explore trans/multi disciplinary supervision and approaches. Increase clinical placement & provide beneficial student experiences.  
6. Make better use of existing clinical placements over 24 hr clock. New models around timing.  
7. Streamlined processes to improve experience of providers. Better managed student placements improve experience and facilitate growth.  
8. Expand the use of electronic student allocation tools to identify requirements. Identify unused capacity of clinical placements locally. Provider specific versions of system wide placement systems. | Aged Care:  
Australian Catholic University & RSL LifeCare Ltd introduces students to the sector. Offers undergrad & postgrad opportunities. Funding not a feature. Leveraged relationship. (p.54)  
Deakin University & Southern Health Nursing Research Centre. Established first teaching nursing home. Recognised centre of excellence.(p.54)  
Mercy Private & the Australian Catholic University. Collaborative planning and coordination assist capacity of providers to accept more placements & attract students. (P.54)  
Australian Catholic University, individual nursing homes & the Benevolent Society. Developed teaching nursing homes & incorporate low care facilities. Students undertake a theory unit that exposes them to aged care & a lab program and three week clinical placement. (p.55)  

On site clinical schools  
Griffith University Dental Clinic |
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<td>(Australian Nursing &amp; Midwifery Council, 2006)</td>
<td>Development of an interdisciplinary model for clinical placements for medical and nursing undergraduate students.</td>
<td>- Involve practicing health professionals in clinical placement design. Collaboration improves willingness and course content. (p.77-79)</td>
<td>Gerontic Nursing Clinical School (La Trobe University) University of Queensland’s School of Health &amp; Rehabilitation Sciences Macquarie University Speech Clinic (p.64)</td>
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<td>(Kline &amp; Hodges, 2006)</td>
<td>Interprofessional model developed and piloted with an evening program.</td>
<td>Barriers to IPE placements included: • Different supervision arrangements Solution: Additional facilitator appointed to match students geographically. • Space Solution: Early organisation and booking of room space for students to meet with the facilitator after participating in the activity. Recommendations: • Engage leadership • Identify barriers &amp; plans to overcome • Flexible IPE activities • Acknowledge students preconceptions • IPE facilitator essential • Different learning models need to be considered.</td>
<td>Pilot study &amp; 2 Trials IPE intervention model</td>
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<td>(National Health Service Education for Scotland, 2007)</td>
<td>Practical guide to models of practice placements. Traditional models outlined and discussed in</td>
<td>Evening program: • Provided a feasible alternative site for undergraduate clinical placement. • Learning outcomes • Patient feedback • Hours of operation not suitable for older population.</td>
<td>Development of model and pilot.</td>
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Advantages: • Opportunity for placements in emerging areas. • Highlights role of profession to
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<td>sd pp</td>
<td>detail with barriers and facilitators indicated. (p.12-31) One non traditional approach discussed. (p.26)</td>
<td>supervision is provided at a distance either via telephone or video link. The student organises the placement experience in a non traditional setting such as private business or corp, commercial, or voluntary sector. Challenges: • Quality assurance process complicated. • Setting up placements problematic due to supervision arrangements. • Challenging for some students with supervision not from own profession. • Used more often with students at end of training. • Health and safety checks to ensure adequate procedures. • Paired students from different learning styles beneficial.</td>
<td>- Strengthens relationship between public and voluntary sector. - Can improve/expand service. - Allows placement opportunities for isolated or remote services. - An industry/business has a project undertaken by student. - Alleviates time pressures from practice educator by self directed learning for students.</td>
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<td>(Clinical Placement System Development Program, 2010)</td>
<td>Workshop analyses two models: Rural Interprofessional Clinical Education Teaching and Training Centres RICETs (p.8) and Tasmanian Clinical Placement Partnership TCPPs. (p.10)</td>
<td>RICETs in five locations increased clinical placements by 18% in medicine, pharmacy, paramedicine, dentistry. Amongst outcomes are: • Enhanced linkages with UTAS enabling future ed and training opportunities in rural locations • Providing assurance of the future availability of a skilled workforce that meets the needs of rural and remote populations. • IPE training • Develop innovative approaches to clinical ed and training • Providing innovative model for future rural health teaching. (p8-9) Tasmanian Clinical Placement Partnership (TCPP) Partnership UTAS, Health, GP training, Private Hospital – Academic Coordinator/educator introduced to work with clinicians – develops skills within the organisation regarding effective supervision and supports them throughout the placement. Admin support relieves the organisation of approximately 50% of workload associated with taking students. 27% increase in student placements over 3 years. • Increased clinical placement capacity • Expanded range of placements in non-traditional settings.</td>
<td>Includes: • refurbishment of infrastructure, acquisition, • utilisation of virtual clinical training technologies (NBN), • additional student residential accommodation to support increase in placements. • 20 new clinical placements for medical • 126 new clinical placements for nursing • 20 pharmacy • 8 physiotherapy • 8 psychology</td>
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<td>(Russell, Hobson, &amp; Watts, 2011)</td>
<td>Team Leader Model alternative approach to preceptorship Placements – supervision in team, student led. A partnership between hospital and university. Strategy to provide reality to placement and reduce preceptor burnout. (p.5)</td>
<td>Assessment of new model based on team approach – Registered nurse, graduate nurse and student nurse. Student takes lead under supervision. “Key elements of the model include: • moving the responsibility for the supervision of undergraduate students from one staff member, the preceptor, to the ward staff together managing their placement and experience; • teams of three: a registered nurse as ‘TeamLeader’ and supervisor, an undergraduate student and the third being a staff member who would benefit from additional support e.g. graduate nurse; • reality of practice - allocation of a patient load to the undergraduate student for the shift; • inclusion of undergraduate students on continuous practice as ward ‘staff’ e.g. on roster; • the support role of ward ‘Student Liaison Nurses’; and • culture change - importance of ongoing staff education.” (p.7)</td>
<td>The Team Leader Model demonstrated that it: • provided an improved allocation model of student supervisors, • students felt a greater sense of reality of practice, and • graduates appreciated the support of the Team Leader.</td>
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<td>(Harmon, 2013)</td>
<td>Dedicated education unit – rural placements for nurses. Pilot project partnership between college and hospital. (p.89)</td>
<td>Designed to address specific issues related to rural placements: • Confidence in proficiency • Struggles of rural hospitals to recruit prepared competent rural nurses. Instead of being housed in one unit of the hospital the DEU consisted of the entire hospital, all units. Each student is paired with one staff nurse for the whole year and works with that nurse on each clinical rotation. Cements one-on-one relationship. Designated number of students accepted (4) and staff (5) designated Hospital Clinical Teachers. Both groups applied and were interviewed for the position.</td>
<td>Key points: • Helped to prepare student nurses for rural nurse generalist roles within a learner-centered context, thereby promoting self-esteem and confidence. • Improved how student nurses are educated and engaging community partners in the preparation process. • Facilitated recruitment and retention (p.95)</td>
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| (Denton, et al., 2012) | 8 hour campus session for Teachers to acquaint themselves with students, roles, responsibilities. Overview of curriculum, alignment of objectives.  
In-service for students and faculty staff at hospital for overview.  
Students paired with teacher for 24 hours per week during colleges three academic quarters. Some worked day, some night, and weekends.  
Frequent meetings between faculty, student, teachers. (p.95) | Increasing the capacity of rural supervisors through shared placements and using technology.                                                                 | • Early childhood settings.                                                                                               |
| (Beecham & Denton, 2010) | Specialist Integrated Community Engagement (SPICE) model outlined at the Speech Pathology Australia National Conference includes providing placements that enable collaborative engagement. http://www.slideshare.net/LibbyClark/spa-going-the-distancefinal | Teams of SP students in 2nd year, mentored by one 4th year student work with teachers in five schools around the region to develop school specific projects. Addresses individual schools needs while embedding the relationship between language and learning in schools ethos. (p.112) | • Addressed schools need for support in outcomes  
• Need for the health service to promote better communication outcomes  
• Need for CSU students to gain alternative clinical practice placements.  
• Benefits |
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| (State Government Victoria, 2013) | Hume Alpine Health restricted in clinical placements by the barrier of limited accommodation for students. Describes the project establishing a clinical teaching space which includes accommodation allowing them to reach sources for medical students placed in rural settings. | Project objectives and expected impacts:  
- Contribute to our strategy of improved organisational effectiveness through the continued development of a defined undergraduate, graduate and postgraduate strategy  
- Develop improved opportunities for student accommodation in the small rural health setting in order to aid recruitment and retention of student numbers  
- Establish facilities that will allow Alpine Health to continue to compete in the student placement market in order to build local workforce planning capacity into the future. (p.3) | Project key outcomes:  
- Experience of placement for student graduate outlook  
- Schools oversubscription to project in hosting sp teams  
- Interprofessional learning aspect. |
| (Health Workforce Australia, 2013a) | Health Workforce Australia report aimed “to determine the elements of an effective clinical placement that are sustainable and transferable to other settings for the expansion of clinical placements in rural and remote areas.” | Effective and efficient model identified as holding three components:  
1. Environmental/infrastructure (accommodation and travel support; financial student support; learning space; IT; clinical variety)  
2. Teacher/supervisor (communication with host institution; culture of learning in placement institution; teachers contribute to curriculum; trained and sympathetic supervisors; experienced supervisors; recognition of extra workload for supervisors; host contributes to resources)  
3. Student (2 students from same discipline co-located; longer placement; interaction between students from other disciplines; real need experience) | Concluded:  
- Existence of opportunities and innovations in rural and remote settings  
- Challenges for non-traditional settings  
- Require committed, qualified, resourced and rewarded supervisors |
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<td>the rural/remote primary care sectors in key disciplines.* (p.5)</td>
<td>defined role for student; students welcomed; formal feedback; adequate briefing of impending placement). (p.8)</td>
<td>Welcoming to students</td>
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<td>Literature review. Recommendations. Stakeholder interviews and surveys.</td>
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<td>Quality program, evaluated regularly</td>
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<td>(Barnett, et al., 2011a) Coded: tnh pp</td>
<td>Teaching Nursing Home model. <em>linking of the separate spheres of research, clinical care and education and training</em> (p. 1) Examination of the model with Case Study analysis.</td>
<td>Benefits: • Education/training provider • Aged care provider • Students • Residents (&amp; Families) • Aged care workforce Challenges: • Ethical and legal issues • Disincentives • Managing different cultures, capacity and expectations Enablers: • Good practice in clinical placement • Attention to planning • Formalised affiliations • Shared commitment • Informed participation • Mutual understanding • Clinical practitioners • Interdisciplinary focus • Sufficient critical mass</td>
<td>Conclusions: The model supports partnerships and shares responsibility providing best practice clinical placement in aged care. Key benefits: • Enhanced recruitment and retention linking research, education and clinical care • Enhanced profile of aged care as location for clinical placement • Dissemination of learnings extends impact for sector • Prevents hospitalisation and length of stay (p.49)</td>
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<td>(Barnett, et al., 2011b) Coded: tnh</td>
<td>A scoping study of enablers and barriers to establishing and operating a teaching nursing home in Australia. Literature review Stakeholder interviews (p.3)</td>
<td>Barriers and enablers to the establishment, ongoing operation, and all stages of a teaching nursing home are explored. Enablers for rural settings:  - Provision of physical infrastructure and funding to accommodate students.  - Small critical mass issue addressed by co-location.  - Provision of support to students away from home and usual support.  - Use of mobile clinics.  - Link rural to larger facilities. (p.42)</td>
<td>Implementing the model:  Lessons learned from scoping study  - Reflect wisdom of those involved in model  - Avoid inflexibility of a single model  - Include evaluation process  - Include database to monitor outcomes relieve reporting burden (p.47)  Extending impact  - Joining the education and training, aged care, and sub-acute and acute care sectors  - The Hub &amp; Spokes approach – centre for excellence guiding by example</td>
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Appendix 2: Lists of topics explored during health service semi-structured interviews

Overall health service focus on learning and clinical placements

Processes and Agreements
- Current disciplines hosted and reasons for selection
- Decision making process on taking students
- Collection of placement data
- Relationships and agreements with education providers
- Experience liaising with education providers
- Experience using ClinConnect (if appropriate)
- Dedicated staff to employed to arrange clinical placements (if any)

Students
- Availability and transparency of learning objectives of students
- Orientation procedures

Funding and Infrastructure
- Funding from educational providers and/or government (if any)
- Release from clinician caseload to teach students
- Facilities available to students including accommodation
- Support systems for clinical placements

Clinical and Supervision
- Qualifications and skills for staff to supervise students

Other factors impacting clinical placements
- TAFE sector, secondary school and ClinConnect impact

Enablers and solutions
- Strategies for successful clinical placements
- Key areas needing addressing to ensure sufficient capacity

Untapped capacity
- Additional placements able to be taken (numbers or disciplines)
- Opportunities able to be provided
- Motivating factors or incentives to take more students
- Additional services who may take new clinical placements
- Opportunities to consult with regional or local groups
Appendix 3: Lists of topics explored during education provider semi-structured interviews

**Professional-entry health course(s) currently offered by the education provider**

**Processes and agreements**
- Clinical placements currently coordinated into the Riverina ICTN
- Decision making processes on placing students
- Relationships and agreements with health services
- Experience liaising with health services
- Experience using ClinConnect (if appropriate)
- Collection of placement data
- Dedicated staff to employed to arrange clinical placements (if any)
- Criteria for appropriate placement (size, clinical load, supervisors etc)

**Benefits and reasons for rural clinical placements**
- Decisions surrounding which students attend rural placements and students who are unable to be placed in rural health services

**Funding and Infrastructure**
- Cost of rural clinical placements and how this is funded (if appropriate)
- Organisation of accommodation
- Financial assistance to students on rural placements

**Potential challenges and barriers**
- Competition for placements
- Ensuring the quality standard of rural placements

**Enablers and solutions**
- Strategies for successful clinical placements
- Key areas needing addressing to ensure sufficient capacity
- Motivating factors or incentive to utilise more rural placements
- Potential models for rural placement organisation

**Untapped capacity**
- Unused or untapped capacity within the Riverina ICTN
- Opportunities to consult with further clinical placement stakeholders
Appendix 4: ClinConnect vignette

ClinConnect is the NSW public health clinical placement database. Health services offer placements on the ClinConnect site and then education providers select which placements they would like to pursue for their students. While it was not the intention of this project to evaluate ClinConnect, many interviewees commented on its role and impact and therefore we are presenting participants’ experiences of the use of ClinConnect as an additional item in the report.

Participants had both positive and negative experiences of using ClinConnect. We acknowledge that any new system may have initial difficulties during its start-up phase, however some of the issues that were reported directly affect the opportunity for increasing capacity for student placements in the Riverina ICTN. Some participants experienced ClinConnect as stifling innovation and relationships, and reducing capacity for placement opportunities. In addition, another layer of complexity was added to the system and all users had to develop new skills. However, a benefit of the system was that it enabled health services to feel a greater sense of control by enabling the more even spread of placements throughout the year.

ClinConnect is not available for health services outside of the NSW public system and therefore private practices, private hospitals, and non-government organisations are excluded.

“Yeah, and we’ve sort of been left off the radar because of ClinConnect”. HS18

Omitting these organisations is disadvantageous to them and it may also result in unused placement capacity because potential placements in these organisations may be less visible to education providers.

"It doesn’t at all cover any placements outside of the health service, so in general practice or in other non-health service community health organisations it just… they don’t feature at all in the database, so it doesn’t help in that regard… there might be advantages on paper, but I think in reality it can be really difficult to get those all on board." EP10

ClinConnect may enable placement opportunities

The ability to plan student intake in advance and distribute clinical placements more evenly across the year is a positive effect of ClinConnect. Being more in control of when placements occur means that health services feel less burdened and they have more power to structure placements so that students have an excellent learning opportunity.

"So there’s actually a much better control over students. Last year we were actually overbooked really with students that were coming and some of them were booking in just for a couple of weeks that had missed out on placements somewhere else… and so last year we actually had way too many students and this I feel is much better, a much better way of organising students so we have a fair spread of students at any one time. Because there are students that come, they need to be buddied up with people and I need to be able to roster them morning or afternoon to share them because you want them to have a good"
experience, not to be just standing around or not having someone to buddy up or supervise them... because not only do we have those students but we also have work experience from the schools... and the TAFE... so there’s this big influx of people whereas now with the ClinConnect it’s much more spread out and much better. HS5

Another benefit of ClinConnect is that once the placements are confirmed in the database, there is less risk to the education providers that the placements will be cancelled.

Now through ClinConnect it’s very transparent and people can’t say “no”. Now, like the fellow from [name of town] rang me and said; “I know I can’t say ‘no’ to your student, but yes I’m worried”, but even at the end he said; “Look, I know they’ve got to come, they’ve got to come,” whereas, before he would have just rung me and said “we’re not taking a student.” So I think from an education provider we’re most probably more positive at the moment because they can’t just, you know [cancel], and some nurse educators are very nice and would take 150 students and some nurse educators will just down right refuse to. So they can’t do that now, it’s very transparent and I do believe health has the capacity and it’s better managed now. EP 16/17

**Threat: placement capacity has reduced at the same time placement coordination workload has increased**

Compared to systems used before ClinConnect, capacity has been reduced with the advent of this new database. As it was beyond the scope of this project, no further exploration was done as to why this is so.

ClinConnect I think potentially can be good but certainly in this experience we’ve got fewer placements, I don’t know why but we just didn’t get the offers that we think we might’ve got had we gone back through our traditional way of doing things. This is the first year in [allied health discipline] that I haven’t had almost double the number of placements that I’ve required in fourth year because fourth year’s usually people who offer placements because you’ve future employees, double might be an exaggeration but we’ve certainly got a lot of extra, we maybe had two left over. EP5

The ClinConnect system has increased the workload of clinical coordinators in educational institutions.

... instead of a placement taking us a very short period of time of just sending out an email to sites and then collating all those offers when they come in, we now have to go in pretty much over a whole twelve month period and spend time actually requesting individual offers, which takes us a lot of time because we’ve got to go in and change the dates and go into every individual site. So the timeframe is costing us a lot time and then we are actually getting a lot more rejections. EP 22-25

**Threat: allied health placements are difficult to secure on ClinConnect**

Arranging allied health placements in ClinConnect are more problematic than other disciplines such as nursing, which may reduce capacity for a large range of health professions.
Instead of coming up with a facility such as like if I want to send them to [HS] all I do is click on [HS], but for allied health you have to select either some type of discipline, say physiotherapy or OT [occupational therapy] or whatever but then you’ve got to know who that person is who is in charge of that hospital to contact them so like try to get your students in. EP11

**Threat: verifying vaccinations and police checks is administratively onerous**

Students must have completed procedures such as police checks and vaccinations, and they must be properly entered into ClinConnect before the student can participate in placement. This can be an onerous process and non-compliance is an issue, increasing workload and reducing capacity.

The student must be allocated to the placement and if the name of the student is not allocated to the placement by 28 days it actually drops off the system. Now the student can only be allocated to a placement if they have their occupation, health and screening vaccination verified. So if that’s not verified they can’t be allocated to the placement so that’s another challenge. HS20

I mean it is a way in which it’s supposed to be, that all of these people who are trainees are on a database and they can basically move from place to place and everything is there. Well, it’s just not the case; it’s just not there. EP13

**Threat: Information technology challenges with the database**

The ClinConnect system is reliant upon computerised information technology. As with all technology sometimes there can be technical problems that impede a user’s ability to access the system. Technological problems were reported by some of the participants and these problems can cause extra workload for both education providers and health services.

I’ve had a couple of hospitals call me up … something happened in ClinConnect and, you know, it dropped off the system and came up as, came back to us as not approved. So, yeah, there’s a bit of an issue, it doesn’t seem to be very user friendly…Yeah, I’ve had, with [AH], I’ve had a few sites come back and say we didn’t even see that you had requested it, so we didn’t even approve it because we couldn’t see it. EP22-25

**Threat: using technology for placement coordination has reduced communication**

The introduction of ClinConnect has altered the relationships and communication pathways that people previously had. With the new system there is a designated ClinConnect coordinator for each health service who is responsible for collecting and entering placement data into the system, whereas previously health providers may have dealt more directly with clinical supervisors. This additional gatekeeping role has limited the ability of education providers to negotiate directly with clinical supervisors. Funnelling enquiries about placements through a specific person enables health services to have more control over placements however it limits the negotiating power of education providers and this dynamic is another layer to navigate. Relationships, partnerships and communication are key to successful clinical placements, and any negative impact on these would reduce capacity.
It’s also that flexibility where if you’re actually talking to someone... you can ring a site in the good old days and go “Do you think you could just take one more student?” And you’d know who was capable and that person would either say “Yay or nay,” but probably 80% of the time they’d go “That won’t be any problem.” ClinConnect has just removed all of that, and that whole extra layer of talking to the coordinator... EP4-7

The other thing was people were so used to talking to each other the system almost put a gag on people who suddenly thought “I’m not allowed to speak to you anymore.” Which was ridiculous but in fact that’s what the IT system created was a lack of communication, gradually people have started to break that down but equally you’ve suddenly got the ClinConnect coordinator you have to go through instead of going through the person you’ve always talked to. EP4-7

**Threat: currency and accuracy of information on the system is questionable**

Out of date information, inaccurate placement details and lack of dedicated resources to maintain the data negatively impact on placement capacity through ClinConnect.

...some sites aren’t even using it, so the system is rejecting it. So they’re not even going in and, you know, saying yes or no to the placements... some are also that when ClinConnect started eighteen months ago, they went round and said, okay, this site exists, how many students can you take? And we are working on a lot of those numbers. A lot of sites haven’t gone in and changed that capacity so we’re requesting for placements that might not even exist at sites that might not even exist. EP22-25

**Threat: requesting and booking an appropriate number of places**

Getting the balance of requesting the correct number of places in the right mix of towns and facilities can be problematic, which impacts on capacity.

So the other problem that we have is we don’t know how many students we’re going to get in each group. We don’t know where they’re going to come from and that’s where some of the problems come up - we’re trying to find places that will suit them, and they may never get a place near their house. Do I book 24 places or do I book 16 or do I book 20? That’s always the problem for that six months that you’re unsure of what’s going to be happening. EP11

...I think cut it quite fine because she thought she was doing the right thing because ClinConnect said “Don’t just blitz it, don’t just go and say you want everything.” Whereas another university would go and just say they want everything. I’m not sure they were any better off by doing that. I’ve got no idea but the reality is that then these placements started to say no, then we got left with no placements. I’m sure the system will improve, so I’m not negative about the system, but that stifles innovation.” EP4-7

When too many places are requested by education providers who are then later unable to allocate enough students, it reduces capacity if health services can’t offer them to anyone else.
...when universities place, they often panic and they request everything and then they can’t fill them… Which means we can’t give them to anybody else. That’s a problem that comes up* HS21

**Threat: the system is inflexible and planning rosters for supervisors is difficult**

When education providers pay for or supply a facilitator/supervisor, it is generally accepted that is one for each eight students. The ClinConnect system does not always allow communication about the reason placements are being rejected, but not having 8 students accepted into the same shift means the facilitator cannot be funded and the placements are lost.

For the public system checking ClinConnect,...mostly we facilitate it with our students. And it’s up to 8. We pay for a facilitator for a group of 8 students. If ClinConnect accepts only 6 students or fewer and we have to negotiate or cancel the placement because we can’t afford to send our facilitators for 1 to 4, 1 to 6 would even be a stretch. EP9

...I would say we would prefer things that are outside of ClinConnect. [It] is so, because it has to be, so rigid and so ruled out that it gives us absolutely no flexibility whatsoever. So the more systems that go in there, the more healthcare providers that go into the system, the harder it is for us to have any flexibility. So once that flexibility, for example, you know like if we get reports back for the placement for this semester we’ve only got it through to the 30 June and we’ve found that only 74 per cent of our placement requests were supported. EP9

One of the things that has also been a problem is a lack of communication in that, and this happened quite a few times last year and I’m predicting that we could be more affected now that ClinConnect is up and running, is I can actually have XXX who’s the facilitator deployed fulltime for this placement and they could ring me here and say, “We’ve only got four students”, so I can only give her four hours a day instead of eight hours a day; a real problem because rosters are out, things are in place. I think that’s going to happen a bit more this year because ClinConnect is a little bit more robust and rigid and it sort of might be, “Oh no, we’ll just drop that placement at XXX”, but that has a huge effect for us. HS18
Appendix 5: Quantitative Survey findings: SurveyMonkey©

**Barriers and Enablers to Clinical Placements: Results of surveys of health service providers and education providers**

Health service and education providers approached during the course of the project were asked to complete a survey tool seeking information on challenges/barriers and enablers/solutions.

**Who completed the survey?**

The results presented below generated from SurveyMonkey© represent 34 health service providers and 12 education providers.

The majority of health service respondents were senior health service staff with managers/team leaders being the highest individual category (Appendix 5 Table 1). Some respondents indicated they held multiple roles and specified these in the ‘other’ category. Other roles were described as:

- Other kinds of directors (2), managers (1), coordinators (2); and
- Administration (1), community (1).

### Appendix 5 Table 1: Health service staff completing survey by employment category (may select more than one category)

<table>
<thead>
<tr>
<th>Employment Category</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager/Team leader</td>
<td>41.2%</td>
<td>14</td>
</tr>
<tr>
<td>CEO/Director</td>
<td>20.6%</td>
<td>7</td>
</tr>
<tr>
<td>Clinician</td>
<td>14.7%</td>
<td>5</td>
</tr>
<tr>
<td>Educator</td>
<td>5.9%</td>
<td>2</td>
</tr>
<tr>
<td>Clinical placement coordinator</td>
<td>5.9%</td>
<td>2</td>
</tr>
<tr>
<td>HR/Training</td>
<td>2.9%</td>
<td>1</td>
</tr>
<tr>
<td>Business/Operations</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Quality Unit</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>23.5%</td>
<td>8</td>
</tr>
</tbody>
</table>

### Appendix 5 Table 2: Education providers completing survey by category (may select more than one category)

<table>
<thead>
<tr>
<th>Employment Category</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of Faculty/School/Department</td>
<td>29.4%</td>
<td>5</td>
</tr>
<tr>
<td>Course convenor</td>
<td>17.6%</td>
<td>3</td>
</tr>
<tr>
<td>Educator (lecturer/tutor)</td>
<td>17.6%</td>
<td>3</td>
</tr>
<tr>
<td>Unit coordinator/convenor</td>
<td>11.8%</td>
<td>2</td>
</tr>
<tr>
<td>Clinical education coordinator</td>
<td>11.8%</td>
<td>2</td>
</tr>
<tr>
<td>Course administrator</td>
<td>5.9%</td>
<td>1</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>41.2%</td>
<td>7</td>
</tr>
</tbody>
</table>
Similarly, the majority of education providers completing the survey held managerial roles within their organisations (Appendix 5 Table 2). Some respondents indicated they held multiple roles and other roles including:

- Other kinds of heads of school (2), managers (1);
- Workplace learning roles (2);
- Project development (1); and a
- Health service provider (1)

**Motivation of health service providers to host clinical placements**

Health service provider respondents were asked to indicate their motivation, benefits and reasons for hosting clinical placements by providing a list of predetermined answer options and indicating that they should tick as many as apply so multiple responses were possible (Appendix 5 Table 3).

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>A sense of professional responsibility to contribute to education of future professionals.</td>
<td>72.7%</td>
<td>24</td>
</tr>
<tr>
<td>Contributing to a range of learning experiences students can encounter through clinical placements.</td>
<td>66.7%</td>
<td>22</td>
</tr>
<tr>
<td>Workforce planning strategy - helps to improve image of sector, rural health and aid in recruitment.</td>
<td>60.6%</td>
<td>20</td>
</tr>
<tr>
<td>Intellectual stimulation and self-learning, contributes to development of my/my staff’s clinical knowledge base, academic thinking and examination of care practices.</td>
<td>54.5%</td>
<td>18</td>
</tr>
<tr>
<td>An organisational culture that values learning and teaching.</td>
<td>54.5%</td>
<td>18</td>
</tr>
<tr>
<td>Personal satisfaction.</td>
<td>36.4%</td>
<td>12</td>
</tr>
<tr>
<td>Links with education providers and potential access to other resources, e.g. research.</td>
<td>33.3%</td>
<td>11</td>
</tr>
<tr>
<td>Recognition of student supervision for Continuing Professional Development (CPD) credits.</td>
<td>27.3%</td>
<td>9</td>
</tr>
<tr>
<td>Evolving job requirements, part of my position description.</td>
<td>18.2%</td>
<td>6</td>
</tr>
<tr>
<td>Policy of this health service.</td>
<td>9.1%</td>
<td>3</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>5%</td>
<td>5</td>
</tr>
</tbody>
</table>

*answered question* 33

Most health service providers indicated a sense of professional responsibility to future professionals as the reason, motivation and benefit to hosting clinical placements, followed by making a contribution to the range of learning experiences for students. Health service providers indicated that the policy of the service was ranked the lowest motivation factor. Only three included organisational policy as the motivation behind hosting students. Those responding to the ‘other’ motivations indicated:

- They did not host /do not currently host students (4); and
• Intellectual stimulation as contributing to scope of practice and workforce planning (1).

**Challenges and barriers to clinical placements**

Health service and education provider respondents were asked to rank potential challenges/barriers attributed to clinical placements on a scale of 1-5, with 1 being the major and 5 being the least challenge/barrier in relation to various pre-determined issues.

While the predetermined issues for both groups differed on the questionnaires there were some answer options that provide interesting trends in the ranking when looking at both health service and education providers.

**Appendix 5 Table 4: Assessment of predetermined challenges/barriers by health service providers**

(sorted according to greatest challenge on average to least challenge on average)

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Rating</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity of health service to accept further placements.</td>
<td></td>
<td>2.63</td>
</tr>
<tr>
<td>Competing demands on supervising students while also supervising junior or other staff.</td>
<td>4</td>
<td>2.69</td>
</tr>
<tr>
<td>Lack of funding sources and support targeted towards the needs of clinical supervisors.</td>
<td>4</td>
<td>2.72</td>
</tr>
<tr>
<td>Increasing pressures on health services to accommodate escalating clinical case loads.</td>
<td>4</td>
<td>2.75</td>
</tr>
<tr>
<td>Answer Options</td>
<td>Rating Average</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>Fluctuation in demand for clinical placements during peak/off peak times.</td>
<td>2.81</td>
<td></td>
</tr>
<tr>
<td>Small clinical teams.</td>
<td>3.00</td>
<td></td>
</tr>
<tr>
<td>Lack of recognition of workloads and balance between service delivery or other core duties and clinical supervision responsibilities.</td>
<td>3.00</td>
<td></td>
</tr>
<tr>
<td>Part-time staffing levels.</td>
<td>3.03</td>
<td></td>
</tr>
<tr>
<td>Changing academic environments competing for finite clinical placements.</td>
<td>3.09</td>
<td></td>
</tr>
<tr>
<td>Difficulty in matching clinical placement with...</td>
<td>3.13</td>
<td></td>
</tr>
</tbody>
</table>
### Training/qualifications of potential supervisors/facilitators.

- **Major challenge barrier:**
  - 2
  - 3
  - 4
- **Not a challenge barrier:**
  - 10

**Average Rating:** 3.28

### Growth in health profession tertiary places.

- **Major challenge barrier:**
  - 2
  - 3
  - 4
- **Not a challenge barrier:**
  - 10

**Average Rating:** 3.28

### Lack of communication, coordination or partnerships between education providers and health services; complexity of process.

- **Major challenge barrier:**
  - 2
  - 3
  - 4
- **Not a challenge barrier:**
  - 10

**Average Rating:** 3.28

### Physical constraints of the building, workspace, lockers, clinical space or IT access.

- **Major challenge barrier:**
  - 2
  - 3
  - 4
- **Not a challenge barrier:**
  - 10

**Average Rating:** 3.28

### Cost associated with student supervision.

- **Major challenge barrier:**
  - 2
  - 3
  - 4
- **Not a challenge barrier:**
  - 15

**Average Rating:** 3.31

### Issues with student accommodation.

- **Major challenge barrier:**
  - 2
  - 3
  - 4
- **Not a challenge barrier:**
  - 15

**Average Rating:** 3.38
Lack of clear learning objectives and information on what students should, can and cannot do.

Students limited in their access to patients.

Confidence to supervise.

Unaware of potential to provide clinical placements or innovative models of clinical placements.

Issues with student transport.

Student unprepared, lack of orientation to rural health, organisation, sector.
The most highly ranked answer options included by health service providers were the capacity of a health service to accept further placements and increasing pressures to accommodate escalating clinical case loads (Appendix 5 Table 4). The lack of commitment by health services to student education was ranked by most respondents as the least potential challenge or barrier to clinical placements.

Appendix 5 Table 5: Assessment of predetermined challenges/ barriers by education providers
(sorted according to greatest challenge on average to least challenge on average)
<table>
<thead>
<tr>
<th>Challenge</th>
<th>Major Challenge</th>
<th>Rating Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request for payment from health services.</td>
<td>2</td>
<td>1.94</td>
</tr>
<tr>
<td>Changing academic environments competing for finite clinical placements.</td>
<td>2</td>
<td>2.06</td>
</tr>
<tr>
<td>Issues with student accommodation.</td>
<td>2</td>
<td>2.31</td>
</tr>
<tr>
<td>Capacity of health services to accept further placements.</td>
<td>2</td>
<td>2.63</td>
</tr>
<tr>
<td>Uncertainty of capacity and interest of sites especially 'non traditional' or expanded scopes and models.</td>
<td>2</td>
<td>2.81</td>
</tr>
<tr>
<td>Difficulty in matching clinical placement with education provider and course requirements or expectations.</td>
<td>2</td>
<td>2.81</td>
</tr>
<tr>
<td>Answer Options</td>
<td>Rating Average</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>Lack of knowledge of possible expanded scope of health services, contact details for potential clinical placement sites.</td>
<td>2.88</td>
<td></td>
</tr>
<tr>
<td>Student transport issues.</td>
<td>2.88</td>
<td></td>
</tr>
<tr>
<td>Quality of placements versus quantity.</td>
<td>2.94</td>
<td></td>
</tr>
<tr>
<td>Lack of training or qualifications of potential supervisors/facilitators.</td>
<td>3.06</td>
<td></td>
</tr>
<tr>
<td>Lack of health service flexibility and acceptance of different innovative models and types of experiences.</td>
<td>3.25</td>
<td></td>
</tr>
<tr>
<td>Lack of commitment by health service to student education.</td>
<td>3.25</td>
<td></td>
</tr>
</tbody>
</table>
### Answer Options

<table>
<thead>
<tr>
<th>Perception</th>
<th>Rating Average</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lack of communication, coordination or partnerships between education provider and health services; complexity of process.</strong></td>
<td><img src="image" alt="Graph" /></td>
<td>3.31</td>
</tr>
<tr>
<td><strong>Ability to assess new sites to determine suitability of placements, e.g. Does it meet regulations, accreditation or competency standards, organisational or physical expectations.</strong></td>
<td><img src="image" alt="Graph" /></td>
<td>3.50</td>
</tr>
<tr>
<td><strong>Lack of student flexibility and acceptance of different models and types of experiences.</strong></td>
<td><img src="image" alt="Graph" /></td>
<td>3.50</td>
</tr>
<tr>
<td><strong>Difficulty in resolving issues.</strong></td>
<td><img src="image" alt="Graph" /></td>
<td>3.63</td>
</tr>
<tr>
<td><strong>Lack of clinical best practice at health services.</strong></td>
<td><img src="image" alt="Graph" /></td>
<td>3.63</td>
</tr>
<tr>
<td><strong>Student unprepared, lack of orientation to rural health, the organisation, or sector.</strong></td>
<td><img src="image" alt="Graph" /></td>
<td>3.81</td>
</tr>
</tbody>
</table>
Education providers ranked the request for payment from health services as the biggest potential challenge/barrier to clinical placements and found the ‘student unprepared, lack of orientation to rural health, the organisation or sector’ as the least potential challenge or barrier (Appendix 5 Table 5). The respondents stated additional challenges/barriers as:
- Student numbers due to increase from 2014 and need for external placements will increase;
- Priority being given to University needs over TAFE needs by health services;
- Difficulty in matching clinical placements with education providers in Allied Health.

When comparing the responses from the two sectors it is noted that education providers ranked the request for payment from health services for clinical placements as the highest potential barrier, while health service providers ranked costs associated with supervision as very low. Also health service providers did not see lack of commitment to student education on their behalf as a potential challenge, while education providers ranked this much higher.

**Enablers and solutions to clinical placements issues**

Health service and education provider respondents were asked to rank potential enablers/solutions to clinical placements issues on a scale of 1-5, with 1 being the major and 5 being the least suitable enabler/barrier in relation to various pre-determined issues.

The most highly ranked answer option included by health service providers was developing genuine partnerships, better coordination and communication between education provider and the health service (Appendix 5 Table 6). Offering student’s accommodation was ranked as the least enabler/solution to issues relating to clinical placements. The respondents included in the ‘other’ category stated potential barriers as:
- Staff needing support to recognise student learning opportunities;
- Sharing information on innovative models;
- Assistance with travel.

**Appendix 5 Table 6: Assessment of predetermined enablers/solutions by health service providers**

<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Rating</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing genuine partnerships, better coordination and communication between education providers and health services.</td>
<td>3</td>
<td>1.75</td>
</tr>
</tbody>
</table>

*Major enabler/solution*
<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Rating Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Upskilling of staff to be able to support students.</td>
<td>1.75</td>
</tr>
<tr>
<td>- Clear policies, guidelines and procedures for clinical placements.</td>
<td>1.84</td>
</tr>
<tr>
<td>- Sharing information on innovative models which have worked elsewhere.</td>
<td>1.91</td>
</tr>
<tr>
<td>- Well developed orientation programs for students.</td>
<td>2.00</td>
</tr>
<tr>
<td>- Clinical placements recognised as core business within the organisation.</td>
<td>2.06</td>
</tr>
<tr>
<td>- Improving level of clinical supervision/facilitation from education providers.</td>
<td>2.19</td>
</tr>
<tr>
<td>- Customisable orientation or resource kits for clinical supervisors.</td>
<td>2.22</td>
</tr>
<tr>
<td>- Increasing flexibility in placements.</td>
<td>2.25</td>
</tr>
</tbody>
</table>
Education providers ranked the development of genuine partnerships, better coordination and communication between education providers and health services as the biggest enabler/solution to issues with clinical placements followed by recognition by the health service that clinical placements represent core business (Appendix 5 Table 7). There was no clear least ranking enabler/solution ranked by this group. The respondents who included the ‘other’ category indicated enablers/solutions were:

- Clinical education workshops to upskill supervisors;
- More resources on-line;
- Funding.

Appendix 5 Table 7: Assessment of predetermined enablers/solutions by education providers
(sorted according to greatest enabler on average to least important enabler on average)
<table>
<thead>
<tr>
<th>Answer Options</th>
<th>Rating Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical placements recognised as core business within the health service.</td>
<td>2.06</td>
</tr>
<tr>
<td>Offering students accommodation.</td>
<td>2.13</td>
</tr>
<tr>
<td>Up skilling of health service staff to be able to support students.</td>
<td>2.19</td>
</tr>
<tr>
<td>Increasing flexibility in placements.</td>
<td>2.31</td>
</tr>
<tr>
<td>Customisable orientation or resource kits for clinical supervisors/facilitators.</td>
<td>2.38</td>
</tr>
<tr>
<td>Improving level of clinical supervision/facilitation from education providers.</td>
<td>2.38</td>
</tr>
<tr>
<td>Clear policies, guidelines and procedures for clinical placements within health services.</td>
<td>2.50</td>
</tr>
<tr>
<td>Sharing information on innovative models which have worked elsewhere.</td>
<td>2.50</td>
</tr>
</tbody>
</table>
Developing partnerships was ranked highly as an enabler/solution to issues relating to clinical placements by both health service and education providers, however more education providers identified accommodation issues for students as a key factor. Clear policy and guidelines were seen as enabling by health service providers but were not ranked as highly by education providers.

**Discussion of survey results**

The Victorian Government Clinical Placement Innovation projects report, (State Government of Victoria, 2007a), identified barriers to clinical placements categorising them as:

- Student-related factors;
- Planning for clinical placements;
- Clinical teaching and supervision;
- Education providers;
- Clinical agencies; and
- Regulatory, policy and funding environment.

In 2011 the Victorian Government Strategic Plan for Clinical Placements (State Government of Victoria, 2011) identified key enablers for clinical placements as:

- Funding support; and
- Data and information systems.
A recent study carried out by Health Workforce Australia, (Health Workforce Australia, 2013a) which aimed to find the elements for a good model for rural and remote clinical placements, a similar survey to the Riverina ICTN project was undertaken. Stakeholders overwhelmingly reporting that the ‘sufficiency of teachers and supervisors, accommodation/teaching space and incentives for teaching and supervision” (p.9), were the most important issues.

The Riverina ICTN project survey included some of these challenges/barriers and enablers/solutions as predetermined answer options for health service and education providers to chose from indicating what they saw as the challenges/barriers and enablers/solutions to clinical placement issues within their organisations. The surveys revealed that developing genuine partnerships was the top ranking option for enhancement of clinical placements by both health service and education providers.

One example of tackling difficulties in achieving placement requirement in a rural setting, the Tasmanian Clinical Placement Partnership (TCPP) is analysed in a report from a workshop looking at expansion of clinical placements into non-traditional settings (Clinical Placement System Development Program, 2010). This project plans to deliver increased capacity in a range of disciplines, rural and remote areas, public, private and community and with enhanced supervision skills, (Clinical Placement System Development Program, 2010) Appendix B: Fact Sheet TCPP.

In the Riverina ICTN surveys, access to student accommodation was seen by education providers as an enabler to clinical placements. One response to concerns about accommodation issues is highlighted in the Alpine Institute Accommodation (State Government Victoria, 2013) innovative project. Medical, nursing, primary health, aged care, business, community, personal care and overseas nursing students being hosted by a rural/regional health service in Victoria, an essential clinical placement experience. Costs of accommodating students limited the capacity of the service to host students in a region with high tourist accommodation needs such as the Alpine areas. Development of a Learning Centre offering multipurpose learning space, bedrooms, kitchens, dining area, common room, bathrooms resulted in enhanced capacity to attract and maintain students in a secure environment, close to their learning space, providing improved learning culture for students and staff, (State Government Victoria, 2013) p.4-5.

**Limitations of the survey**

The sample size was small, especially in the Education Provider respondents, limiting deeper analysis of the data. Questions on the two surveys did not mirror each other so detailed comparative analysis was not possible. The majority of respondents from both sectors had senior/managerial roles and survey results can be interpreted as reflecting the views of this group within the organisations.
## Appendix 6: Mapping exercise draft

<table>
<thead>
<tr>
<th>Course</th>
<th>Year</th>
<th>Placement requirements</th>
<th>Learning objectives</th>
<th>Clinical placement opportunities identified &amp; capacity for supervision</th>
<th>HS projects or areas of need or core business</th>
<th>Health service name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>GP BB: observe immunisations</td>
<td>1. Review of DD system</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Capacity on Mon &amp; Thurs.</td>
<td>2. Immunisation program</td>
<td>GP clinic BB</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1. Completion of EE forms</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Health service FF: Capacity to take students following pts from acute to home, x number students at any time.</td>
<td>2. GG program review</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Health Service FF: assist with review of GG program</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>Health service FF</td>
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<td>- Build rapport</td>
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<td>- Observe immunisations</td>
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<td>2</td>
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<td>3 weeks Med/Surg</td>
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<td>5 weeks Med/Surg</td>
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Appendix 7: Evaluation of project implementation

The evaluation was developed by adapting the Community Sustainability Engagement Evaluation Toolbox (Evaluation Toolbox, 2010) into a monitoring and evaluation framework (Appendix 7 Table 1) and an informal diary to jot evaluation musings. Due to the short timeframe and broad scope of the project, the evaluation was necessarily non-onerous and has proved useful as a reflective process, to inform report writing, and as an on-going structure for the Riverina ICTN to continue the evaluation process post-project.

The importance of an auspice agency that handled initial project coordination in a proactive, timely fashion was the first entry in the evaluation diary, acknowledging that having processes well administered in advance of project commencement meant that the full 19 weeks was available for planning, implementation and reporting.

Jan 2013: The value of having a proactive ‘sponsor/champion’ as lead partner in the project, i.e. Tony/CSU, to have processes in place for recruitment, administration, concurrently with project funding confirmation, so all was in place to start ASAP; other projects still unstarted but same completion timelines.

The project team went through a period of self proclaimed ‘chaos’ while defining the scope and project purpose, when a perceived disconnect was identified between the KPIs of the Riverina ICTN, the project proposal and HETI reporting requirements. This was a confusing, necessary and illuminating time, as noted in the diary.

Feb 7.13 The value of reflection, debate, questioning and recognising that the process of defining the project scope, methodology, inclusions/exclusions is as valuable as the outcomes, it’s a model of discovery. While it feels more like a quagmire of quicksands, ultimately the outcome will be enhanced because of all the robust discussions and critical reflection. The risk is that we are both information gatherers and marketers of clinical placements. What happens when the facilities are sold to expand their clinical placements and there are no matches for them? Recognise we don’t have all the answers, and that process itself is of interest to the Brains Trust.

As existing networks and relationships were tapped into, alongside the semi-structured interviews, findings and ideas began to be floated amongst the team and copying these into the evaluation diary meant they were able to stay on the radar to inform our thematic analysis, as evidenced in this email between team members after a discussion with an allied health educator.

In each placement there should be a consideration of whether the competency that is trying to be met can be achieved. A contributing factor to this is that students must be well prepared through the course to be able to successfully undertake the placement and so achieve the competency.
With small numbers of students and no current serious pressure on sites for clinical placement, these two points can be considered. With increasing numbers of students, demands for payment and increased pressure on clinical placements, I can see how this becomes blurred/diluted. We must include this quality issue in our consideration of non trad placements.

Planning for and arranging appointments for face to face and telephone interviews with health services was frustratingly laborious and hugely time consuming. This occurred at the beginning of an academic year, which was not considered when trying to establish contact with placement coordinators at education providers, which resulted in more effort needed to by the project officers to engage these stakeholders, at a time when the coordinators were at their busiest.

Feb 19/13 the sheer volume of time, phone calls and emails it takes to coordinate face to face interview appointments with part-time availability of staff in varying geographic locations, combo of people not returning phone calls, private nursing home needing owner approval, contact details in spreadsheet incorrect, people not available when we are, etc – perhaps also this time of year is stressful on clinical placement Coordinators with placements soon to start, and we are adding extra stress to their timetable wanting appointments to talk about how it could be done better!!!

Our whole of community case studies data gathering included unintended outcomes when transacting at local businesses as this diary entry suggests.

Feb 26/13 Got into a conversation with the frock shop owner (I invested in Narrandera’s economy!) and a customer, about accommodation options here, an idea to float is billeting students with people who live on their own and want company, another way to feel a part of the community.

The final entries were again an opportunity to capture findings and reflections that may have gotten lost in the vast quantities of data being generated.

Feb 22/13 insular ‘What’s In It For Me WIIFM’ nature of private for profit businesses and its effect on participation in the project, willingness to share?

Feb 22/13 barriers of expanded scope of placements are often the same as traditional clinical placements

March 8 Personal views of interviewees may not reflect organisational views.

The evaluation was found to be adequate and valuable for the project’s needs, and can serve as a framework for the Riverina ICTN as they consider how best to proceed with the project findings and opportunities for actions.
### Appendix 7 Table 1: Riverina ICTN Untapped Capacity project evaluation framework

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Monitoring</th>
<th>Evaluation</th>
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</thead>
<tbody>
<tr>
<td><strong>Broad Evaluation Questions</strong></td>
<td><strong>What do we want to know? (Monitoring Question)</strong></td>
<td><strong>Where will the data come from? (Data Source/Method)</strong></td>
</tr>
<tr>
<td>To what extent did the project meet the overall needs?</td>
<td>Was the research question answered in a practical, solution focussed way?</td>
<td>Interviews; Survey Monkey; HWA &amp; other stats; Brains Trust</td>
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<tr>
<td>How valuable are the outcomes to stakeholders and participants?</td>
<td>Are the findings worthwhile? Are they what the Riverina ICTN AC needed to know?</td>
<td>Brains Trust, Riverina ICTN AC meetings, feedback; Observation &amp; discussions</td>
</tr>
<tr>
<td>How has this knowledge influenced practice?</td>
<td>Has there been a behaviour or work practice or culture change?</td>
<td>Riverina ICTN AC meetings &amp; feedback; Observation &amp; discussions</td>
</tr>
<tr>
<td>What worked and what did not?</td>
<td>What methodology and tools achieved their objectives and which did not?</td>
<td>Team meetings &amp; data analysis</td>
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<tr>
<td>Were there unintended positive or negative outcomes or consequences?</td>
<td>What were the unintended outcomes and their consequences?</td>
<td>Observation &amp; discussions</td>
</tr>
<tr>
<td>Were there impacts on relationships and partnerships as a result of or within the project?</td>
<td>Have any new relationships, partnerships, collaborations resulted from this work?</td>
<td>Observation &amp; discussions</td>
</tr>
<tr>
<td>Were any resources shared across stakeholders in the region?</td>
<td>What resources or networking was shared across stakeholders in the Riverina or elsewhere as a consequence of the project?</td>
<td>Interviews; Observation &amp; discussions Riverina ICTN AC meetings &amp; feedback</td>
</tr>
<tr>
<td>To what extent is the project work sustainable? How has the sustainability been fostered?</td>
<td>Will the project findings and recommendations be implemented? Are the recommendations aligned with Riverina ICTN strategic aims and are strategies capacity building initiatives?</td>
<td>Riverina ICTN AC meetings</td>
</tr>
<tr>
<td>What is the potential transferability of project initiatives or outcomes to other health projects?</td>
<td>Are the methodology, findings and recommendations transferrable to other settings?</td>
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