health

CPN Strategic Projects

Final report

Capacity building for clinical placements across the Southern Metropolitan CPN: A focus on community placements and supervisory capacity

Submitted by:

Southern Health

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Aims and objectives of the project

This project aimed to facilitate effective and efficient usage of clinical placements within the community setting of the Southern Metropolitan Clinical Placement Network (SMCPN) by identifying latent capacity and maximising opportunities for clinical placements of undergraduate health professional students from across all disciplines. It was anticipated that in community and a range of other settings, supervisory capacity is a significant impediment to clinical capacity.

The project also sought to develop a generic supervisor program for all SMCPN stakeholders.

Project activities and methodology

The activities of this project were undertaken in four phases:

- Stage 1 – Project initiation:
  - Appointment of personnel and project scoping activities
- Stage 2 – Development:
  - Identification of opportunities for increased capacity in community health and strategies for implementation developed
  - Community health clinical placement capacity mapping
  - Development of SMCPN supervisor training program
- Stage 3 – Implementation:
  - Strategies developed in Stage 2 implemented
  - Implementation of SMCPN supervisor training program
- Stage 4 – Evaluation:
  - Measurement of change in SMCPN community health clinical placement capacity
  - Recommendation for future action

Key outcomes

- The activities of the SMCPN strategic project enabled a significant increase in the understanding of current clinical placement activity within the community setting of the SMCPN.
- This project implemented strategies to address barriers to increasing clinical placement capacity in the community setting.
- Increased clinical placement capacity within the community setting of the SMCPN in 2013 by more than 20%.
- Developed and implemented an agreed supervisor training program, delivered to over 730 stakeholders via face-to-face workshops and available as an online activity.
- Supported eight community health organisations in participating in the Department of Health (DH) clinical placement planning activity.
- Developed and piloted a clinical placement supply/demand matching program for use by clinical placement providers and education providers that is aimed at reducing the workload in coordination of community health clinical placements for education providers, clinical coordinators and community health settings.
- Identification and implementation of quality interprofessional clinical learning opportunities.
- Improved communication across the SMCPN through collaboration to deliver this project.

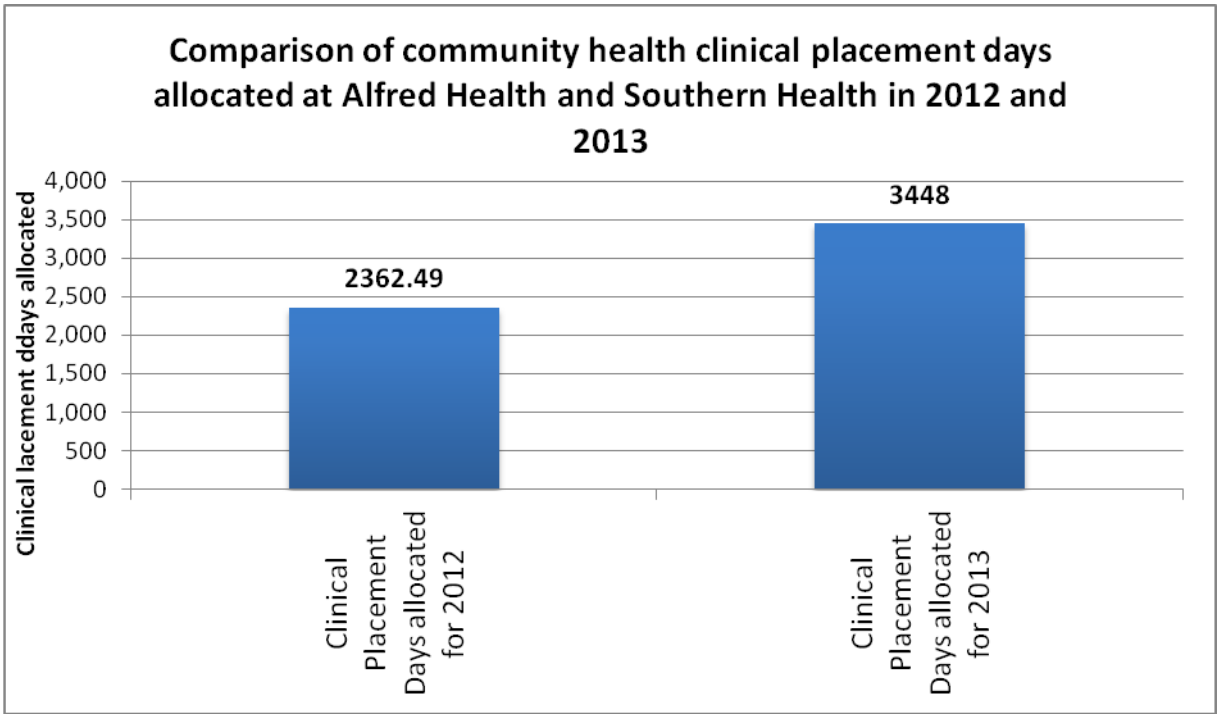
Conclusions

- This project has achieved its aims of facilitating effective and efficient usage of clinical placements within the community setting of the SMCPN. It has identified latent capacity and maximised opportunities for clinical placements for health professional students from across all disciplines.
- The activities of the SMCPN strategic project enabled a significant increase in the understanding of current clinical placement activity within the community setting of the SMCPN. This understanding enabled the development and implementation of strategies to address barriers to increasing clinical placement capacity in the community setting.
- As expected, one of the key barriers was supervisor preparedness. A supervisor training program was developed and delivered to over 730 stakeholders via face-to-face workshops and will be an enduring feature of this project through the online mode of training delivery.
- Through a range of strategies including: various methods of stakeholder engagement, assisting stakeholders to access and participate in concomitant SMCPN activities, observing the available data on clinical placements and piloting a clinical placement supply/demand matching program, this project was able to report an increase in community health clinical placement activity exceeding 20%. In addition to this, a large amount of unutilised capacity was also identified.
- A clinical placement supply/demand matching program for use by clinical placement providers and education providers was developed and piloted; this demonstrated great potential for improving communication between clinical placement providers and education providers in a manner that is flexible and efficient. The scope of this activity was limited by the time available. A larger trial would enable a more sophisticated user interface and the ability to be more dynamically responsive.

Recommendation for future direction

Latent capacity was identified, particularly for the nursing disciplines. An opportunity exists for clinical placement providers to collaborate with education providers to further explore ways in which clinical placements might better align with the undergraduate curriculum and potentially offer an integrated interprofessional approach that more closely aligns to clinical work practices.

The overall increase in clinical placement activity in the community for Alfred Health and Southern Health for the 2012–13 period is 45.9%.



Background and context

In Victoria, clinical education is predominately undertaken in the acute setting, leading to misalignment between student training and future workforce and community requirements. The community health setting has been identified as an area that could be strengthened and expanded to alleviate clinical placement capacity pressures and provide health students with a broader and more rounded learning experience. The community setting may also provide the ideal environment for piloting new models, such as interprofessional clinical learning. The clinical placement capacity of the community setting is largely unknown and under-supported in a variety of ways, including the development of supervisory capacity. Meaningful identification and mapping of capacity is required. Supervisor training is a key barrier to increasing clinical placement capacity. To help ensure quality clinical placements in the future and to assist the community setting to increase capacity, a standardised supervisor training program will be developed and/or implemented for the SMCPN. This could be based around (i.e., built upon) the implementation of Health Workforce Australia's (HWA's) Clinical Supervision Support Program (CSSP) currently under development. The program will be applicable to all disciplines and settings.

Objectives

This project aimed to facilitate effective and efficient usage of clinical placements within the community setting of the SMCPN by identifying latent capacity and maximising opportunities for clinical placements of undergraduate health professional students from across all disciplines.

It was anticipated that in community and a range of other settings, supervisory capacity is a significant impediment to clinical capacity.

The project also sought to develop a generic supervisor program for all SMCPN stakeholders.

Project activities and methodology

Project initiation

The project manager was recruited and commenced employment in August, 2011. The selection process enhanced stakeholder engagement through the involvement of the host organisation, Southern Health, SMCPN committee chair and SMCPN committee community health sector representative and SMCPN project manager.

All SMCPN stakeholders were invited to participate in a project working party. Ten SMCPN stakeholders attended the first meeting held on 7 September 2011.

Attendees at this meeting included:

- Chris Au, Director of Higher Education, Institute of Health and Nursing Australia
- Vanessa Brown, Human Resources Manager, Inner South Community Health Service
- Shelley Black, Undergraduate Clinical Placement Coordinator, Southern Health
- Annette Davies, Podiatry Manager, Southern Health
- Thomas Kuster, DHS – Monash University
- Toni Lamarche, Program Officer Workforce, CPD and GP Wellbeing, Monash Division of GPs
- Shyla Mills, Palliative Care Education Coordinator, South East Palliative Care
- Wayne Pelling, Education & Learning Consultant, Southern Cross Care
- George Robinson, General Manager (Primary Health), Central Bayside Community Health Services
- Jill Walsh, Senior Allied Health Leader Governance, Southern Health
- Cylie Williams, Senior Podiatrist, Southern Health
- Loretta Bull, Project Manager, SMCPN
- Theo Does, Project Manager, SMCPN Strategic Project, SMCPN

Attendance at working party meetings fluctuated. The following individuals also provided input from time-to-time on behalf of their sectors and organisations:

- Angela Casey, Development Manager, Alfred Clinical School Network; subsequent role: transition to Practice Manager, Nursing Education, Alfred Health
- Joan Leo, Executive Officer, Alfred Southern Clinical School Network
- Sue Moulton (for George Robinson), Program Manager, Acting General Manager (Primary Health), Central Bayside Community Health Services
- Michael Olasoji, Clinical Nurse Educator, Undergraduate Program, Alfred Health
- Victoria Oxley, Clinical Placement Project Officer, South City, Monash and Bayside General Practice Divisions
- Arlene Parry, Clinical Coordinator/Lecturer, Monash University

The dates and times of these meetings were chosen by consensus and were initially conducted every two to three weeks. Following this, a calendar of monthly meetings was established in early 2012. Working party meetings were conducted in a range of community health venues throughout the SMCPN. The project manager chaired the meetings, coordinated the venues and ensured minutes and agendas were distributed to all interested parties in a timely fashion.

A total of eight meetings were conducted between September 2011 and May 2012. Due to competing demands on working party members, attendance at the meetings declined and many meetings required cancellation. Members of the project working party remained a ready resource for the project manager and supported and facilitated their organisation's participation in project activities.

The responsibilities of working party membership included:

- To set the policy and strategic direction for the SMCPN strategic project;
- Engaging, participating and contributing to strategic project initiatives, activities and opportunities;
- To perform and monitor the SMCPN strategic project operations;
- To provide timely and constructive advice and sharing information with the strategic project working party to strengthen consistent approaches to student clinical placements in the SMCPN;
- To market the SMCPN strategic project;
- To communicate effectively with SMCPN stakeholders.

The project working party developed Terms of Reference and a Communication Strategy. Some of the key activities of this working party were to provide some scoping limitations for the project by creating functional definitions of 'community health' and the range of health disciplines to be included in the project work. This involved considerable discussion and particularly highlighted the differences between the traditional conceptualisation of the health workforce, which appears to be derived from a large, tertiary hospital model and the current reality. Consideration was given to the overlapping nature of roles and services within the community health sector, the indicated priorities of the project funding sources and anticipated resource opportunities for the near future.

For the purposes of this project, community health was initially defined as organisations, practitioners and other entities through which qualified health professionals provide health services directly to, or are directly accessible by, individuals and groups within the general community except where the service provision occurs in an inpatient or residential setting. It soon became apparent that there were significant efficiencies to be gained through the inclusion of all mental health and aged care providers as there exists significant resource and personnel overlap. This inclusion was also due to the fact that there was little other activity within the CPN at the time that was targeting clinical placements in the mental health and aged care sectors.

Initial organisations targeted in this project were the larger, multidisciplinary community health centres/services and similar organisations or networks outside of the acute care environment. This project endeavoured to incorporate all individuals or organisations that demonstrated an interest in engaging in clinical placements.

The project working party decided to focus the project on clinical placements for students studying towards an initial qualification (i.e., first-time entry into the health workforce) at a certificate IV level or above in a health discipline subject to statutory registration. Disciplines were prioritised according to their relative volumes of need for clinical placements and projected growth in levels of demand. As a result registered nurses (formerly Division 1) and physiotherapy were targeted in the first instance, then enrolled nurses (formerly Division 2), podiatry, psychology, social work, audiology and diagnostic radiology as the next level of priority.

Medicine was initially excluded from the range of disciplines on the basis that there was, or was likely to be, independent project(s) targeting medicine. The SMCPN committee discussed this and recommended medicine be included; this action was subsequently taken. Non-tertiary disciplines, e.g., certificate III and certificate IV allied health assistants were excluded as these disciplines were felt to be insufficiently standardised in terms of roles and educational expectations such that they would assume too great a portion of the project time and resources to be consistent with the working party's understanding of the project's objectives. This was revised as the project progressed and it was realised that there was a supply demand mismatch and an opportunity existed to realise latent clinical placement capacity with minimal resource expenditure.

From the outset of this project, it was uncertain what level of participation there would be. The working party determined that all project undertakings should be as inclusive as possible, that they should aim to be efficient and should avoid duplication of other projects wherever possible.

A project assistant was recruited and commenced February 2012 as it was felt at this point that there was sufficient clarity to define this role.

Development

Stakeholder consultation

A key task for the strategic project was to identify the range of organisations that might be included in this project. Data sources utilised for this process included: SMCPN stakeholder list; DH Victoria 2009 clinical placement data; ViCPlace; DHS online services directory; placement data and information supplied by coordinators from Alfred Health and Southern Health; White and Yellow Pages telephone directories; university websites; local government areas (LGAs) maps; and the networks of the strategic project working party and SMCPN committee members.

This information was then reviewed to conform to the project scope. The resultant database included 296 community health organisations and 67 education providers. This counts Alfred Health and Southern Health each as single organisations due the fact that they have centralised processes for most or their clinical placement coordination. Both of these organisations host a large number of community health services at multiple sites. Interstate education providers were excluded as were those that had only incidental clinical placement requirements.

Initial consultations were made directly with the SMCPN community health stakeholders by the project manager. These consultations considered broadly: current clinical placement capacity and the level of interest in expanding this; constraints to expansion of clinical placement capacity; provision of information on current and emergent resources to support organisations clinical placement providers and education providers. These consultations were targeted at senior managers and clinical placement coordinators. These meetings were typically of 60 to 90 minutes duration and conducted at the site of the stakeholder(s) involved. During these meetings, which were often done in collaboration with the SMCPN project manager/coordinator, stakeholders were introduced to the SMCPN, its team and the role of CPNs, the strategic project and its objectives and any other current SMCPN or DH activities. Often there would be a follow-up meeting, thus enabling the stakeholder the opportunity to seek clarification and consult within their organisation. Many of these meetings included more stakeholders than indicated in the list. In addition, there were a large number of brief and/or unplanned telephone and email conversations. In several cases this has led to stakeholders assuming an active role within the strategic project, other SMCPN projects or, in three instances, assuming a leadership role in the SMCPN through participation as a SMCPN committee member, thereby adding experiential depth and breadth of

sectoral representation to the committee. The following representative list provides some examples of the range of stakeholders with whom formal meetings were held.

Education providers

- Elizabeth Armaund, Vanessa Rice, John Birchall, Exercise Science, Australian Catholic University
- Chris Au, Institute of Health and Nursing Australia
- Andrew Beveridge, Medical Community Health Placements, Monash University
- Sarah Bridges and Kirsty Brown, Clinical Coordinators, Care Training Australia
- Michael Browning, Deputy CEO, Director Education, Mayfield Education
- Angela Casey, nursing, midwifery, occupational therapy, orthotics, orthotics, orthotics, physiotherapy, podiatry, prosthetics, social work, speech pathology, La Trobe University/Alfred Clinical School
- Associate Professor Judy Currey, School of Nursing and Midwifery, Deakin University
- Robyn Howley, nursing – registered and enrolled, Holmesglen
- Bijo Kunnumpurath, CEO, Institute of Health and Nursing Australia
- Danice Kuzmic, General Manager, Primary Health Care, Bentleigh Bayside Community Health Service
- Carylin Lenehan, Program Manager – nursing and allied health, RMIT University
- Joan Leo, nursing, midwifery, occupational therapy, orthotics, orthotics, orthotics, physiotherapy, podiatry, prosthetics, social Work, speech pathology, La Trobe University/Alfred Clinical School
- Angela Marshall, audiology, Melbourne University
- Ruth Nicholls, Bronwyn Davidson, speech pathology, Melbourne University
- Claire Palermo, dietetics, Monash University
- Arlene Parry, nursing (community health), Monash University, Peninsula and Berwick campuses
- Jen Rawet and Karen Leemon, nursing, midwifery, Deakin University, Burwood campus
- Pamela Reed, Program Coordinator, Health & Community Care, Chisholm Institute
- Whitney Williams, School of Paramedicine, Monash University

Clinical placement providers

- Lauren Bartlett, Nursing Clinical Educator, Community Health, Southern Health
- Shelly Black, Southern Health, Mental Health Nursing Clinical Placement Coordinator
- Felice Borghmans, Southern Health Ambulatory & Community Care, Manager Acute Care Streams – HITH, PAC, Resi-Inreach, Primary Care Clinics – nursing
- Claire Button, Clinical Nurse consultant, In Reach Program, Southern Health
- Caitlin Coleman and Joel Robins, Student Unit Project, Salvation Army Adult Services
- Samuel Crinall, ERMHA
- Justin Delaney, Southern Health Community Rehabilitation Centres
- Caroline Dickson, Strategic Planner, City of Casey
- Sue Durham, Student Placement Coordinator and Paul Bourke, Program Manager, Health Services, Sacred Heart Mission
- Sue Fleming, Acting Manager Chronic and Complex Care HARP for Health Independence Program, Southern Health
- Athina Georgiou, CEO, and Claire Powell, Manager, Clinical Services, Queen Elizabeth Centre
- Dianne Holbery, CEO and Gina Lovel, Mental Health coordinator, Southern Impact Support Services
- Kate McRae, Southern Health, Acting General Manager and Director Ambulatory and Community Care – GPLU
- Dr Benny Monheit, Director and Sharon O'Reilly, Clinic Manager, Southcity Clinic
- Sue Moulton, Health Promotion Program Manager, Central Bayside CHS
- Michael Olajasi and Russell James, Clinical Nurse Educators, Undergraduate Program, Mental Health (Alfred Community Services)

- Sam Sevenhuysen, Southern Health Allied Health Workforce Development Coordinator
- Christine Thornton-Gaylard, Director, Service Development, ERMHA
- Amanda Vautin, Nurse Unit Manager, Care Link Services, Southern Health
- Jill Walsh, Southern Health Senior Allied Health Leader – Governance
- Colleen White, Caulfield Community Health
- Karin White, Nursing Clinical Education Coordinator, Southern Health
- Liz Wise, Nursing Clinical Educator, Southern Health.

The tenor of these meetings was very positive: in general within the community health sector there is a tremendous amount of goodwill and enthusiasm for enhancing and increasing clinical placements. Many organisations see it as a priority for both workforce development and for increasing awareness of their service.

From these meetings and other consultative activity it was clear that there exists significant variation in size, organisational complexity and the nature of health services provided by the SMCPN community health stakeholders. There was also a high degree of variability in the understanding of what is required and expected in order to provide clinical placement opportunities.

Clinical placements in community health services, sometimes even within large organisations tend to happen on an ad hoc basis and are largely dependent on an opportunistic connection between individuals in the community health service and the relevant education provider (e.g., past student and lecturer).

All clinical placement providers indicated a desire for greater predictability in nearly all aspects of clinical placements. This included: planning, clear expectations in relation to student activity and performance evaluation, clear understanding of what is expected from the organisation, information about support available to the organisation, and clarity and transparency regarding any financial arrangements between the health service organisations and the education provider.

In addition to the process described, other stakeholder consultation activities included:

- Regular email and telephone correspondence with relevant stakeholders
- Attendance and updates by the project manager at several SMCPN committee meetings
- CSSP marketing
- Newsletter updates in SMCPN newsletters
- Web updates on DH website
- Attendance at external meetings related to community health
- Attendance at regional community CEO meetings
- Attendance and presentations at DH events
- Provision of assistance to prepare submissions for funding applications, particularly in relation to the CSSP and later, its expansion.

SMCPN clinical placement provider survey

A ten minute stakeholder survey was developed to gain insight into the level of engagement and the needs and priorities of the community health sector in relation to clinical placements. It aimed to discern what areas of clinical placement practice the resources of the SMCPN strategic project would be best targeted and was intended to help identify key contact individuals within SMCPN community health organisations. Question logic within the survey enabled questions to be targeted towards management/executive personnel (hereinafter called ‘executive respondents’) and clinical supervisors and coordinators, or both. This survey was then piloted with five clinicians from the Central Bayside Community Health clinical team. This group workshopped the survey tool through a number of iterations to ensure it was functional and relevant. The survey tool was then put out to all SMCPN stakeholders. The strategic project working party agreed to encourage the distribution of this survey within their practice networks.

CSSP project design and submission

As part of the planning for this project, it was identified that lack of clinical supervisor preparation was a major barrier to increasing clinical placement availability. Stakeholders from the SMCPN were invited to participate in a working group to develop a funding proposal for submission to DH under the CSSP funding stream. This resulted in 28 SMCPN stakeholders attending and contributing to the development of the final funding proposal. Attendees at this meeting included:

- Andrew Beveridge Monash University, medicine
- Angela Casey, La Trobe University
- Athina Georgiou, CEO, Queen Elizabeth Centre
- Cheryle Moss, Monash University
- Chris White, Navitas
- Elizabeth Molloy, Monash University
- Paul Ferguson, Alfred Health
- Heather Grusauskas, Monash University
- Julie White, Australian Catholic University
- Katrina Nankervis, Southern Health
- Benita Kirkpatrick, William Buckland Radiotherapy Centre
- Laurel Hillock, Care Training Australia
- Leanne Satherley, Southern Health
- Liz Molloy, Monash University
- Louise Kelly, Navitas
- Lucy Whelan, Southern Health
- Mary Mathews, Dandenong Casey General Practice Association
- Megan Pearson, William Buckland Radiotherapy Centre
- Tanya Morgan, William Buckland Radiotherapy Centre
- Peter Barton, Monash University
- Robyn Adamson, Care Training Australia
- Robyn Howley, Holmesglen Institute
- Shelley Black, Southern Health
- Simone Gibson, Southern Health
- Suzie Hooper, St John of God Health Care
- Toni Lamarche, Monash Division of General Practitioners
- Victoria Oxley, Bayside General Practice Network
- Wendy Cross, Monash University

Key determinations of the initial meeting were:

- No stakeholder would be excluded from the program;
- The design of this program would include a focus on clinicians outside of the acute care setting;
- The design would be a multimodal program, deliverable in half-day face-to-face workshop and an online equivalent;
- Workshops would be conducted at venues that would enhance access and appeal to community health stakeholders.

This work coincided with the requests for funding proposals from the DH. The collaborative nature of this work is evidenced by the list of organisations that formally partnered in this submission:

- Alfred Health
- Cabrini Health
- Central Bayside Community Health Services
- Department of General Practice, Monash University
- La Trobe University
- Monash Division of General Practice
- Monash University
- Queen Elizabeth Centre (QEC)
- St John of God Health Care (SJGHC)
- Southern Health.

The project submission, expanded upon the request of the DH, was successful in achieving funding. It subsequently developed as a collateral project. SMCPN community health stakeholders were further engaged to assist with this funding proposal. This expansion resulted in a further 26 face-to-face workshops being funded, the addition of context specific online modules and the aged care interdisciplinary clinical placement pilot.

Implementation

Stakeholder consultation activities

Stakeholder consultation activities have already been described in detail as part of the development phase of this project. These activities also formed part of the Implementation phase for this project as, through these interactions, much of the information sharing and enabling occurred that subsequently impacted on the ability to realise latent clinical placement capacity. Ongoing stakeholder engagement; included informing and assisting community health organisations link with education providers and to utilise resources such as ViCPlace and clinical supervisor training. For example, through ongoing engagement with the Central Bayside Health Service, that organisation was enabled to participate in the clinical placement planning, using ViCPlace to identify opportunities with a range of education providers.

SMCPN stakeholder forum 1

An SMCPN stakeholder event was held on Wednesday 28 March 2012 at the Yarra Yarra Golf Club. At this event an opportunity was provided to facilitate discussion around community health clinical placements within the SMCPN.

This event saw the attendance of forty seven stakeholders from a broad range of sectors within and beyond the SMCPN. The chair of the SMCPN committee, Ben Canny, Deputy Dean Faculty of Medicine and Health Sciences, Monash University, was the master of ceremonies (MC) for the forum and introduced the SMCPN staff and committee members/sector representatives to the stakeholders.

The forum included presentations from the following: Jacky Fernandez: Information Support Officer SMCPN, Theo Does: Project Manager SMCPN Strategic Project, Leone English: Dean, Faculty of Health Science, Community Studies and Education, Holmesglen Institute and Michele Speak: Program Manager, Monash Division of General Practice.

Presentations included: ViCPlace, viCProfile; the SMCPN strategic project, clinical placements within community health and the following successful Request for Funding Proposals (RFPs) for the SMCPN. Simulated Learning Environment: Sustainable Simulation in a Patient Safety Framework, Expanded Settings: Expanding and Strengthening Capacity within General Practice and CSSP: Creating Quality Clinical Supervisors. Presentations were made available for viewing on the DH website.

SMCPN stakeholder forum 2

A second forum to specifically focus on how community health clinical placements within the SMCPN might be supported and coordinated was conducted on 12 June 2012 at the Yarra Yarra Golf Club. With the absence of definitive information from the clinical placement provider survey, the intention of this forum was to develop strategies and direction for the Implementation phase of the SMCPN strategic project.

Potential participants were identified from earlier project scoping activities and invitations were sent to all stakeholders a month in advance. These were followed up with targeted telephone calls and emails to encourage attendance and ensure an appropriate representation of community stakeholders. This event was advertised in the May SMCPN newsletter. Committee members were asked to encourage stakeholders from their sectors to attend.

This event saw the attendance of 68 SMCPN community health stakeholders: 31 education providers from 14 distinct programs and 37 clinical placement providers from 17 separate health organisations.

Loretta Bull, SMCPN Coordinator, was the MC and facilitator for the forum and introduced attending SMCPN staff and committee members/sector representatives to the stakeholders.

The forum was structured to progress from information sharing to priority-setting:

- A series of presentations from SMCPN stakeholders that showcased the community health sector, highlighted innovative clinical placement initiatives and identified some of the key challenges and opportunities the community health sector faces in relation to clinical placements.
- An opportunity to meet and network with other stakeholders.
- A facilitated, interactive workshop during which stakeholders explored some of the issues and options available relating to community health clinical placements.
- A final activity in which it was expected that stakeholders would help inform the priorities of the implementation phase of the SMCPN strategic project.

The forum included presentations from the following:

- Amanda Anderson, Researcher, Increased Clinical Training Capacity (ICTC), Monash University – Multidisciplinary Clinical Placements
- Chris Fox, Chief Executive Officer, Central Bayside Community Health Services – Community Health Services
- Victoria Oxley, Program Coordinator – Clinical Placements, Bayside Medicare Local – Clinical Placements in General Practice
- John Witschi, Project Officer Training and Development, Ermha – Community Mental Health
- Sue Durham, Student Placement Coordinator, Sacred Heart Mission – Clinical Placements with Outreach Services
- Jane Coward (for Jill Walsh, Director – Ambulatory & Community Care, Allied Health and Health Promotion), Southern Health – Community Health Services and Clinical Placements at Southern Health.

Presentations were made available for viewing on the DH website.

Clinical supervisor training program

This component of the strategic project will be reported separately as it achieved funding through a separate HWA/DH funding stream. Delivery of the clinical supervisor training program (as a CSSP project) commenced in April 2012 with the half-day face-to-face workshops and November 2012 for the online module.

Clinical placement supply and demand matching pilot

Following consultations within Southern Health (the project lead organisation), it was decided to take advantage of the goodwill evidenced in earlier phases of the project throughout the community health sector and endeavour to map clinical placement demand and supply and where possible, match these in an efficient manner. This approach was reviewed and agreed to by the DH. An information technology (IT) consultant was engaged to design the necessary programming required and prioritised access was provided to the Southern

Health chief information officer and the Southern Health IT teams. Within the limitations on the type of programming and interface that could be achieved in the available timeframe, a program was designed, tested and implemented.

The first phase of this was to determine clinical placement demand. All SMCPN education providers were emailed to ask if they had unmet community health clinical placement demand for 2013 and if they would like any assistance in meeting this demand. Non-respondents were followed up with at least two telephone calls to invite participation. Respondents that indicated in the affirmative were then asked a few questions relating to the nature of the clinical placements they were seeking. The nature of responses to clinical placement details was sufficiently variable to follow up with telephone enquiries to each education provider so that clinical placement descriptions could be aligned to a series of criteria. In total, 67 education providers were consulted.

The next phase of this process was the design of the clinical placement provider user interface. The challenge was to provide them with as much information as possible without appearing as a large administrative exercise. Using an online survey tool it was possible to 'tag' emails to identify respondents without having to ask for their details again (as was used to send the survey). This phase required the services of an IT consultant and considerable resources that were made accessible at short notice.

Data-entry screens were provided to facilitate the data collection, and an audit trial was provided to trace when, who and where changes were made to the data collection. Correspondence was also able to be attached to the data records. Summary reports are also provided.

Once clinical placement demand was established, this information was cross matched against the community health organisations to identify potential matches for discipline. These community health organisations were contacted in two phases:

- A brief introductory email providing some background and forewarning of the coming request.
- A second email inviting the community health organisation to explore the current clinical placement demand and to nominate if they could potentially provide any of the clinical placements requested.

Finally, where a match occurred, this was communicated to both the education provider and clinical placement provider along with contact details for them to finalise arrangements.

Throughout this process, entries were observed and evaluated to determine if the process design was efficient and effective.

Evaluation

A mixed-method approach was taken to evaluate this project and included the following:

- Feedback and information gleaned from direct consultations with SMCPN stakeholders.
- Feedback from two stakeholder forum whereby stakeholders were informed of the SMCPN activities and provided their insights into the priority areas and strategic opportunities in the SMCPN community health sector.
- Data relating to community health clinical placements for all disciplines collated to enable an empirical comparison between the years 2012–13. Data sources included in making this comparison were:
  - Reported HWA/DH clinical placement activity for 2011–12. This was sourced by utilising the newly created viCPlace software data for comparison of clinical placement capacity and demand over the life of this project;
  - All currently available community heath clinical placement data for Alfred Health and Southern Health;
- The data produced from the development of an IT portal also allowed the collection of clinical placement demand/supply statistics for disciplines yet to utilise the viCPlace software and provided the opportunity to extrapolate a true picture of the clinical placement demand/supply balance within the SMCPN community health sector for 2013.
  - Reflective evaluation to determine if the process design of the final stages of the project were efficient and effective.

Project management

Governance arrangements

The SMCPN committee bears overarching responsibility for this project. The project manager worked in close consultation with the SMCPN coordinator and has provided project updates as requested to the SMCPN committee. The project manager is responsible for overall project coordination, funds disbursement and coordination and marketing of the program.

Southern Health is the lead organisation and fund holder for this project. Executive responsibility for this project within Southern Health sits with the director of nursing and midwifery education and strategy. The signatory to the original contract, Katrina Nankervis, has recently resigned from Southern Health. Lynne Bickerstaff temporarily filled this role until the commencement of the permanent appointee who commenced November 2012, Samantha Powell. A working party for this project was established from stakeholders within the SMCPN as part of the initial activity of this project to set the strategic plan.

Stakeholder engagement and consultation

Stakeholder engagement for this project included but was not limited to the following activities:

- Formal and informal meetings with stakeholders
- Regular email and telephone correspondence with relevant stakeholders
- Stakeholder forum 1
- Stakeholder forum 2
- Attendance and updates by project manager at several SMCPN committee meetings
- Working party meetings
- Advisory group updates
- CSSP marketing
- Newsletter updates in SMCPN newsletters
- Web updates on DH website
- Attendance at external meeting related to community
- Attendance at regional community CEO meetings
- Attendance and presentations at DH events.

Timelines

Timelines were initially developed then continually revised with the lead organisation, the working party and the SMCPN committee. This project was conceptualised as four phases rather than a sequence of progressive milestones. The activities and outcomes of earlier phases inform and shape the subsequent phases. As expected, this interdependency of phases saw elements of each phase being conducted at various times throughout the project. The timelines for this project required constant updating. The ability to conduct various elements was impacted positively and negatively by events both internal and external to the project. Due to unforeseen circumstances, the final stages of this project warranted submitting and receiving approval from the DH for an extension of the project from 30 November to 31 December 2012. An example of an external event influencing the project included the delayed release of viCPlace. The four project phases were: Stage 1 – Project initiation; Stage 2 – Development; Stage 3 – Implementation and; Stage 4 – Evaluation as described above.

Outcomes and impacts

Scoping activities and stakeholder consultation

SMCPN database

This project has resulted in the development of an SMCPN community health database that includes 296 community health organisations and 67 education providers. It should be noted that this counts Alfred Health and Southern Health each as single organisations due the fact that they have centralised coordination for most of their clinical placement activities. Both of these organisations host a large number of community health services at multiple sites.

SMCPN clinical placement provider survey

A ten minute stakeholder survey was developed to gain insight into the level of engagement and the needs and priorities of the community health sector in relation to clinical placements. The aim of the survey was to discern which areas of clinical placement practice the resources of the SMCPN strategic project would be best targeted and was intended to help identify key contact individuals within SMCPN community health organisations. Question logic within the survey enabled questions to be targeted towards management/executive personnel (hereinafter called 'executive respondents') and clinical supervisors and coordinators, or both. This survey was then piloted with five clinicians from the Central Bayside Community Health clinical team. This group workshopped the survey tool through a number of iterations to ensure it was functional and relevant. The survey tool was then put out to all SMCPN stakeholders. The strategic project working party agreed to encourage the distribution of this survey within their practice networks.

This survey was emailed to over 200 stakeholders. A total of 30 responses were received of which 19 were usable. Of these, two respondents indicated that their role included executive or senior management (strategic planning) responsibilities, nine respondents indicated they were directly involved in the planning, coordination or provision of clinical placements while five respondents indicated their role involved both (executive and coordinator) roles.

Results of this survey are included in the graphs that follow:

Q1. Does your role include executive or senior management (strategic planning) responsibilities?

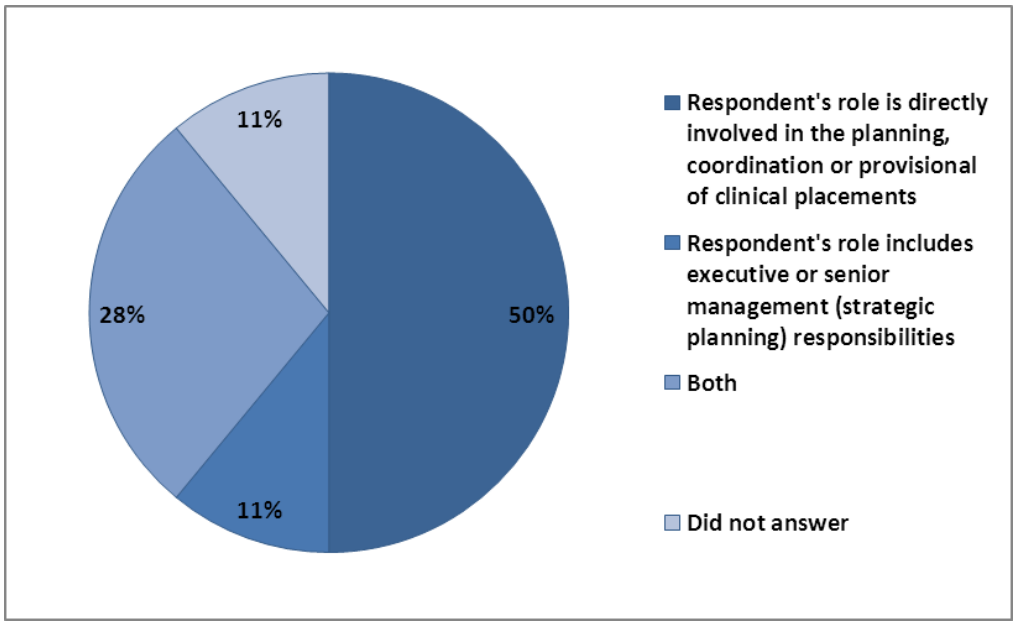


Figure 1: SMCPN clinical placement provider survey – respondent roles

Q2. Will your organisation be providing clinical placements in 2012 for students enrolled in a health-related course?

All respondents (n = 21/100%) indicated their organisation's would be providing clinical placements in 2012 for students enrolled in a health-related course.

Q3. For which health discipline(s) are/will your team/department/program provide placements? Tick all that apply.

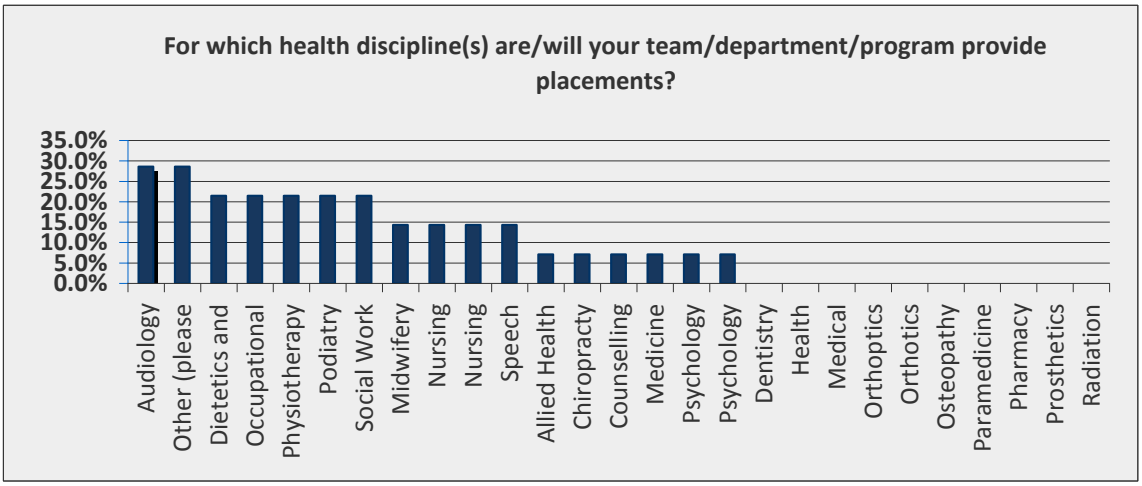


Figure 2

'Other' disciplines included: exercise physiology; mental health and drug and alcohol; music therapy.

Q4. Does your organisation's business plan include any strategies to increase student clinical placement capacity?

All executive respondents indicated their organisation's business plan include strategies to increase student clinical placement capacity. Comments arising from this question included:

"Student placements are seen as imperative to the professional development of students who will be entering the sector. (organisation name) is committed to providing students an opportunity to apply theoretical knowledge to practice with the objective of better trained and experienced new entrants to the workforce for the sector and for (organisation name)."

"Facilitating placements in clinics and services that not normally involved because no financial incentive can only provide limited time or not ever used before."

"Dedicated student coordinator positions, grant applications for increased training capacity."

Q5. A series of questions were asked regarding the resources and preparation available for providing clinical placements (key findings are illustrated below in Figures 3 and 4):

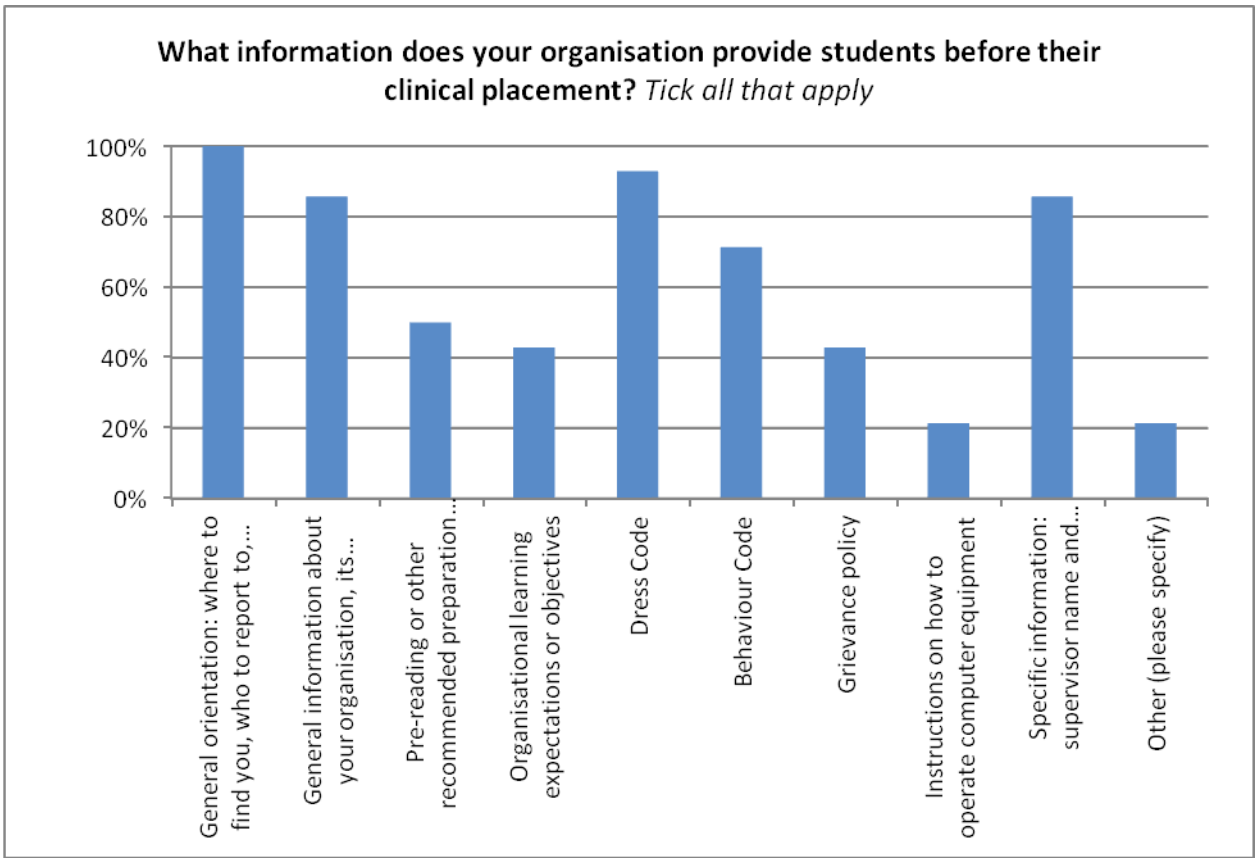


Figure 3

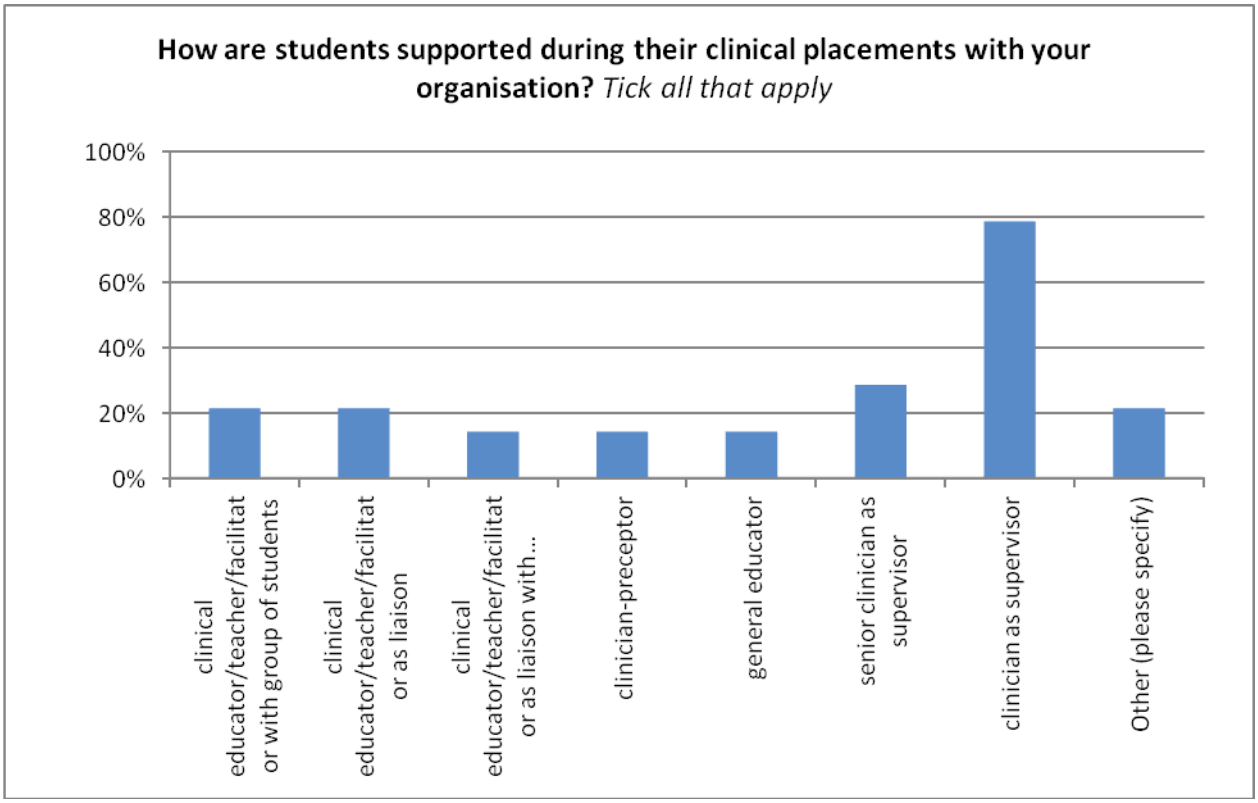


Figure 4

Q6. The next series of questions identified the support clinical placement providers felt was more important (Figures 5 and 6):

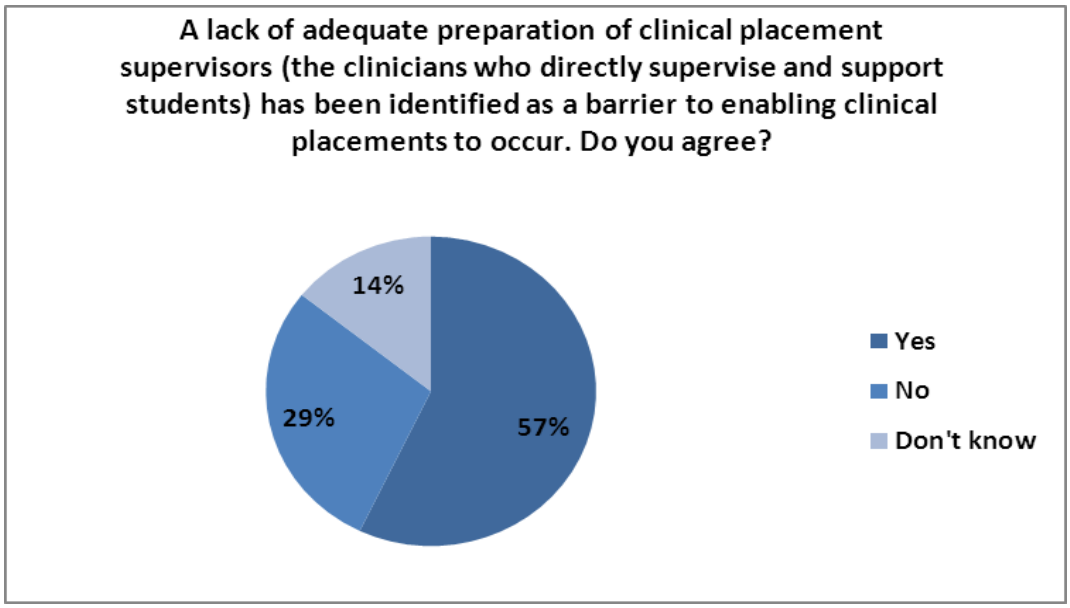


Figure 5

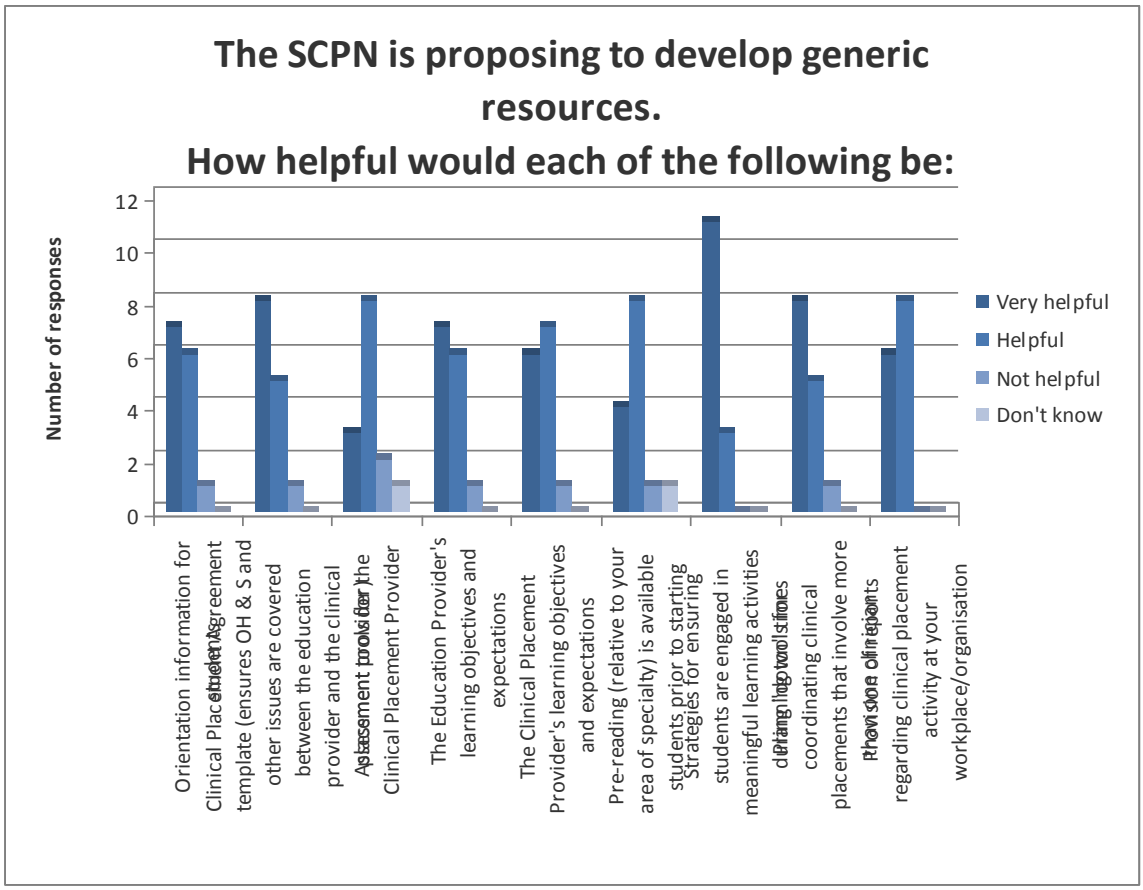


Figure 6

Q7. The next series of questions investigated community health workplace practices in relation to clinical placements (Figures 7 and 8):

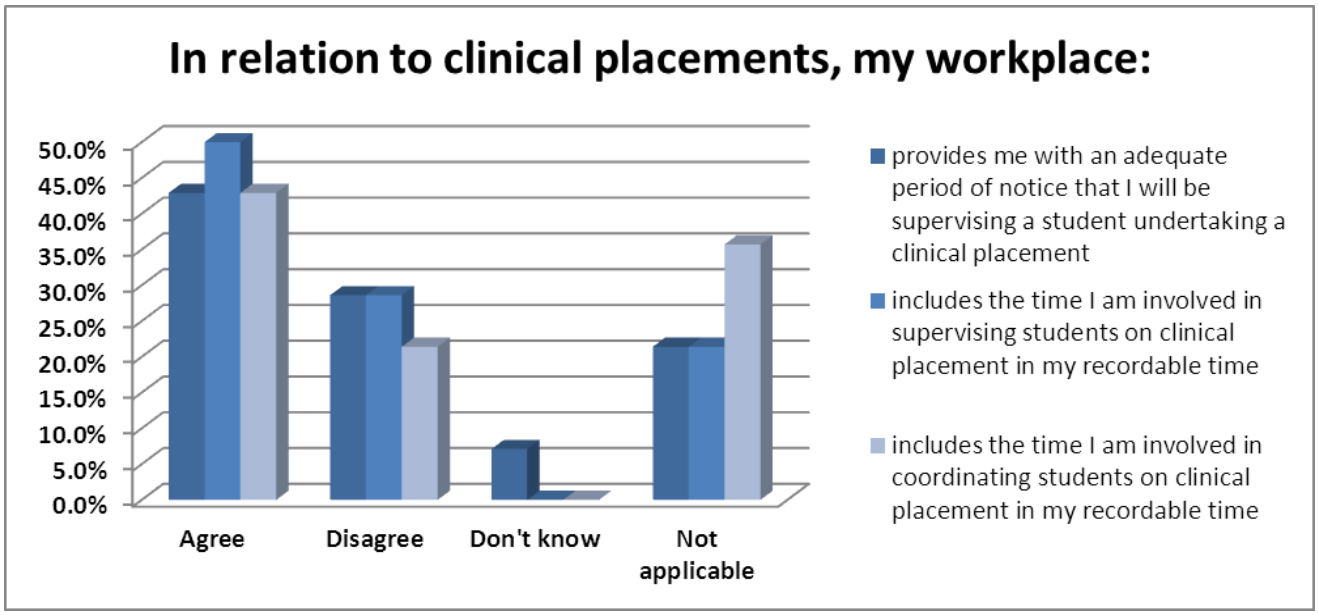


Figure 5

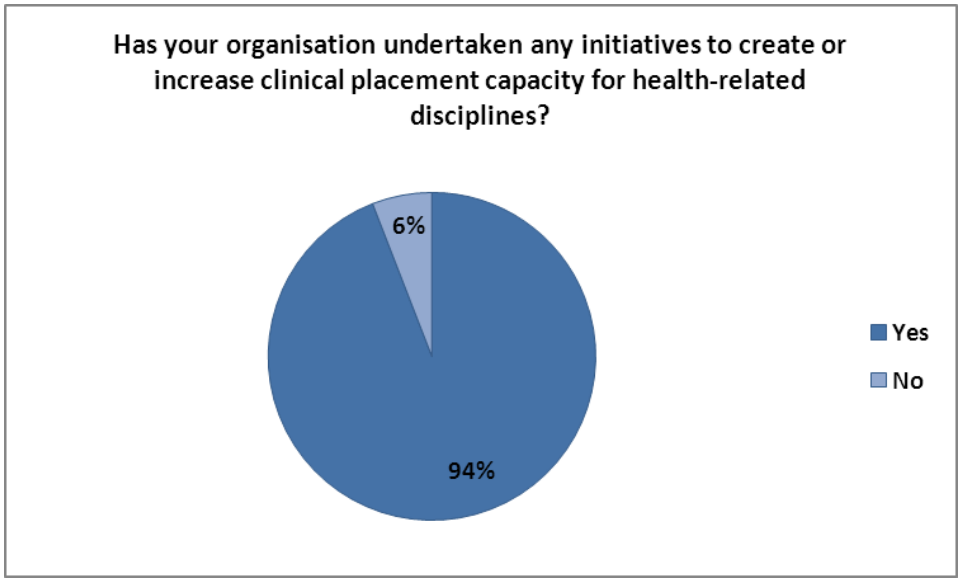


Figure 6

Themes extracted from responses

Improved systems and processes

For example, the creation of a student coordinator role, policy and procedure development, standardised student orientation.

Reward and recognition

For example, student survey results are distributed to highlight the importance and positivity of the placement from a student's perspective, 'Thank you' plaques given.

Scoping project undertaken a formal review of capacity

Selected responses

"Thank you plaques given to supervisors/agencies."

"2011 represented a firm commitment to student placements with 23 students placed. Placements were coordinated and planned to provide the best experience for students. This included: a visual and site orientation, development of website and a practice manual which included relevant policies and procedures and legislation which regulated and impacted on students and organisation."

"Student surveys demonstrated the value of the experience and reflected well with the academic institutions involved."

"Employment of a student placement coordinator role to support placements and to develop supportive organisational processes around student placement – in response to identification to student placement focus in the organisational strategic plan."

"Recent nomination of a student coordinator role has meant that the energy and focus around finding student places has grown – and the whole issue is discussed more because of whole organisation focus on the whole student placement topic."

Q8. Indicate how far in advance you believe clinical placements should be planned (Figure 9):

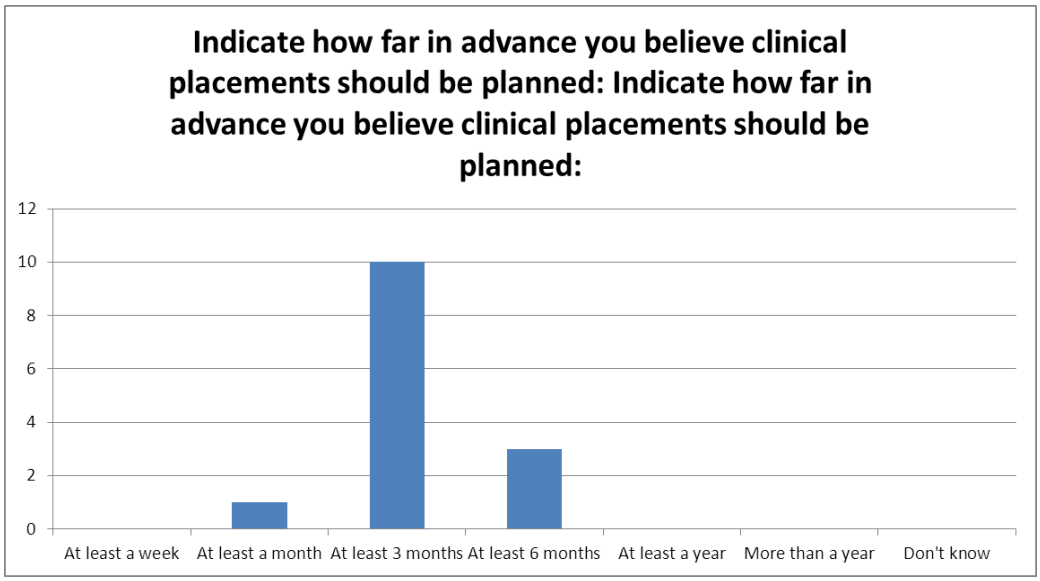


Figure 7

Q9. Does your organisation have any ongoing formal arrangements in place regarding clinical placements; for example, a clinical placement agreement? (In this instance, 'ongoing' relates to any arrangement that lasts for at least twelve months.)

Seventy-one per cent of executive respondents indicated their organisation has ongoing formal arrangements in place regarding clinical placements; for example, a clinical placement agreement. One respondent, (14.3%) responded "did not know" and one respondent, (14.3%) did not respond. Those that provided comments in relation to this (71.4%) all indicated that they had formal arrangements in place with multiple organisations.

Q11. What are your views around clinical placements in community health settings in general?

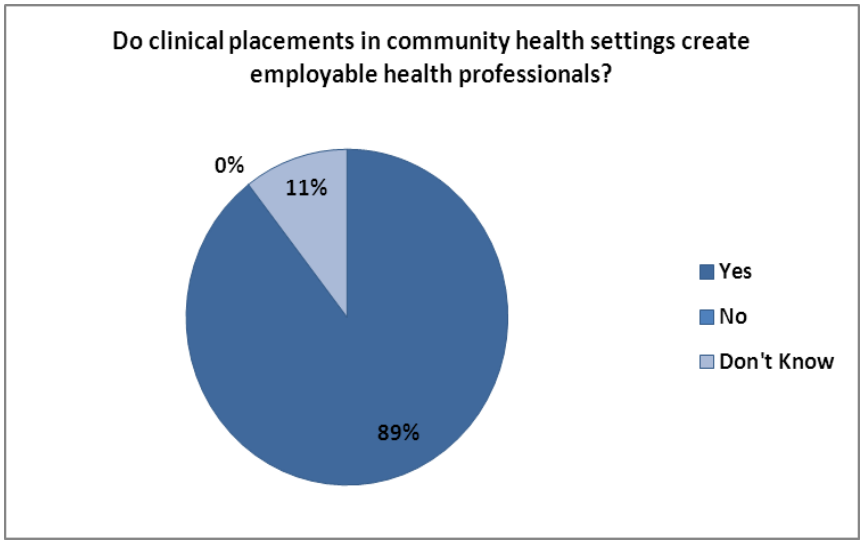


Figure 9

Themes extracted from responses

- Overwhelmingly the respondents articulated their willingness and engagement to offer opportunity to increase clinical placements for health professionals within the community setting. The recognition of student placements adding value to the clinical setting and the profession was noted. It was identified as an opportunity to highlight opportunities within the community health setting and as a potential career pathway for consideration.
- It was recognised that the landscape of healthcare provision was changing and that community health settings were playing a greater part in the provision of that care. The importance of developing a capable and competent workforce for the future included the opportunity to expand and increase clinical placement activity for all disciplines within the community sector.
- A strong focus on the development of interprofessional clinical placement opportunities was also highlighted.

Selected responses

"We are very keen to expand the placements available to students in community health programs. This is limited at the moment. We find these placements to be extremely valuable for our students."

"We recognise the value of a multi-discipline teams, though our barriers have always been related to remuneration based on funding constraints."

"Essential part of the curricula as they 'round out' the experience for the student. The student benefits from understanding the complete journey the patient may take in relation to health issues. Inpatient based clinical experiences are very valuable but are not able to support the student understand the total patient experience, especially in relation to chronic illness."

"Very much in favour – excellent learning opportunities if students are provided with adequate supervision."

"Increasing importance today (so now very important) as more patients are now managed in the community (rather than in hospitals)."

Q12. Question: What are the primary barriers to increasing clinical placements in community health issues and health service settings?

Themes extracted from responses

- Limited capacity
- Competition between disciplines and education providers vying for the same opportunity
- Cost and lack of funding to support

- Cultural barriers – students seen as ‘more work’
- Clinical supervision

Selected responses

“Lack of funding to support coordination, supervision and resourcing for effective placements. The capacity to deliver effective placement experiences within the framework of current tasks and roles of those supervising students on placement. The lack of suitably qualified staff to provide specialist supervision for relative disciplines.”

“Availability of places.”

“Competing with physio student placements.”

“Staff who haven’t supervised students before and are anxious/feel unprepared/are intimidated by students.”

Q13.List any strategies or actions you can think of that would increase undergraduate student clinical placement capacity in community health settings:

Themes extracted from responses

- Increase financial support for a dedicated student coordinator and or clinical supervision
- Training for clinical supervisors
- Simplify assessment tools
- Increase the opportunity for interprofessional clinical placements.

Selected responses

“Utilise interprofessional learning opportunities."

"Funding the coordination and administrative support required to make it successful for student, organisation and academic institution.”

“Improve status of people providing placements by offering assistance with teaching, recognition, and lobby government to increase remuneration.”

“Simplify assessment tools. Very clear lists of learning objectives for students. Ongoing support for supervising clinicians.”

"Training.”

In spite of the poor response rate, this information was still felt to have value as it resonated with the discussions and consultations with SMCPN stakeholders. Caution was exercised when extrapolating this data more broadly or attempting conclusive determinations from the data. It was felt that that this may be an ineffectual mode of accessing information in this context as this workforce appears to prefer a direct, face-to-face consultation methodology.

CSSP project design and submission

In addition to enhancing SMCPN community health stakeholder engagement, the CSSP advisory body helped develop a proposal that was successful in securing significant funding for the development of a multimodal clinical supervisor training program. This program is delivered in both face-to-face workshops and via an online portal (https://clinicalsupervisionsupport.org). To date, the face-to-face workshops have been delivered to over 730 individuals. The CSSP project timeline extends through to May 2013.

SMCPN stakeholder forum 1

This event saw the attendance of forty-seven stakeholders from a broad range of sectors within and beyond the SMCPN. The chair of the SMCPN committee, Ben Canny, Deputy Dean Faculty of Medicine and Health Sciences, Monash University, was MC for the forum and introduced the SMCPN staff and committee members/sector representatives to the stakeholders.

The forum attendees were from a broad range of sectors and included representatives from health service providers (54%) and education providers (40%). Of the health service provider attendees, 54% were from public health, 14% from community health and Medicare Locals and 9% from both private health and community mental health. Of the education providers; 52% were from higher education and 24% from both Vocational and Educational Training (VET) and Registered Training Organisations (RTOs).

When asked, participants identified their disciplines as: nursing (43%), allied health (35%), medicine (10%) or other (13%) such as, aged care, mental health and community development.

In general feedback was very positive with 91% indicating they found the forum extremely informative (ratings 4 to 5). At the completion of the forum 97%, felt that they were highly informed (rating 4 to 5) in relation to SMCPN activities.

Of the forum topics presented, feedback indicated that the most relevant topics were; clinical supervision training (21%), viCPlace (20%), viCProfile (17%) and the SMCPN strategic project (15%).

SMCPN stakeholder forum 2

A second forum to specifically focus on how community health clinical placements within the SMCPN might be supported and coordinated was conducted on 12 June 2012 at the Yarra Yarra Golf Club. With the absence of definitive information from the clinical placement provider survey, the intention of this forum was to develop strategies and direction for the Implementation phase of the SMCPN strategic project.

This event saw the attendance of 68 SMCPN community health stakeholders: 31 education providers from 14 distinct programs and 37 clinical placement providers from 17 separate health organisations.

The forum attendees were from a broad range of sectors and included representatives from health service providers (54%) and education providers (46%). The health service provider attendees represented 17 organisations, including public, private, and not-for-profit organisations. The education provider attendees represented 14 organisations including higher education, VET and RTOs.

All attendees were invited to complete a prepared evaluation form. Of the 68 attendees, 46 (75%) completed an evaluation form.

When asked, participants identified their disciplines as: nursing (46%), allied health (40%), medicine (15%) or other (13%) such as, aged care, mental health and community development.

In general feedback was very positive with 94% indicating they found the forum extremely informative (ratings 4 to 5). Of the forum activities and presentations presented, feedback indicated that the most relevant items were; being able to network with other SMCPN stakeholders (80%); Presentation: multidisciplinary clinical placements (71%); Presentation: community health services and clinical placements at southern health community health services (71%); Presentation: community health services (66%); Discussion: SMCPN resources and supports (66%); Interactive workshop activity (57%).

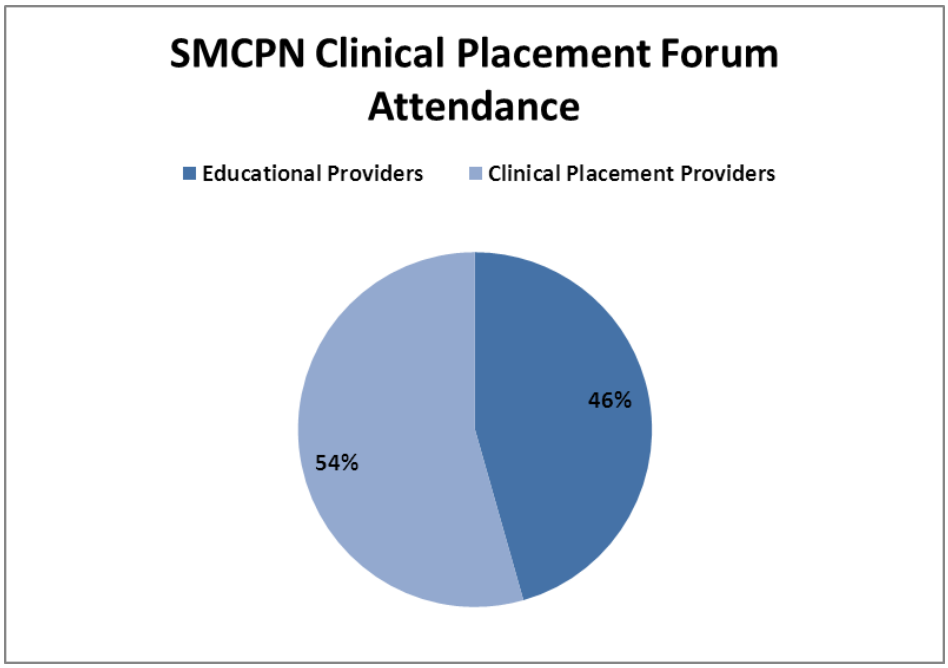


Figure 8

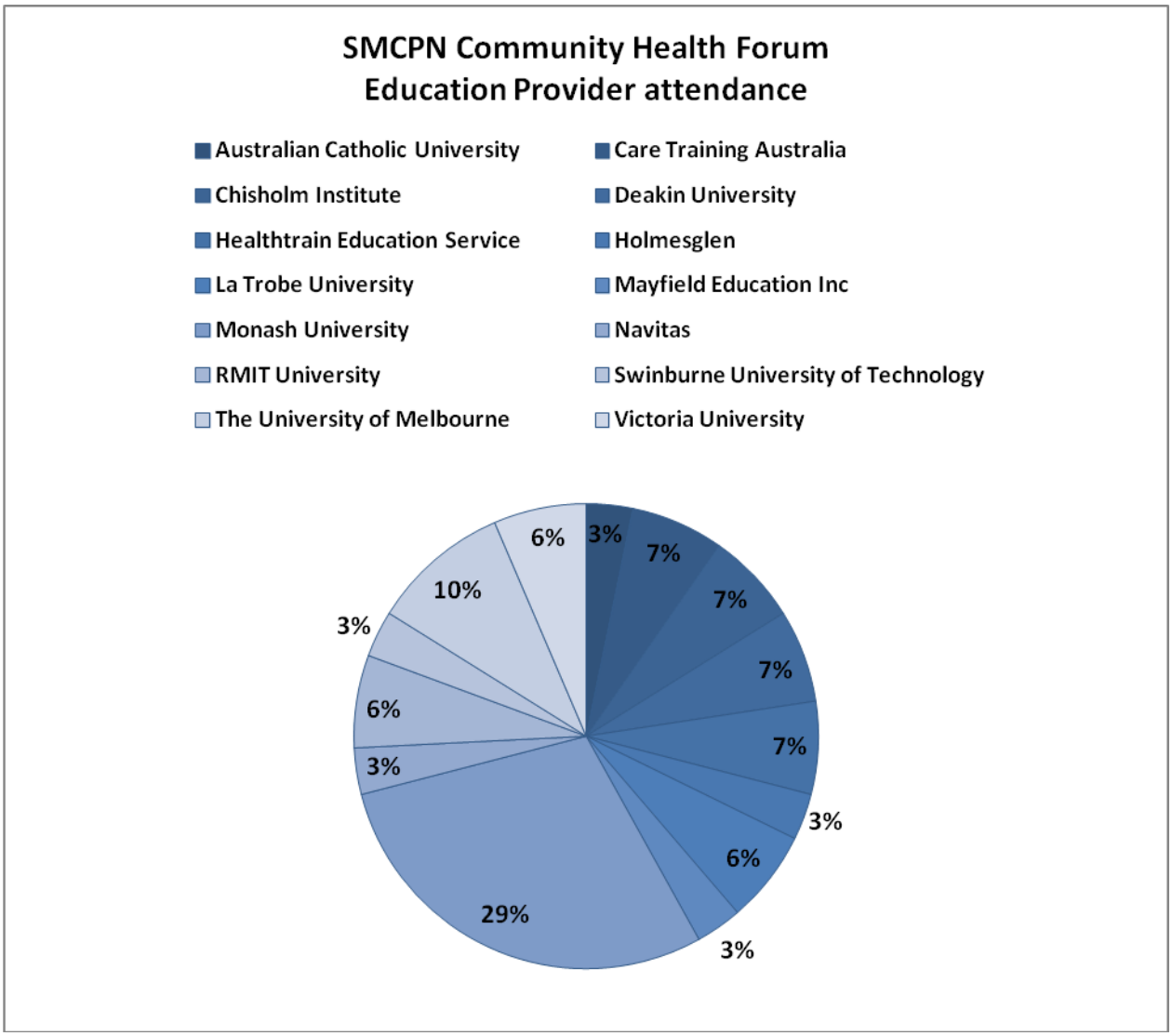


Figure 9

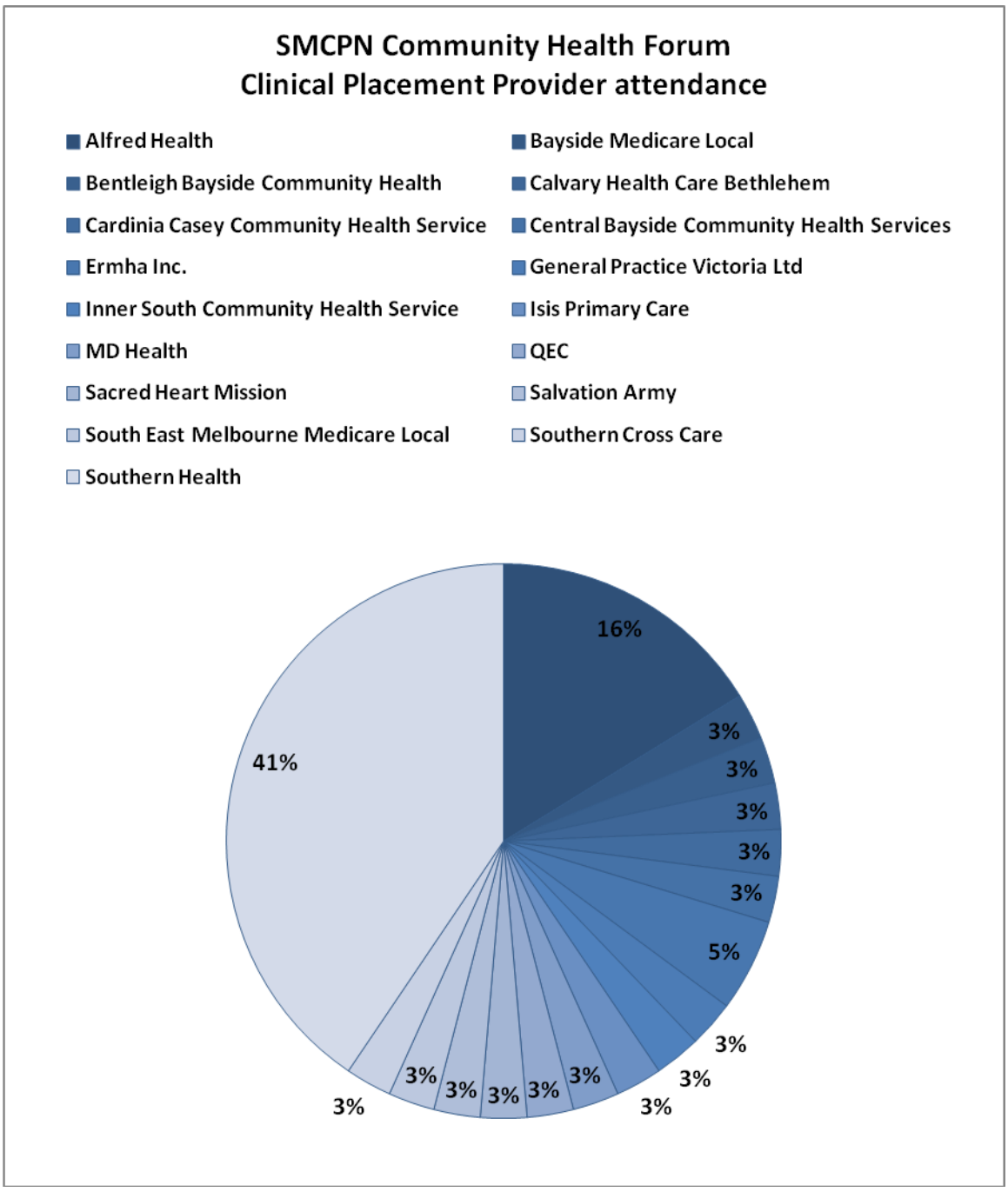

SMCPN Community Health Forum
Clinical Placement Provider attendance
Alfred Health
Bayside Medicare Local
Bentleigh Bayside Community Health
Calvary Health Care Bethlehem
Cardinia Casey Community Health Service
Central Bayside Community Health Services
Ermha Inc.
General Practice Victoria Ltd
Inner South Community Health Service
Isis Primary Care
MD Health
QEC
Sacred Heart Mission
Salvation Army
South East Melbourne Medicare Local
Southern Cross Care
Southern Health
16%
3%
3%
3%
3%
3%
5%
3%
3%
3%
3%
3%
3%
3%
3%
41%

Figure 10

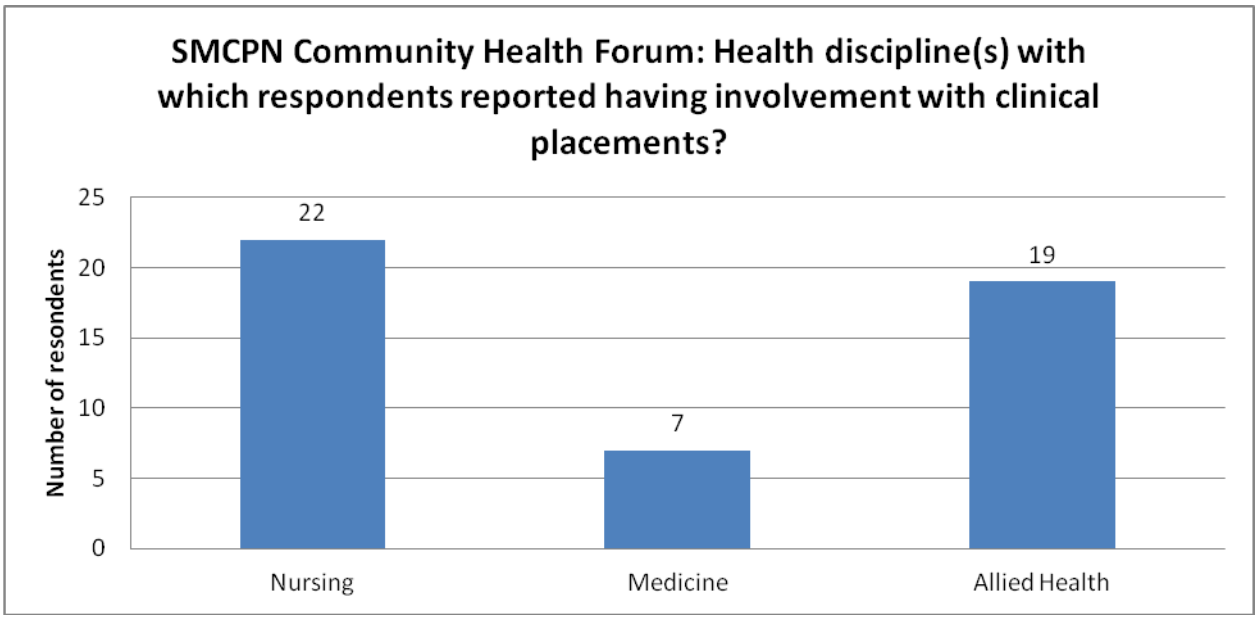


Figure 11

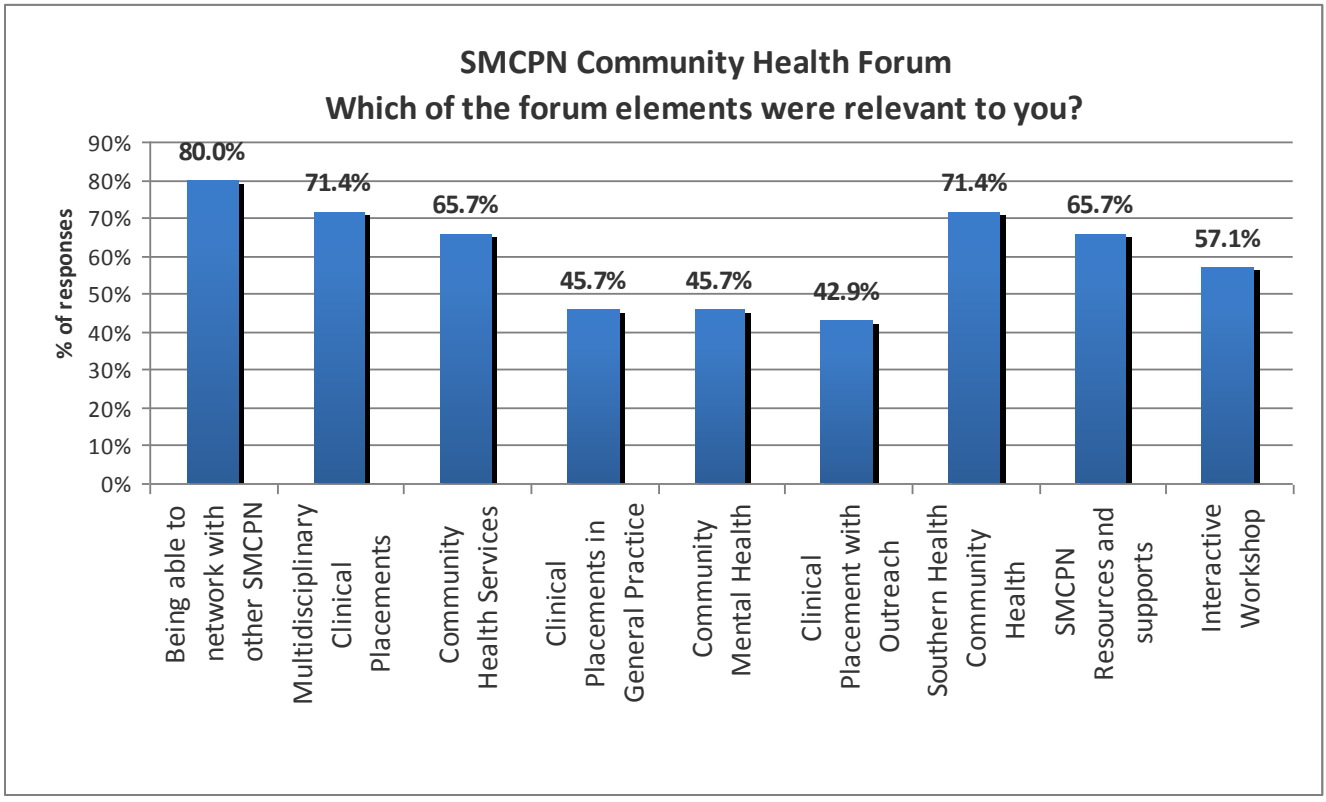


Figure 14

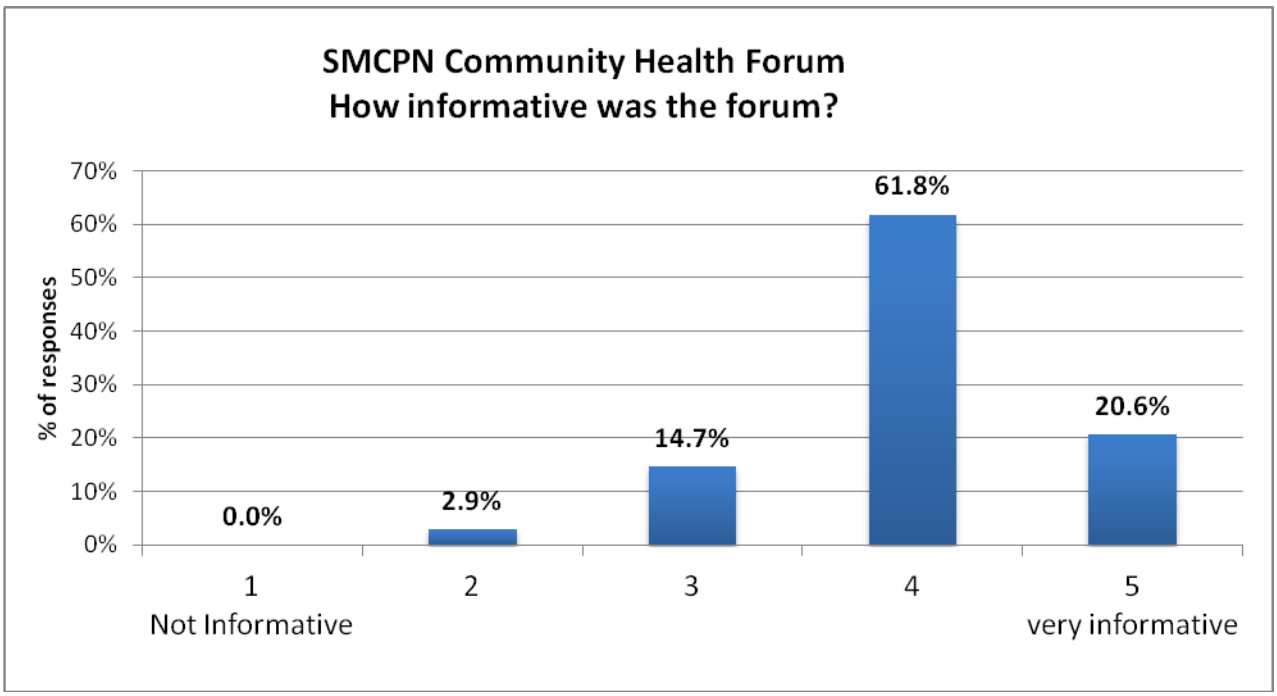


Figure 12

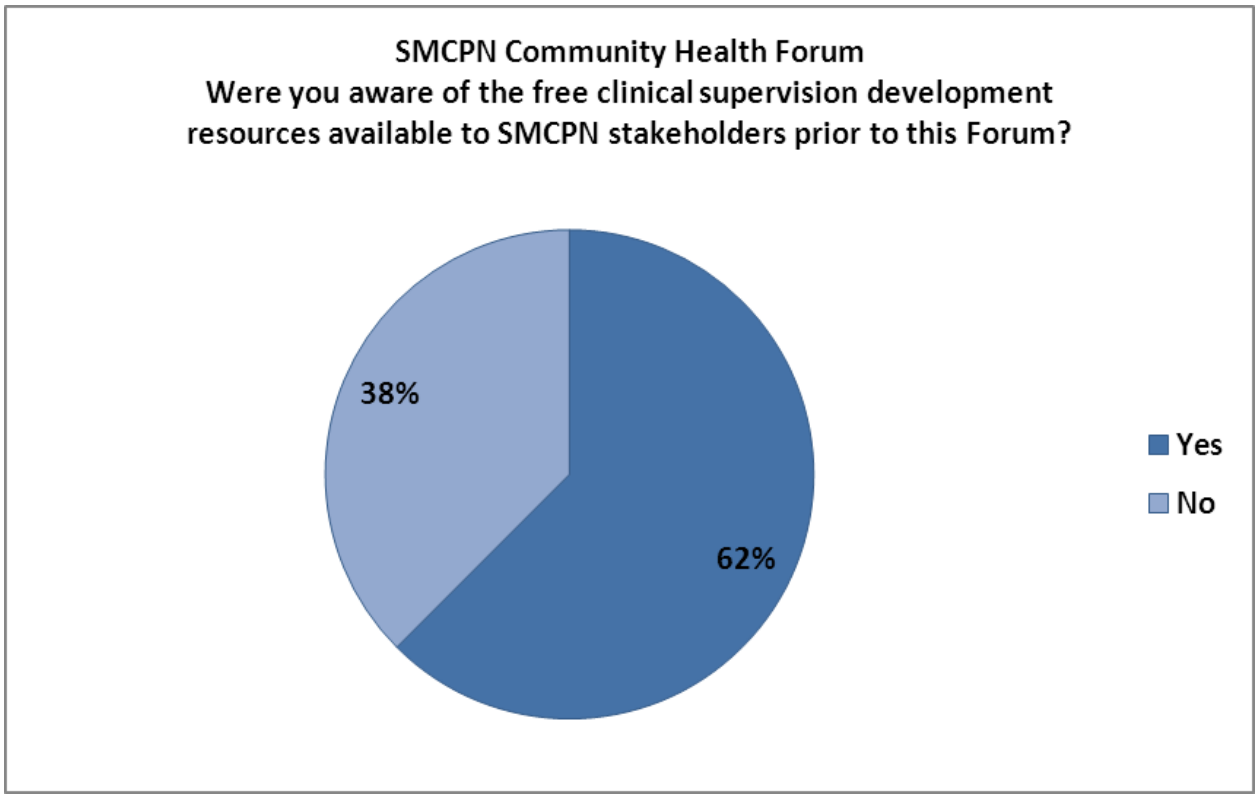


Figure 13

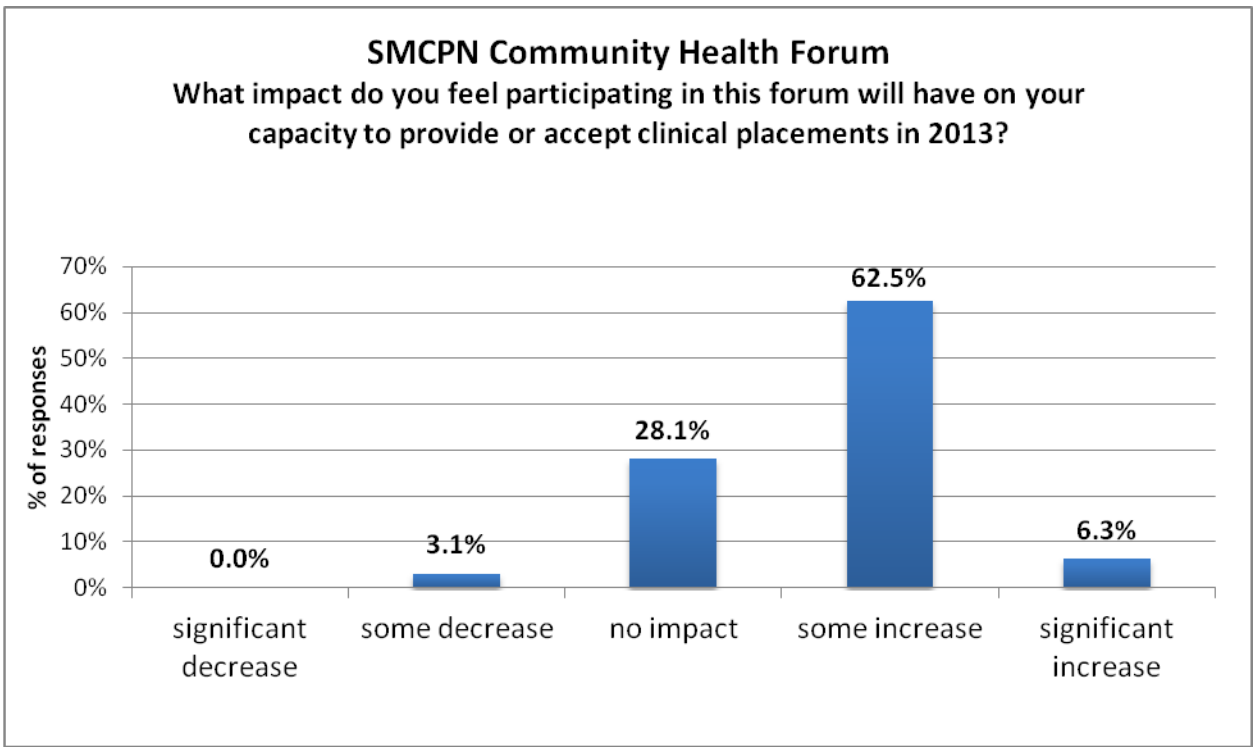

SMCPN Community Health Forum
What impact do you feel participating in this forum will have on your capacity to provide or accept clinical placements in 2013?
% of responses
70%
60%
50%
40%
30%
20%
10%
0%
0.0%
3.1%
28.1%
62.5%
6.3%
significant decrease
some decrease
no impact
some increase
significant increase

Figure 14

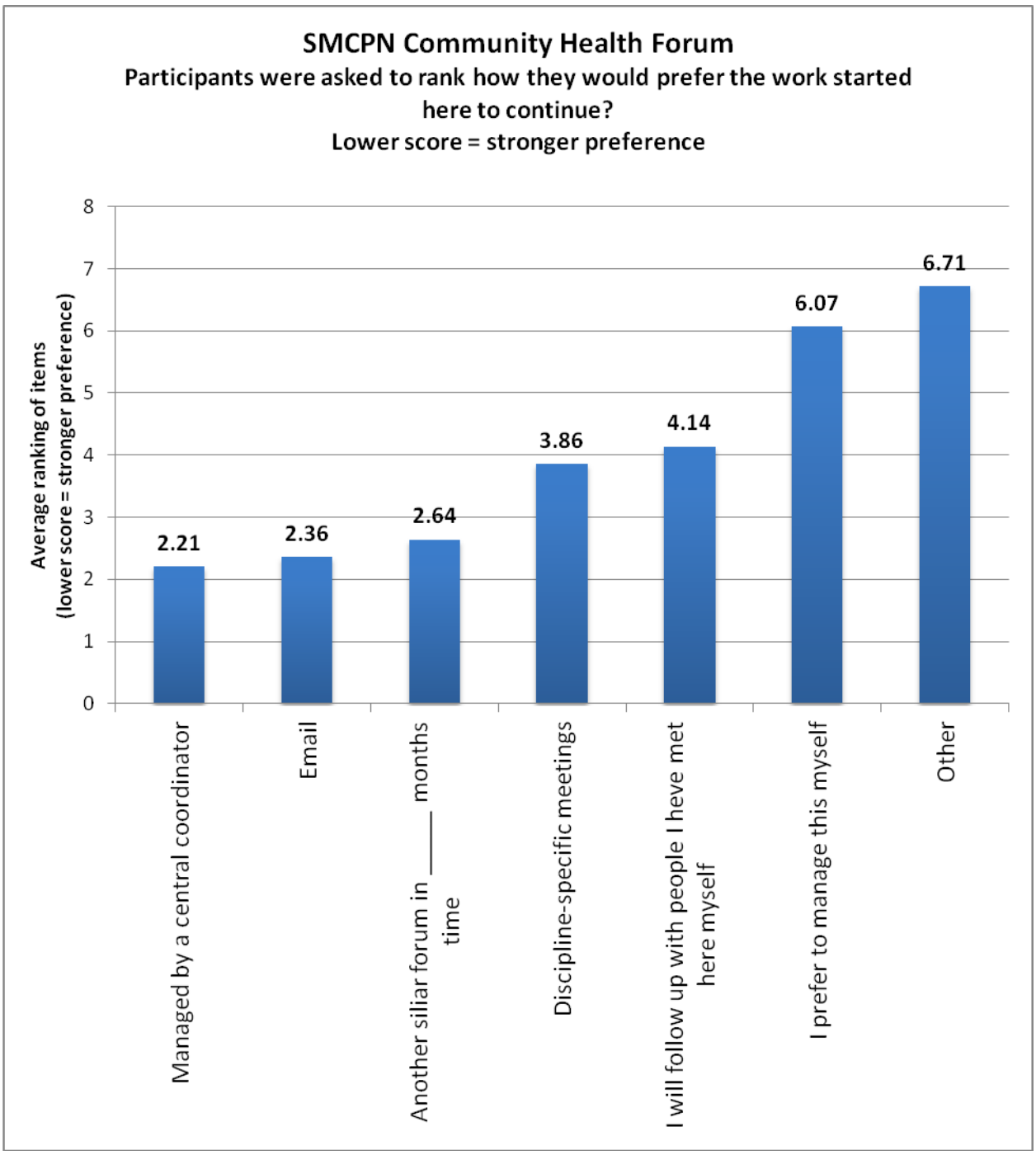


Figure 18

Note: This was forced ranking question, several respondents chose to tick some options; there were 14 complete responses to this question.

Direct consultations with SMCPN community health stakeholders: Health service providers (actual or potential clinical placement providers) and education providers

A range of themes emerged from the stakeholder consultations:

- There is a great deal of goodwill across the SMCPN community health sector towards clinical placements. Community health organisation view clinical placement provision as an opportunity to increase awareness of their services by health professionals; an opportunity to attract and recruit new staff. In addition to this, SMCPN clinical placement providers indicated that they felt that providing clinical placements for students added value to their organisations.
- Current clinical placement arrangements are largely ad hoc, they are reliant on an existing relationship between individuals from both the education provider and the clinical placement provider. Often this stems from a relationship as past colleagues or recent graduate lecture. This creates a lack of permanency in arrangements as they are dependent on the ongoing presence of either individual. Other aspects of this ad hoc nature of clinical placement planning include; minimal and inconsistent record keeping; lack of awareness of clinical placement activities within organisations; variable governance over clinical placements.
- There is a mismatch between community clinical placement providers and education provider expectations.
- Education providers work from a single discipline perspective whereas community health clinical placement workplaces are typically multidisciplinary. Addressing this would require curriculum and or registration policy change.
- Preparedness of the clinician to be a supervisor featured prominently.
- Physical space to support students is often cited as an obstacle. This generally presupposes a clinical placement model that requires the student an area to work independently of the clinicians for a period of time.
- Time, particularly to coordinate and evaluate students. This is exacerbated when students are coming from more than one education provider, which is the experience of most community health clinical placement providers.
- A positive aspect of clinical placements in community health is that students often get a more immersive experience because the volumes of staff and clients at any one time tend to be lower. The clients are more relaxed and able to provide insights that the student might not glean in a tertiary facility.
- One of the challenges facing education providers is the small volumes of clinical placements allocated to individual health organisations. This requires that coordination processes be undertaken with a large number of organisations at one time.
- Education providers and clinical placement providers acknowledged the limitations created by the academic calendar; it means that clinical placements are sought at specific times, in between which there is minimal demand. Some disciplines address this through part-time clinical placements but this solution does not fit all disciplines.
- Governance is of primary importance to many clinical placement providers. They do not want any external body having control over their data or the capacity to influence their internal activity. This theme was consistent with clinical placement providers when exploring their reservations for sharing availability data or using an automated system: they are determined to be responsible for the decisions that affect their practice.
- The part-time nature of the community health workforce has a significant bearing on the ability to provide clinical placements particularly if the placement is a full-time model.

As a result of engagement with the community health sector, several stakeholders increased their level of engagement with clinical placements in general and/or the activities of the SMCPN. Three additional stakeholders joined the SMCPN committee as community representatives adding broader acumen in community health and mental health.

Clinical placement planning (CPP) 2012

Engagement of stakeholders in this project resulted in eight community organisations registering for clinical placement planning activities for nursing conducted by DH. This process is a formal statewide approach, shaped by local input from CPN stakeholders. These eight organisations included 32 facilities with initial availability of 22 798 placement days. This process resulted in 7850 placement days being taken up and 14 948 placement days remaining available. Comparative data is not available, however all of the listed organisations informally indicated that the clinical placement allocation committed to for 2013 is an increase on that provided in 2012. The total available clinical placement capacity following the conclusion of the clinical placement planning activity 2012 of that allocated indicates substantial latent capacity within these organisations. This data was obtained from the availability reports generated during this process and viCPlace.

Detailed below is the breakdown of CPP activities results by organisations:

Health care organisation (SMCPN community health)	Clinical placements (clinical placement days) allocated at conclusion of clinical placement planning activity 2012	Clinical placements (clinical placement days) available after conclusion of clinical placement planning activity 2012
Aged Care Services Australia Group (ACSAG)	3 598	12 530
Australian Unity Care Services	1 698	882
Gold Age	2 376	40
Southern Cross Care (Vic)	0	1 260
Swinburne University Health Service	178	0
Uniting Aged Care	0	236
Bayside Medicare Local	0	0
Central Bayside Community Health Services	0	0
Total	7 850	14 948

Without baseline data it is not possible to state the gain in clinical placement capacity that this represents. Because these organisations were in regular contact with the project team through concurrent activities, it can be said that there is strong anecdotal evidence that this represents a significant increase in clinical placement activity for these organisations and that they will be providing clinical placement opportunities for some disciplines for the first time in 2013.

It can be claimed that there is clearly a substantial volume of latent capacity; 14 949 days of current clinical placement allocation is potentially available.

Alfred Health and Southern Health entries in viCPlace resulting from the 2012 clinical placement planning activity relating to community health clinical placements were not readily distinguishable from the tertiary hospital-based (acute) sector placements. Clinical placement coordinators from Alfred Health and Southern Health were asked to provide their clinical placement data for 2012–13 to enable a comparison.

Alfred Health and Southern Health community health clinical placement activity:

Health care organisation	Discipline	Clinical placement days allocated for 2012	Clinical placement days allocated for 2013	
Southern Health	Audiology	51.24	79	
Southern Health	Exercise physiology	190	160*	Planning for exercise physiology clinical placements for 2013 has not yet been finalised
Southern Health	Nursing registered	985	1 135	
Alfred Health	Nursing registered	1 062.25	1 900	
Southern Health	Occupational therapy	58	158	
Southern Health	Physiotherapy (paediatric)	24	24	
Total		2 362.49	3 448	Planning for social work clinical placements for 2013 has not yet commenced
Southern Health	Social work	885	n/a*	

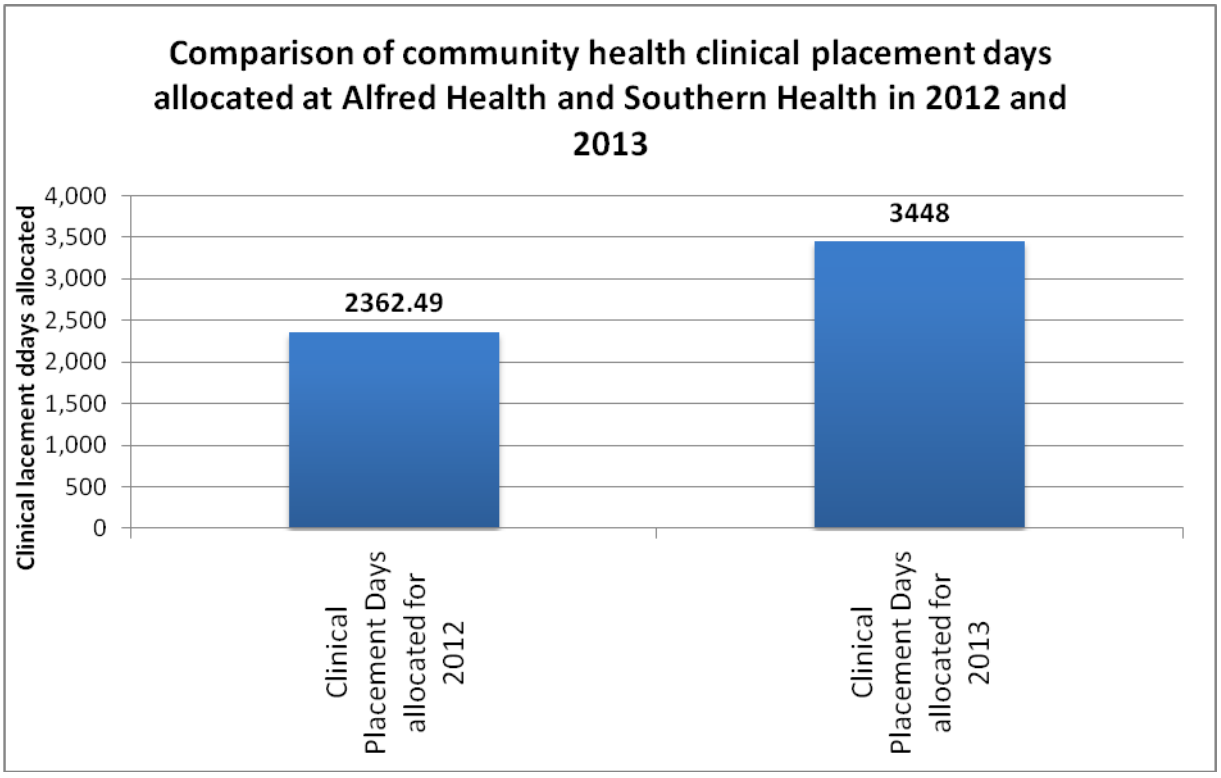


Figure 19

The overall change in community health clinical placement activity for the combined Alfred Health and Southern Health from 2012–13 was 1086 clinical placement days or an increase of 45.9%.

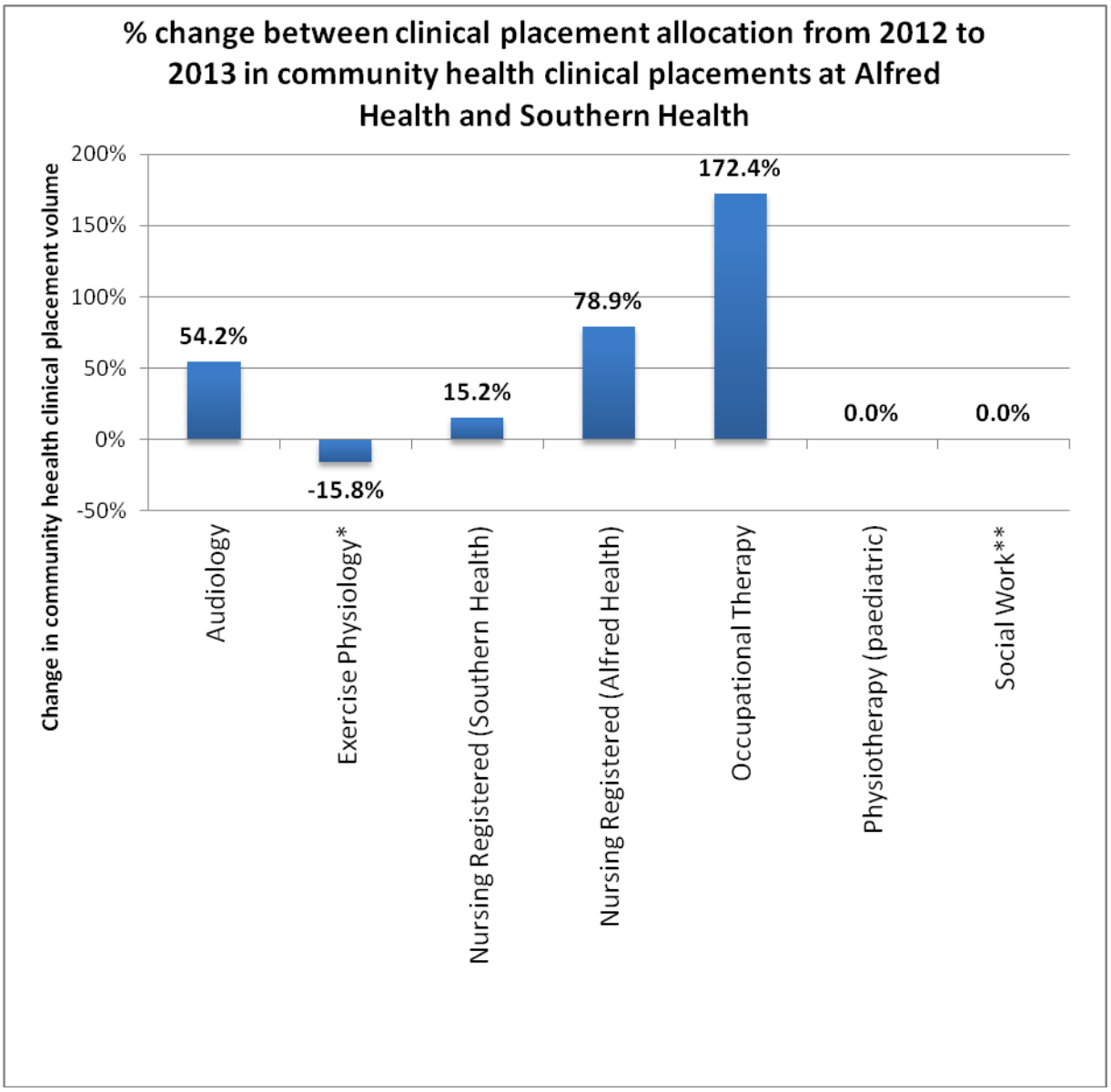


Figure 20

* Exercise physiology has not yet finalised community health clinical placement allocation for 2013

** Social work has not yet commenced clinical placement allocations for 2013

Clinical placement supply and demand matching pilot

A database system was established to record educational provider demand for clinical placements in the community sector and this demand was offered to community health clinical placement providers who were asked if they were interested in satisfying the demand.

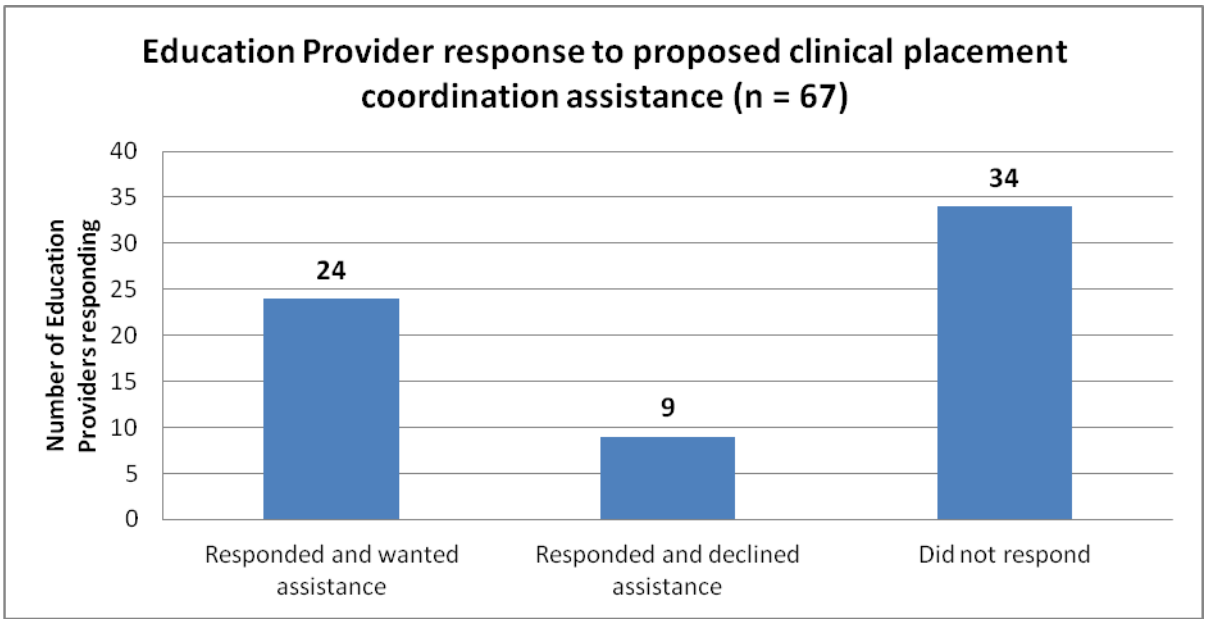


Figure 21

Demand for six disciplines: 7895 clinical placement days

Disciplines: allied health assistants and mental health workers (certificate IV) clinical psychology, exercise physiology, enrolled nursing and social work.

Absent: Monash University nursing and many other Monash University disciplines declined to participate in this process. They had ongoing, independent projects targeting their own community health clinical placement needs.

Notable: All psychology education providers indicated they had unmet demand and that their enrolment capacity is directly determined by clinical placement availability.

One education provider indicated they did not require help as some our other personnel were already doing an excellent job of assisting them source community health clinical placements. It was later clarified that these team members were in fact working on a parallel project, also funded through HWA, and the education provider, having met with the project manager on a number of occasions understood the projects to be one and the same.

As described earlier, 184 SMCPN community health organisations (from the project database of 299 potential CPPs) were identified as having a potential match according to of disciplines. Each of these organisations was emailed.

This process resulted in 43 responses (23.4%).

Successful supply/demand matches created 420 clinical placement days, providing clinical placement opportunities for 20 students across four disciplines. These disciplines included: allied health assistant, psychology, nursing (enrolled) and social work.

Some potential clinical placement providers indicated that they had capacity for which there was no demand. This disciplines included: clinical psychology, counselling (other than psychology), dietetics, occupational therapy, physiotherapy and social work. As one of the integral processes to the program was the ability to choose calendared clinical placements, it was not possible to quantify this latent clinical placement capacity.

Most respondents who indicated they did not have any clinical placement capacity left a comment. Four of these indicated it was due to other clinical placement commitments. Some of the other comments are included here:

"I am the only therapist and I work only part time."

"Organisation undergoing restructure in new year and downsizing (possible redundancy)."

"We don't have the capacity at this point as yet."

"We are a private clinic, so not sure if we qualify for community health placement. Keen to take physiotherapy students if possible."

This 5% clinical placement fill must be considered in the context that it was achieved in early December. Typically most clinical placement planning has been halted until the following February. Another aspect influencing stakeholder engagement was the short lead in time. More time would have enabled greater opportunity to introduce the process to stakeholders. Lastly, is should be noted that a significant portion of the unmet demand was for certificate II and certificate III programs that were newly commenced. They were included in the activity as this was achievable without any loss of efficiency but sit outside the proscribed project scope.

The level of completion was due in part to the simplicity of the process. Participants commented that, once in the survey, this was quick to use and they were appreciative of the ability to go back and change choices.

There were no problems due to the fact that it was multidisciplinary or because of the potential number of organisations involved.

Limitations and management strategies

The enormity of the SMCPN was an issue of significance in this project. As well as the physical size there were several layers of complexity to be negotiated. These included:

- Organisational interdependencies; whether it be facilities or personnel, community health facilities often share personnel.
- Alternative structural alignments: sometimes it is unclear when an organisation is an autonomous entity or a dependent body. This may occur within a shared physical space or across sites. This can be further complicated by organisational affiliations such as local networks of practitioners. In particular, the realignment of Divisions of General Practice into Medicare Locals in this region restricted the capacity of these groups to fully engage for a period.
- Role clarity and identifying who is the key individual to discuss clinical placement planning. Often this was a process worked through with an organisation as their perceptions and engagement with clinical placements evolved.

LGA and other organisational boundaries meant some health organisations excluded themselves from the SMCPN. Efforts were continually made to maintain stakeholder communication to clarify activity.

Difficulties in obtaining reliable or complete baseline data were encountered during this project. Data obtained by the DH in 2009 underpinned the initial scoping activities but this data lacked specificity in relation to community health and was too broad to consider replication. Other data sources such as viCPlace and placement coordinator planning data from the major health organisations were sourced to compensate.

At the onset of this project the SMCPN committee anticipated there would be a large demand for community health clinical placements, particularly in nursing. This is due in part to the commencement of Bachelor of community nursing program at Monash University but due also to other indications by various disciplines at Monash University. Several of these teams were successful in obtaining independent funding from HWA for projects aimed at creating more community health clinical placements. This created potential competition with this project and, at times, stakeholders expressed confusion regarding what was being asked of them. Wherever possible this was addressed through collaborative communication, clear branding and a preparedness to consult with stakeholders to clarify information.

The risk of duplicating other activities had a significant impact on this project. It was necessary to tailor the activity of the project to align with current DH activity/projections and/or defer some activity. There has been, and remains, a large amount of activity in relation to clinical placements occurring at local, State and National levels. In the first instance, viCProfile delayed the design of the SMCPN clinical placement provider survey as is was anticipated that it might provide a large amount of the information sought. Consultations with the DH reinforced the project team's desire that nothing should be undertaken that might duplicate or diminish the quality of their information harvesting. In this case the delay created the opportunity to concentrate on the development and submission of the CSSP proposal. Upon the release of viCProfile it was evident that this information, while generally lauded by stakeholders, did not clearly align with the immediate needs of this project. In the second instance this project was depending on the release and general availability of viCPlace for its mapping and clinical placement support functions. ViCPlace however had its own path and was therefore not available in the form or function desired. This placed significant time stress on this project and was managed by undertaking a pilot activity to examine the feasibility of a central clinical placement matching process.

It was anticipated that each phase if this project would provide the information and insight to develop subsequent phases. In particular, the SMCPN community health forum (forum 2) was intended for stakeholders to prioritise the issues in this space and suggest some strategies. Instead, the forum participants indicated that all the issues deemed significant enough to warrant addressing were too large or complex to be tackled with the resources and time available to this project. This created a vacuum with regards to the direction of the project. The counsel of the project working party and the SMCPN committee was sought. Following repeated consultations, the ideas put forward were: to have an extraordinary meeting (time did not allow for this); and to await the release of viCPlace (anticipated for early November) and support its implementation (even though its scope for implementation was still unknown). This lack of clarity from stakeholder groups created significant time pressures. With the support of Southern Health as the lead organisation for this project and in consultation with the DH, the idea of the clinical placement matching of supply and demand emerged. As stated the DH approved an amendment to the project that included a reallocation of some funding towards this activity and en extension of the timeline so that the project could conclude 31 December 2012.

Although most organisations were actively engaged in clinical placement planning activities, limited human and IT resources within some organisations, particularly the smaller ones, resulted in failure to fully engage in the process including attendance at the DH clinical placement planning.

The current strategy of mediated dialogue, while effective at demonstrating stakeholder engagement and in principle support, is inefficient and does not create systems or common ground readily accessible to clinical placement providers and education providers.

Evaluation

A mixed-method approach was taken to evaluate this project and included the following:

- Feedback and information gleaned from direct consultations with SMCPN stakeholders.
- Feedback from two stakeholder forums whereby stakeholders were informed of the SMCPN activities and provided their insights into the priority areas and strategic opportunities in the SMCPN community health sector.
- Data relating to community health clinical placements for all disciplines collated to enable an empirical comparison between the years 2012–13. Data sources included in making this comparison were:
  - Reported HWA/DH clinical placement activity for 2011–12. This was sourced by utilising the newly created viCPlace software data for comparison of clinical placement capacity and demand over the life of this project;
  - All currently available community heath clinical placement data for Alfred Health and Southern Health.

The activities of the SMCPN strategic project enabled a significant increase in the understanding of current clinical placement activity within the community setting of the SMCPN. Key elements of this increased understanding include:

- There is a great deal of goodwill across the SMCPN community health sector towards clinical placements.
- Current clinical placement arrangements are largely ad hoc, organisations would be able to increase clinical placement opportunities if an efficient manner of centralising clinical placement coordination existed.
- There is a mismatch between community clinical placement providers and education provider expectations. Addressing this would require curriculum and or registration policy change.
- Preparedness of clinicians to be a clinical supervisor is perceived by clinical placement providers and education providers as integral to the success of a clinical placement.
- A positive aspect of clinical placements in community health is that students often get a more immersive experience because the volumes of staff and clients at any one time tend to be lower.
- Education providers and clinical placement providers acknowledged the limitations created by the academic calendar and curriculum.
- Clinical placement providers possess unique insights into their local circumstances and have the same governance issues as larger organisations. Facilitation rather than allocation must be the method by which clinical placements are coordinated
- The part time nature of the community health workforce has a significant bearing on the ability to provide clinical placements particularly if the placement is a full-time model.

As a result of engagement with the community health sector, several stakeholders increased their level of engagement with clinical placements in general and/or the activities of the SMCPN. Three additional stakeholders joined the SMCPN committee as community representatives adding broader acumen in community health and mental health. Eight community health organisations were supported in participating in the DH clinical placement planning activity.

Through this engagement and the development and trial of a clinical placement supply/demand matching pilot, this project implemented strategies to address barriers to increasing clinical placement capacity in the community setting.

The target of this strategic project was to increase clinical placement capacity within the community setting of the SMCPN in 2013 by more than 20%. The lack of baseline data makes any claim approximate however it was identified that among SMCPN community health clinical placement providers that took part in the DH clinical placement planning activity, there has been a significant increase in clinical placements over the past twelve months. In addition, these organisations have declared additional clinical placement capacity that is nearly double (190%) their current commitment.

The community health clinical placement activity for the major health organisations in the SMCPN: Alfred Health and Southern Health were demonstrated to have increased by 45.9% from 2012–13 over a range of health disciplines.

The collaborative development and implementation of an agreed supervisor training program delivered to over 730 stakeholders via face-to-face workshops actively addresses one of the key barriers to creating clinical placement opportunities. This accomplishment will be sustained through the ongoing availability of this material through its online format.

A clinical placement supply/demand matching program for use by clinical placement providers and education providers was developed and piloted; this demonstrated great potential for improving communication between clinical placement providers and education providers in a manner that is flexible and efficient. This project activity identified further supply/demand matching opportunities. The emerging presence of VET students in the area was observed. The scope of this activity was limited by the time available and time of year it was conducted. A larger trial would enable a more sophisticated user interface and the ability to be more dynamically responsive.

During this project, quality interprofessional clinical learning opportunities have been identified and implemented in the form of the interdisciplinary clinical placement in an aged care setting (part of the CSSP project).

Future directions

Interest and engagement from the broad range of SMCPN stakeholders was a unique feature of this project and stems from this project's activities being clearly intent on supporting clinical placement activity. The lines of communication and relationships created will endure beyond the life of this project. In order to sustain the active interest in clinical placements there should be ongoing opportunities for initiatives with locally focused interaction.

The SMCPN stakeholder forums were rated very highly for their information and the opportunity they created for stakeholders to network. These could be conducted on a regular basis.

The clinical placement supply/demand matching program for use by clinical placement providers and education providers demonstrated great potential for improving communication between clinical placement providers and education providers in a manner that is flexible and efficient. The scope of this activity was limited by the time available. A larger trial would enable a more sophisticated user interface and the ability to be more dynamically responsive. Development of this program could possibility include an interface with or inform a subsequent evolution of viCPlace.

Latent capacity was identified, particularly for the nursing disciplines. An opportunity exists for clinical placement providers to collaborate with education providers to further explore ways in which clinical placements might better align with the undergraduate curriculum and potentially offer an integrated interprofessional approach that more closely aligns to clinical work practices.

Conclusion

This project has achieved its aims of facilitating effective and efficient usage of clinical placements within the community setting of the SMCPN. It has identified latent capacity and maximised opportunities for clinical placements for health professional students from across all disciplines.

The activities of the SMCPN strategic project enabled a significant increase in the understanding of current clinical placement activity within the community setting of the SMCPN. This understanding enabled the development and implementation of strategies to address barriers to increasing clinical placement capacity in the community setting.

This information also highlighted an array of opportunities for increasing clinical placement activity in the community health sector. Realising this latent capacity presents an additional opportunity for education providers and clinical placement providers to collaborate to align the undergraduate curriculum to community health clinical work practices and offer an integrated interprofessional approach to community health clinical placements.

As expected, one of the key barriers was supervisor preparedness. A supervisor training program was developed and delivered to over 730 stakeholders via face-to-face workshops and will be an enduring feature of this project through the online mode of training delivery.

Through a range of strategies including: various methods of stakeholder engagement, assisting stakeholders to access and participate in concomitant SMCPN activities, observing the available data on clinical placements, and piloting a clinical placement supply/demand matching program, this project was able to report an increase in community health clinical placement activity exceeding 20%. In addition to this, a large amount of unutilised capacity was also identified.

A clinical placement supply/demand matching program for use by clinical placement providers and education providers was developed and piloted; this demonstrated great potential for improving communication between clinical placement providers and education providers in a manner that is flexible and efficient. The scope of this activity was limited by the time available. A larger trial would enable a more sophisticated user interface and the ability to be more dynamically responsive.