

*Connecting education
to health care*


ClinEdq

Clinical Education and Training **Queensland**

***Output Evaluation of the
Clinical Education
Workload Management Initiative***

Young Futures

2011



*Connecting education
to health care*

ClinEdq
Clinical Education and Training **Queensland**

Research and Publication Initiative 2011

Copyright Statement



Licensed under a Creative Commons Attribution 2.5 Australia licence. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc/2.5/au>.

© State of Queensland (Queensland Health) 2011

In essence, you are free to copy, communicate and adapt the work for non-commercial purposes, as long as you attribute the authors and abide by the licence terms.

For permissions beyond the scope of this licence contact:

Mail	Intellectual Property Officer Queensland Health GPO Box 48 Brisbane QLD 4001
Email	IP_Officer@health.qld.gov.au
Phone	(07) 3234 1479

Project team

This project involved contributions from a number of people including:

Principal investigator(s)

Gretchen Young (Young Futures)
Katy O'Callaghan (Outpost Consulting)
Karen Hollands (Karen Hollands Consulting)
Rachel Healy (Rachel Healy Consulting)

Report authors

Gretchen Young (Young Futures)
Katy O'Callaghan (Outpost Consulting)
Karen Hollands (Karen Hollands Consulting)
Rachel Healy (Rachel Healy Consulting)

Project contributors

Jen Egan (ClinEdQ)

Suggested citation

Young, G., O'Callaghan, K., Hollands, K., & Healy, R. (2011). *Summary Report: Output Evaluation of the Clinical Education Workload Management Initiative*. Brisbane: Clinical Education and Training Queensland.

Funding

The work which is reported in this document was funded under the Research and Publication Initiative of Clinical Education and Training Queensland.

Further information

For further information about this work please contact Young Futures via email on gretchenyoung@optusnet.com.au



Table of contents

Executive summary	5
Introduction	5
What has happened? From inception to implementation	5
How deeply is change occurring?	6
Conclusions.....	7
Part A – Background	9
1.0 Introduction.....	9
2.0 About the Clinical Education Workload Management Initiative	9
2.1 History of the Initiative	9
2.2 Design of the Initiative	10
3.0 The output evaluation process	11
3.1 The output evaluation	11
3.2 Development of a program logic.....	12
3.3 Analysis of activity data	12
3.4 Feedback from internal and external stakeholders	13
3.5 Ethical issues.....	14
4.0 Participants in the evaluation	14
4.1 Online surveys	14
4.2 Interviews.....	15
Part B – Findings	16
1.0 Program logic	16
2.0 What has happened? Initiative inception to implementation.....	18
2.1 Allocation of resources	18
2.2 Communication about the Initiative	18
2.3 Development of agreements	19
2.4 Discipline models.....	19
2.5 Take up and governance of resources.....	22
2.6 Congruence with original Initiative intent.....	22
2.7 Change in activity	23
3.0 How deeply is change occurring?	25
3.1 Leadership	25
3.2 Organisational culture.....	26
3.3 Training and support.....	27
3.4 Workload balance.....	29
3.5 Recognition and career path	30
3.6 Quality and evidence-based education	30
3.7 Collaboration and stakeholder involvement	32
4.0 How is change being measured?.....	33
4.1 Activity data collection	33
4.2 Monitoring and feedback	33
4.3 Reviews	33
5.0 Conclusions.....	34
References	36
Appendices	37
Appendix 1 Information Sheet	37
Appendix 2 Evaluations Questions.....	38
Appendix 3 Interview Guides.....	42
Appendix 4 Output evaluation survey participants.....	48
Appendix 5 Clinical educator discipline profiles.....	51

Executive summary

Introduction

The Clinical Education Workload Management Initiative (the Initiative), which is administered by the Allied Health Clinical Education Training Unit (AHCETU), provides funding to allied health disciplines within Queensland Health (QH) to deliver support for clinical education to pre-entry students and support for new graduates.

In May 2011, Young Futures was commissioned to evaluate the achievements of the Initiative to date, including providing:

- a description of the implementation of the resource over the past two years;
- a description of observable outputs; and
- an assessment of supports and barriers to effectively and efficiently increase clinical education capacity and support to new graduates.

The methodology included:

- development of a program logic to capture the rationale behind the Initiative and the relationships between its expected outcomes. This was used to frame the evaluation questions and processes;
- analysis of activity data for pre-entry clinical education from 2008 – 2010 and new graduate support in 2010; and
- collection of feedback about the Initiative specifically, as well as pre-entry clinical education and new graduate support generally, through surveys and interviews of clinical educators employed through the Initiative, QH allied health professionals and external stakeholders.

What has happened? From inception to implementation

Funding equivalent to 139 FTE positions at HP3.5 was distributed across 16 allied health disciplines. Allocation of the resource across the disciplines was determined through negotiations between the Allied Health Governance Group and the QPSU and LHMU based on pre-entry and new graduate clinical support requirements. Statewide discipline working groups then determined the model their discipline would use to implement the resource.

The approach taken varies across disciplines. The majority of disciplines use the funding to employ designated clinical educators and/or clinical education coordinators. Most of these positions have been established at HP4 or above in recognition of the skills and expertise required for the roles. Other models that have also been implemented include those that rotate the clinical educator role and provide backfill to the professional within the role at any given time, and models that specifically focus on attracting, recruiting and supporting new graduates. Some smaller disciplines, that received relatively small funding allocations, designed innovative models to suit their unique circumstances and to enable them to gain the most from the available resource. Most disciplines have attempted to accommodate the needs of rural and remote areas in the design of their models. Even so, many disciplines recognise that non-metropolitan areas are not as well served as metropolitan areas. Twenty three per cent of clinical educators who responded to the evaluation survey indicated that 'inadequate recognition of the unique needs of rural and remote areas' is a weakness of the Initiative. However, given that each discipline had the responsibility to design and implement a model most suited to their circumstances, and individual disciplines continue to be responsible for the ongoing review of the models in place, there is the opportunity to give this issue greater attention at a discipline level.

Within their roles, some clinical educators focus on coordination and administration of clinical placements; some provide training directly to students; some support other professionals in providing clinical education; and in some disciplines promotion of the value of pre-entry clinical education and support is a key function. Most clinical educators perform a range of functions and the models are flexible enough to allow individual facilities to design the role to suit local requirements.

Overall, the resource appears to be rolling out in line with the original intent. Of those who responded to the surveys:

- nearly 70 per cent of AHPs receive support from a clinical educator;
- nearly half of clinical educators have seen a moderate to large increase in clinical education to pre-entry students over the past two years;
- more than half of clinical educators have seen a moderate to large increase in support for new graduates;
- thirty per cent of AHPs say they are providing more clinical education than they were two years ago, and 30 per cent of these people say the increase is due in part to support from designated clinical educators; and
- twenty four per cent of AHPs are providing more support to new graduates than they were two years ago. 'Improved coordination for new graduate support' and 'support from a clinical educator' are cited as the most common reasons for the increase.

The survey data also indicates that satisfaction levels in providing pre-entry clinical education and new graduate support are relatively high. Sixty per cent of those who have provided clinical education to pre-entry students in the past two years and 65 per cent of those who have supported new graduates rate their satisfaction levels in these areas as high or very high.

There have also been a number of additional benefits arising from the introduction of the clinical education resource. These benefits go beyond the original intent of the Initiative. These include:

- professionals having greater exposure to the latest thinking and research through the combined benefits of the increased presence of pre-entry students and new-graduates and better connections with universities;
- services being able to advance research projects by better using the resources of pre-entry students and new graduates;
- developing and implementing more formal and comprehensive arrangements for effectively meeting the registration requirements for new graduates within professions that require a pre-registration or intern year;
- allowing facilities to justify provision of low-demand services because providing such services meets the additional need of giving students the breadth of clinical training needed;
- giving some small disciplines an identity and governance structure within allied health which previously did not exist; and
- strengthening links within disciplines across the State.

How deeply is change occurring?

Although most clinical educators felt they were getting the support they needed from senior management and that a culture of clinical education is being encouraged from the top down, some experience challenges in advocating the importance of clinical education to those in positions more senior to them. In some instances there is a gap in communication with District Managers who may not have a direct link to AHCETU and are not always picking up on clinical education priorities. There was also a call for discipline directors to be more supportive of AHPs in relation to the additional clinical pressures generated when supervising pre-entry students or new graduates.

In many disciplines, AHPs consider that clinical education and new graduate support has been embedded in their professional culture for a long time. In others, the Initiative has played a significant role in putting clinical education at the forefront of people's minds. Of those who responded to the survey:

- eighty per cent of AHPs agreed or strongly agreed that their team values the role of providing clinical education to pre-entry students and support to new graduates;
- seventy three per cent of AHPs agreed or strongly agreed that they have a responsibility to provide clinical education to pre-entry students. Only seven per cent disagreed or strongly disagreed with this proposition; and
- sixty four per cent agreed or strongly agreed that they have a responsibility to provide support to new graduates, with only ten per cent disagreeing or strongly disagreeing.

The profile and status of clinical education as a career path or role is considered to have improved as a result of the Initiative. As yet, however, processes for recognising good practice or high achievement in this area are rarely present. The surveys indicated that 64 per cent of AHP participants think that clinical education is a recognised and valued career path.

Training for clinical supervisors is considered essential if pre-entry students are to have positive and effective clinical education experiences and capacity for clinical placements is to be increased. Ninety per cent of clinical educators who responded to the survey had received training or support in the past two years to assist them in providing clinical education to pre-entry students and support to new graduates. In contrast, only 52 per cent of AHPs had received training or support in this area in the last two years. Access to training outside metropolitan areas remains an issue. The videoconferences that have been introduced by AHCETU are strongly supported. Even so, professionals in some areas would like access to increased opportunities for face-to-face training but are limited by their travel budgets and the challenge of taking leave from departments that do not have adequate staff to provide effective cover during staff absences. Allied health professionals, clinical educators and stakeholders all identified a number of areas where they would like to see more training occur. The two skill areas most frequently identified were 'managing underperformance' and 'advanced supervision'.

There was a strong message that the introduction of the clinical education resource has taken the pressure off staff in a number of areas. Clinical education is now something that clinicians can give more focussed attention to and undertake in a more systematic way. However, a quarter of participants in the AHP survey believe their team does not have appropriate workload management processes in place to provide high quality clinical education and in some places the potential for burnout from the amount of pre-entry clinical education undertaken is still considered an issue. In some professions there is also concern about increasing numbers of allied health programs being offered by universities and the capacity to manage the associated increase in demand for pre-entry clinical education.

The Initiative has been a catalyst for significant collaborative efforts; within disciplines, between disciplines, across regions and between QH and external stakeholders, particularly universities. Formalised clinical educator networks are particularly highly valued. The relationships with universities vary widely across disciplines. There were examples of strong, mutually beneficial arrangements involving joint planning, research projects, mentoring and information sharing. In other places, however, relationships appear to be very limited, with no formal meeting processes or arrangements for ongoing collaboration. Where relationships are limited, this is clearly seen to hinder implementation of the Initiative.

About one third of the nearly 700 AHPs who participated in the evaluation are not confident in their own competence to provide pre-entry clinical education and only 56 per cent believe their knowledge about pre-entry clinical education is up-to-date and evidence-based. Now that the discipline models are in place, clinical educators have been recruited and strategies have been established to improve coordination and increase capacity, many disciplines feel they are in a position to focus more on enhancing and measuring quality. The evaluation indicated, for example, that there are currently unrealised opportunities to:

- successfully transfer clinical educator knowledge to the broader AHP workforce;
- promote the rigour of the programs and processes developed by clinical educators; and
- build a stronger research capacity into the clinical educator's role.

Conclusions

On the whole, it can be said that the Initiative has already had a positive impact on the provision of pre-entry clinical education and new graduate support. It has achieved a lot in a short time and there is support and optimism for it to continue to develop and evolve.

The main strengths of the Initiative so far have been:

- the introduction of designated clinical education resources and a statewide focus applied through AHCETU which has raised the status of pre-entry clinical education and new graduate support;
- the flexibility in the design, which has allowed each discipline to utilise the resource in a way that suits its unique needs; and

- AHCETU's central coordination, support for training and contribution to establishing and maintaining clinical educator networks. This has been of particular value to the smaller disciplines, many of which have not had a governance or support structure within allied health in the past.

Areas within the Initiative that need a greater focus as it evolves further include:

- Communication – general communication to all AHPs about the existence and intent of the Initiative; discipline-specific communication on the role of and access to the resource; and communication processes between disciplines and districts in relation to clinical education.
- Collaboration – systems to facilitate every discipline establishing comprehensive and regular collaboration and building of partnerships with external stakeholders and associated disciplines.
- Data – standardised definitions, tools and processes for collection of activity data that can be used for central, local and discipline specific planning, as well as ongoing monitoring and feedback processes that are understood and used by all disciplines and districts, including means for seeking input from students, supervisors, graduates and universities.
- Quality – actively addressing issues of quality, including measurement and reporting on quality and ensuring evidence-based rigour around programs.
- Capacity – understanding the capacity of facilities to take on additional pre-entry student placements and what additional resources are needed (e.g. staff, accommodation, infrastructure), if growth in student placements is to continue.
- Support in rural and remote areas – consideration of approaches within individual discipline models and within the Initiative generally to better support clinical educators and AHPs providing pre-entry clinical education and new graduate support in rural and remote areas.



Part A – Background

1.0 Introduction

The Allied Health Clinical Education Training Unit (AHCETU) within ClinEdQ administers the Clinical Education Workload Management Initiative (the Initiative). Through the Initiative, funding is provided to allied health disciplines within Queensland Health (QH) to provide support for clinical education to pre-entry students and support to new graduates.

Young Futures was commissioned to undertake an evaluation of the Initiative. This report forms part of that evaluation. It reports on achievements of the Initiative to date, including providing:

- a description of the implementation of the resource over the past two years;
- a description of observable outputs; and
- an assessment of supports and barriers to effectively and efficiently increase clinical education capacity and support to new graduates.

2.0 About the Clinical Education Workload Management Initiative

2.1 History of the Initiative

The 2005 Productivity Commission report on the Australian Health Workforce (Productivity Commission, 2005) emphasised the extent of workforce shortages in a number of health professions in Australia. It also identified acute needs in rural and remote areas and some specific domains of health care. It was recognised that with continuing advances in health technology, an aging population, growing community expectations and inefficiencies in funding arrangements, workforce challenges were likely to continue to grow unless significant action was taken. Education and training of the health workforce was identified as one of a number of issues requiring attention. Specific gaps were identified in the numbers of university training places available, the failure of training programs to respond to changing approaches to health care, and inadequacies in clinical training capacity.

Since this time there have been numerous responses and initiatives to begin addressing these issues at both a State and national level. They have included significant increases in university training places for many health professions; establishment of national rather than state based registration bodies for health professions; and, the introduction of national level workforce responses, initially through the National Health Workforce Taskforce, and more recently through establishing Health Workforce Australia (HWA). HWA has been charged with developing and delivering programs across four main areas, including i) workforce planning, policy and research, ii) clinical education, iii) innovation and reform of the health workforce, and iv) recruitment and retention of international health professionals. HWA is also responsible for considering the adequacy and availability of workforce data (Health Workforce Australia, 2011).

In April 2006, the Queensland Minister for Health established the Ministerial Taskforce on Clinical Education and Training in 'recognition of the growing disparity between Queensland clinical health workforce requirements and the actual numbers and skill mix of available clinical staff' (Queensland Health, 2007). During this period, Queensland was seeking increased Commonwealth Government funding for university student places, which in turn brought the challenge of providing adequate clinical placements and internships to meet the training needs of these students. With this as the backdrop, the Taskforce was mandated to consider professional pre-entry clinical training; specialist clinical training; networking clinical training; and the needs of new graduates, staff new to an area of work, and those returning to the workforce.

In relation to clinical education for pre-entry allied health professionals, the Ministerial Taskforce identified the following key issues:

- the need to increase diversity and complexity in the approaches to allied health pre-entry training;
- the need for a wide range of different requirements for pre-entry clinical training across disciplines;
- a predicted 30 per cent increase in student numbers between 2006 and 2011;
- a lack of funding for clinical training for allied health professionals embedded in the Commonwealth Grant Scheme, in contrast to pre-entry education for medicine and nursing; and
- challenges in providing adequate support to new-graduates generally, with particular issues noted for disciplines that require completion of a pre-registration intern period.

The Ministerial Taskforce also identified a number of critical areas relating to clinical education provided by Queensland Health that warranted attention. These included:

- commitment to clinical education and training;
- quality of and capacity for clinical education and training;
- coordination and integration of clinical education and training;
- funding;
- data systems supporting clinical education and training;
- collaboration and communication; and
- workforce planning.

In the context of this activity, along with a discontinuation of university clinical educator funding for the physiotherapy profession, a new enterprise bargaining process commenced for Queensland Health allied health professionals. During this enterprise bargaining process, the availability of adequate resources to meet the demands of pre-entry clinical education and new graduate support became a key negotiating point. The confluence of these processes and circumstances, in the context of the broader State and national agenda, ultimately resulted in the Clinical Education Workload Management Initiative being established as a key component of the *Health Practitioner (Queensland Health) Certified Agreement (No 1) 2007*.

2.2 Design of the Initiative

The Clinical Education Workload Management Initiative (the Initiative) funded 164 FTE positions at HP3.5 to increase the capacity of the Health Practitioner workforce to provide clinical education to pre-entry students and support to new graduates¹. Of this resource, 139 FTE was distributed among the following allied health professions (AHPs):

- Audiology
- Clinical Measurements
- Exercise Physiology
- Medical Physics
- Medical Radiation Professions
 - Breast Imaging
 - Radiation Therapy
 - Medical Imaging
 - Nuclear Medicine
- Music Therapy
- Nutrition and Dietetics
- Occupational Therapy
- Orthotics and Prosthetics
- Pharmacy
- Physiotherapy
- Podiatry
- Psychology
- Rehabilitation Engineering
- Social Work
- Speech Pathology

AHCETU facilitated decisions regarding the distribution of the resource following negotiations with relevant Unions (Queensland Public Sector Union and the Liquor Hospitality and Miscellaneous Union) and based on pre-entry and new graduate clinical support requirements.

Once the funding was distributed, each discipline developed a model and performance indicators most appropriate for responding to its pre-entry clinical education and new graduate support needs, through statewide discipline working groups. In most circumstances, this process also involved a representative of the appropriate Union (i.e. either the Queensland Public Sector Union or the Liquor Hospitality and Miscellaneous Union). Each discipline model was approved by the relevant Union and the Allied Health Governance Group prior to implementation. The Allied Health Governance Group is convened by Queensland Health's Allied Health Workforce Advice and Coordination Unit (AHWACU) and includes representation from the Directors of Allied Health across the State.

Over the past two years each discipline has commenced implementation of their model.

¹ Pre-entry students are students who have not yet completed their university training. New graduates are professionals who have completed their university training and have less than two years of experience. Professionals practising in professions that involve an intern or professional development year before gaining full registration are considered to be new graduates.

Each district provides discipline-specific reports to AHCETU twice yearly on relevant activity including: number of clinical placements offered; number of clinical placements provided; number of student days provided; and number of new graduate positions. In recent months, each discipline has been encouraged to review their model and resource distribution using a process and reporting template designed by AHCETU.

3.0 The output evaluation process

3.1 The output evaluation

AHCETU is now seeking to:

1. evaluate the achievements of the Initiative to date;
2. gain advice on a framework for evaluating the impacts of the Initiative into the future; and
3. establish recommendations regarding the skill and support requirements for clinical educators, including professionals employed within specific roles funded by the Initiative as well as AHPs who provide clinical education to pre-entry students and support to new graduates as part of their broader role.

This report addresses the first of these intentions by providing:

- a description of the implementation of the resource over the past two years, including:
 - locations;
 - consistency of roles; and
 - utilisation of resource across Queensland.
- a description of observable outputs
- advice on supports and barriers to effectively and efficiently increasing clinical education capacity and support to new graduates.

This report is written to meet the evaluation and planning needs of AHCETU and ClinEdQ. A summary of this report has also been written and will be made available to Queensland Health staff on the Queensland Health Electronic Publishing Service (QHEPS) and will also be distributed to external stakeholders by AHCETU.

Advice on objectives 2 and 3 of the evaluation - the development of an impact evaluation framework for the Initiative, and recommendations regarding the skill and support needs of clinical educators - can be found in two separate documents provided to AHCETU by Young Futures.

The output evaluation included a number of components including:

- development of a program logic which was to frame the evaluation questions and processes;
- analysis of clinical education and new graduate support activity data available from 2008 - 2010;
- collection of feedback about the Initiative from professionals employed through the Initiative;
- collection of feedback regarding issues pertinent to clinical education of pre-entry students and support of new graduates from QH AHPs and external stakeholders.

AHCETU was responsible for informing QH clinical educators, AHPs and stakeholders of the evaluation and seeking their involvement. This included distributing an information sheet about the evaluation, developed by the project team (see Appendix 1), and inviting participants to contribute to each of the evaluation components.



3.2 Development of a program logic

The first step in the evaluation process was to document how the Initiative was intended to work, using a program logic exercise. A program logic captures the *rationale* behind a program and outlines anticipated outcomes by reflecting the intended *cause-and-effect* relationships between:

- initiative inputs;
- initiative activities;
- intermediate outcomes;
- longer-term desired outcomes; and
- the Initiative's aspirational goal.

It allows program participants to work from the same plan and maintain a focus on both the big picture and the component parts.

- A draft program logic for the Initiative was developed following:
 - a review of relevant documents provided by AHCETU, including:
 - plans, briefings, and internal communications that define the Initiative's rationale and goals;
 - data on proposed and actual allocation of the clinical education resource across disciplines and locations;
 - models for utilisation of the clinical education resource developed by each profession;
 - reviews undertaken by each profession, where available; and
 - discussion with the AHCETU Director and AHCETU Manager of Pre-Entry Capacity Building Team.

This draft was refined and a final version developed through a workshop process that included a number of AHCETU staff and professionals employed in roles funded by the Initiative. The final program logic is presented on page 14.

The program logic *activities* and the first layer of the *intermediate goals* were used to inform the development evaluation questions relevant to the output evaluation. The second layer of *intermediate goals* and the *long term goals* within the program logic were used to inform evaluation questions relevant to developing an impact evaluation framework, to assess the deeper, long term achievements of the Initiative. These evaluation questions are presented in Appendix 2.

3.3 Analysis of activity data

Activity data provided by AHCETU was analysed, including:

- the change in number of student days offered and provided by each discipline and district from 2008 to 2010; and
- the number of new graduate positions provided in 2010 by each discipline and district.

Eight of the 16 disciplines provided data for 2007 and this data was collected retrospectively in 2009. It was, therefore, determined that commencing data analysis from 2008 would provide more reliable information.



3.4 Feedback from internal and external stakeholders

3.4.1 Online surveys

Surveys for three different professional groups were developed, including:

1. *Clinical educators employed through the Initiative* to contribute to building capacity in pre-entry clinical education and new-graduate support. The aim was to seek their perspectives on the Initiative, its achievements and their needs for the future in fulfilling their role;
2. *All other QH AHPs*. The aim was to seek their perspectives on issues pertinent to clinical education of pre-entry students and support of new graduate students, including their skill and support needs for contributing to this aspect of their role; and
3. *Stakeholders, including representatives from relevant Queensland and interstate universities and professional associations*. The aim was to seek their perspectives on issues pertinent to QH's clinical education of pre-entry students and support of new graduates, including their opinions on the skill and support needs of QH AHPs in this aspect of their role.

Surveying students was beyond the scope of this output evaluation.

Each of the surveys can be found at Appendix 3. The Activities and first layer of Intermediate Goals represented in the program logic (see page 14) were used to frame the questions for each of the online surveys.

The surveys were administered online through Survey Monkey². AHCETU sent an invitation and web link for the relevant surveys to potential survey participants. Recipients of this invitation were encouraged to forward the invitation to other relevant colleagues and networks. The surveys were open for a two-week period and two reminders were sent after the initial invitation.

The surveys were designed to be able to be replicated in the future, to enable long-term output evaluation and monitoring of the Initiative.

3.4.2 Interviews

AHCETU developed a list of relevant individuals for the project team to interview and notified these individuals that the project team would make contact to invite them to participate in the evaluation. AHCETU also developed a list of proxies to participate in the interviews should specific individuals not want to participate or were unavailable.

Invitations were sent to a total of 30 professionals, including:

- ten QH clinical educators representing seven different disciplines
- thirteen QH AH discipline directors and seniors representing 11 different disciplines
- five external stakeholders representing 12 different AH disciplines at five Queensland universities
- two Queensland Health AH QPSU representatives

At least one QH representative from each discipline was invited to participate.

All interviews were conducted once the online survey had closed. They were designed to expand on findings from the document review, activity reports and online surveys. All interviewees were provided with a copy of the interview questions at least two days prior to their interview. All interviews were conducted individually by telephone except for the interview with the two QPSU representatives, which was conducted as a single face-to-face interview. The interview questions are provided at Appendix 4.

² Survey Monkey is an online survey software and questionnaire tool. It has templates that can be customised, allows distribution and response by email or website, and includes tools for analysis.

3.5 Ethical issues

The evaluation was designed to maximise the confidentiality of participant involvement and the capacity for objectivity in data collection.

The online surveys did not ask participants to explicitly identify themselves. Even so, it was recognised that some participants could be readily identified by the combination of responses to some survey questions. To protect the confidentiality of participants in relation to this data a commitment was made to only attribute the information source sufficiently to allow the evaluation findings to be understood in their relevant context. For example, in some circumstances, it has not been necessary to attribute information to a specific discipline or geographic location and hence, the source has remained undisclosed. However, in other circumstances, the information was only pertinent to a specific location or profession and it has therefore been necessary to provide more details about the source. Even so, where the project team has judged that providing identifying information could negatively impact on a participant, it has been reported in an unidentifiable way.

Throughout the project, and upon the project's completion, only the project team had access to individual responses. Only aggregated, unidentifiable survey data has been discussed with or passed onto AHCETU.

In relation to the interview process, the project team made direct contact with interviewees to invite them to participate. AHCETU encouraged individuals choosing not to participate in the interviews to notify the project team rather than AHCETU to preserve their confidentiality. In which case the project team either asked the individual for an appropriate alternative representative or contacted a representative from a list of proxies provided by AHCETU.

It was recognised that project team members might be familiar with some interview participants. To minimise the potential impacts of these relationships, all interviews were scheduled between project team members and participants who were unfamiliar with each other.

4.0 Participants in the evaluation

4.1 Online surveys

4.1.1 Clinical educators

One hundred and twenty four QH clinical educators participated in the survey, and 85 per cent of participants completed all survey items. Data was not available from AHCETU to determine what proportion this represents of the total workforce employed through the Initiative.

Participants represented all but six of the 16 disciplines involved in the Initiative. Of the six professions not represented in the survey responses, two do not use their clinical education resource to employ clinical educators and one has not yet filled the clinical educator position.

For 49 per cent of participants, the primary location of their workplace was metropolitan (Metro North and Metro South Districts). A further 46 per cent of participants were located in a regional area and five per cent were located rurally.

Seventy six per cent of participants were employed primarily in a hospital context, nine per cent in a primary health care centre/community health service, five per cent in a community mental health service and one per cent within Breast Screen Queensland. A further eight per cent of participants indicated that their role was within a range of different contexts.

Forty per cent of participants were employed in a full-time capacity through the Initiative, 12 per cent at 0.8 FTE and 19 per cent at 0.5 FTE. The remaining 29 per cent of participants were employed in varying capacities ranging from 0.1 FTE to 0.7 FTE.

Details of the distribution of clinical educators by QH district are presented in Appendix 5, Table 1.



4.1.2 QH allied health professionals

At the time of conducting the online surveys, data from the Queensland Health Workforce Informatics Monthly Workforce Profile (May 2011) indicated that there were 6557 individuals employed in allied health roles within Queensland Health. This figure excludes directors, managers and team leaders employed in Health Practitioner roles who may or may not be from allied health professions relevant to the Initiative. Approximately 10 per cent (697) of this workforce contributed to the survey. Of those who commenced the survey, 79 per cent completed all survey questions.

All districts, and all but one discipline involved in the Initiative, were represented in the AHP survey. The varying representation of different professions is detailed in Appendix 5, Table 2 and the distribution of participants by the district of their primary work place is presented in Appendix 5, Table 3.

Fifty-five per cent of all participants indicated their primary geographic location was metropolitan (Metro South and Metro North Districts). Thirty-three per cent were located in regional areas, 11 per cent in rural areas and two per cent in remote locations.

A range of different workplaces were represented, including: hospitals (66 per cent); primary health care/community health care centres (16 per cent); community mental health services (nine per cent); rehabilitation centres (two per cent); Breast Screen Queensland (one per cent); residential and respite care facilities (one per cent); and a range of other facility types (five per cent).

Eighty per cent of participants were employed in a full time capacity.

4.1.3 Stakeholders

There were 26 participants in the stakeholder survey. Twenty participants completed all survey items.

Stakeholder participants represented all except one of the relevant Queensland universities. There were no responses from universities outside Queensland. Three participants represented the TAFE/Vocational Education and Training sector. Of the 16 professions involved in the Initiative, 11 were represented in stakeholder responses.

4.2 Interviews

Of the 27 interviews scheduled (for 28 individuals), 25 interviews with 26 individuals were conducted.

Twenty interviewees were from the original list provided by AHCETU. Three individuals from the list indicated they were not the most appropriate person to be interviewed and four indicated they were not available during the interview period. All provided names of other appropriate individuals to contact.

The interviews conducted included:

- nine QH AHPs representing eight different disciplines employed using the Initiative resource
- twelve QH AH discipline directors and seniors representing 10 different disciplines
- four external stakeholders representing six different AH disciplines at three Queensland universities
- two Queensland Health AH QPSU representatives

The combination of the nine interviews with AHPs employed through the Initiative resource and the 12 QH AH discipline directors and seniors ensured that each discipline involved in the Initiative was represented in the interview group.



Part B – Findings

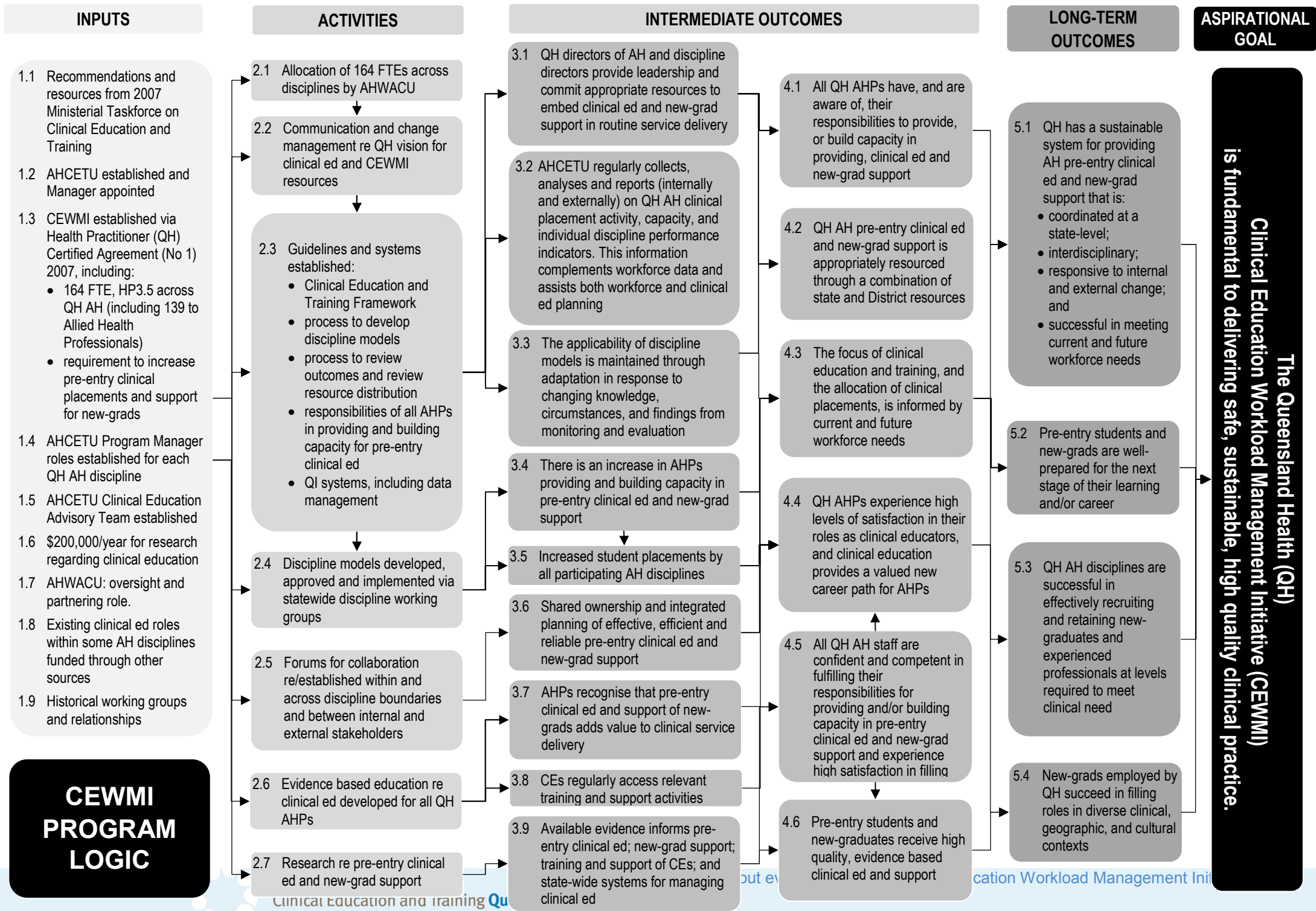
1.0 Program logic

The program logic developed in collaboration with AHCETU is presented on the following page. It includes six different levels of cause and effect relationships:

- inputs (at program commencement or at a later stage);
- Initiative activities (at program commencement or at a later stage);
- two levels of intermediate outcomes;
- long-term outcomes; and
- an aspirational goal.

The program logic served as the guide for undertaking the output evaluation, including the formulation of survey and interview questions and the analysis of evaluation findings. It was also used to develop advice to establish a framework for evaluating the long term impacts of the Initiative; and determining recommendations for the skill and support needs of clinical educators. The outcomes of these latter two processes can be found in two separate documents developed by the project team for AHCETU.





2.0 What has happened? Initiative inception to implementation

2.1 Allocation of resources

Funding of the Clinical Education Workload Management Initiative (the Initiative) through the *Health Practitioner (Queensland Health) Certified Agreement (No 1) 2007* saw the distribution equivalent of 139 FTE positions at HP3.5 across 16 allied health disciplines (see Table 1). Allocations were determined through negotiations between the Allied Health Governance Group and the QPSU and LHMU based on pre-entry and new graduate clinical support requirements.

Table 1: Allocation of clinical education resource by discipline

	HP3.5 FTE equivalent
Audiology	1.3 FTE
Clinical Measurements	2.0 FTE
Exercise Physiology	0.5 FTE
Medical Physics	1.0 FTE
Medical Radiation Professions	17.0 FTE
Music Therapy	0.5 FTE
Nutrition and Dietetics	11.0 FTE
Occupational Therapy	19 FTE
Orthotics and Prosthetics	1.6 FTE
Pharmacy	9.0 FTE
Physiotherapy	29.0 FTE
Podiatry	1.3 FTE
Psychology	15.0 FTE
Rehabilitation Engineering	0.8 FTE
Social Work	19.0 FTE
Speech Pathology	11.0 FTE

Following the allocation of resources, statewide discipline working groups determined the model they would use, including key performance indicators and the distribution of funding across districts and service sites. Details on how each discipline aimed to use their clinical education resource were set out in agreements between each discipline and the Allied Health Governance Group.

2.2 Communication about the Initiative

While all evaluation participants welcomed the injection of resources into pre-entry clinical education and new graduate support, there were very few who demonstrated any confidence in their understanding of the background and context to the Initiative or its specific goals and boundaries. Some believe the main purpose of the Initiative is to help professionals manage workloads in the face of increasing numbers of student placements. This corresponds with the Initiative's industrial beginnings. However, the workload issue is primarily a factor only for large disciplines managing large and possibly increasing numbers of students. Small disciplines see the key opportunity of the Initiative to be around workforce supply and succession planning, regardless of the Initiative's original intent.

Most people closely involved in the Initiative understand its parameters to be provision of support to pre-entry students and new graduates. However, discipline representatives highlighted that, from the outset, there had been a lack of formalised documentation providing clarity about the intent of the Initiative and its parameters. Some wondered why the focus was only on pre-entry students and new graduates, given that there is a need for clinical education across the AH workforce, and that some disciplines do not take on new graduates, and others do not provide pre-entry clinical education.

The reviewers also encountered a lack of documentation about the Initiative with regard to agreed intent and design features.

In the survey of QH AHPs, 60 per cent of the nearly 700 participants had not heard of the Initiative. This figure is similar in metropolitan and regional areas, but rises to 70 per cent for QH AHPs in rural and remote locations. This was the case despite a higher proportion of participants being aware of roles in their profession that exist to facilitate pre-entry clinical education and new graduate support. Thirty per cent of AHPs said they need a better understanding of the roles of clinical educators employed through the Initiative in order to effectively provide pre-entry clinical education and support to new graduates. This figure was consistent regardless of whether the AHPs were located in metropolitan, regional, rural, or remote areas.

2.3 Development of agreements

Despite the lack of clarity around the purpose and parameters of the Initiative, the process of developing agreements on resource allocation within disciplines was generally undertaken in a systematic and consultative way. Interview findings indicated that there were a number of instances where key external stakeholders (universities) were not included in the early planning processes. Given that an interview was not carried out with a representative from every discipline the extent of stakeholder involvement in these initial processes cannot be determined.

While the detail available in written documents varies significantly across disciplines, from talking to the people involved, there appears to have been considerable thought put into how to allocate the resources to best suit the needs of individual disciplines, and to distribute the resources both equitably and effectively across the State. Some disciplines worked quickly to get agreement, others took some time, but there is a sense from those involved that the process was managed well either way.

Discipline representatives particularly appreciated the flexibility of AHCETU in allowing disciplines to distribute the resource as they saw appropriate. A number of participants commented that AHCETU was highly supportive and accommodating during this process. The smaller disciplines were particularly appreciative of AHCETU's understanding of their unique needs. The value of this flexibility is supported by research which has found that clinical education and supervision models need to be delivered in a range of ways to cater for specific needs of a speciality area, discipline or location (Skerrett, 2004; State of Victoria, 2007).

Unfortunately, however, the agreements have not always been used as a 'living document'. Their current status is unclear, many of the documents provided to the project team are undated and unsigned, and there is no evidence that these agreements have been updated or shared with new staff to guide ongoing decision-making around the Initiative.

In terms of the allocation of resources between disciplines, some stakeholders questioned whether the allocation was fair. It was suggested that those disciplines which were already the best resourced and therefore had the greatest pre-existing internal organisation were better able to advocate for their needs and may have done better out of the distribution of the resources than others, irrespective of the relative needs of different professions. Some smaller and younger professions argued that in some respects their needs were greater than the larger professions, given the difference in their starting points.

2.4 Discipline models

The approach to using the clinical education resource varies across disciplines. The majority of disciplines used their funding to employ designated clinical educators and/or clinical education coordinators to enhance clinical education for pre-entry students and new graduate support. However, some models target pre-entry students only, and some target new graduates only. Some of the smaller disciplines, which received relatively small funding allocations, designed innovative models to suit their unique circumstances. Below, several examples of the different models being used are presented to illustrate the variety of approaches taken.

Of those disciplines that employed designated clinical educators (the vast majority), the positions have been employed in a range of different ways. Some clinical educators provide a coordination role, managing the administration of placements; some provide training directly to students; some support other professionals in providing clinical education; and in some disciplines promotion of the value of pre-entry clinical education and

support is a key role. Most people in the clinical educator position perform a combination of roles and the models are flexible enough to allow individual facilities to design the role to suit local requirements. See Table 2 below.

Table 2: Main roles performed by clinical educators

	Response per cent
Clinical education to pre-entry students within my profession	86%
Formal support to new-graduates within my profession	77%
Educating staff within my profession regarding pre-entry clinical education	63%
Educating staff in my profession regarding support for new graduates	61%
Coordinating and administering pre-entry clinical education	60%
Clinical education and support to experienced professionals working in Queensland Health for the first time	38%
Clinical education to general allied health staff within my discipline	33%

Most clinical educators work across several sites, with more than a quarter working across a number of districts, or state-wide. Disciplines with a large enough resource allocation have designed models with dedicated positions in metropolitan and regional centres across the state, and most disciplines have attempted to accommodate the needs of rural and remote areas within their models by including outreach services and/or specific functions within the roles of clinical educators that will benefit professionals across the State. There is recognition, however, that in many instances the rural and remote response has been somewhat arbitrary and that these areas are not as well served as metropolitan areas. Five per cent of clinical educators who responded to the survey are based in a rural area. In the surveys, 'inadequate recognition of the unique needs of rural and remote areas' was cited as a weakness by 23 per cent of clinical educators. Given that each discipline had the responsibility to design and implement a model most suited to their circumstances, and individual disciplines continue to be responsible for the ongoing review of the models in place, there is the opportunity to give this issue greater attention at a discipline specific level.

Appendix 6 provides more detail on how each discipline is using its clinical education resource.

Case Study 1: Clinical Measurement

Professionals in the eight subdisciplines of clinical measurement do not have a single pre-entry training program. They come to their roles from different training backgrounds and receive on the job training. It was recognised that the priority was to ensure the adequacy of training for existing professionals and the effectiveness of training of new professionals entering the subdisciplines.

Two different models were established. cardiac sciences employs 5.0 FTE HP3.1 new graduates across five major hospitals in South East Queensland. Respiratory and sleep sciences each employ 0.5 FTE HP4 clinical educators and neurophysiology sciences has a 0.4 FTE clinical educator.

Although based in metropolitan hospitals, the clinical educator roles support the entire state through the development of clinical practice standards for standardising statewide practice. They also assist in administering clinical placements, but do not have a role in providing clinical education.

In sleep sciences, the clinical educator reports to three line managers across three sites. Although this has its challenges, it ensures the role benefits all service contexts, rather just a single niche or location.



Oversight of the resource in each subdiscipline is through relevant working parties. A Clinical Measurement Advisory Group exists to develop and monitor use of the resource as a whole. This enables development of a common vision across subdisciplines and sharing of knowledge and processes. The AH CETU Clinical Measurement Program Manager plays a key role in working with clinical measurements to progress relevant issues.

Case Study 2: Pharmacy

Before the introduction of the Initiative, pharmacy already had some resources allocated for similar purposes from another source. The profession chose to bring these resources together and manage them centrally through Medication Services Queensland (MSQ). There are also a small number of FTEs managed independently within specific hospitals. The roles of clinical educators employed through MSQ are distributed across the state in metropolitan, regional and rural areas. All are focussed on supporting intern pharmacists. Where rural areas have difficulties filling positions, mechanisms have been established for pharmacists from other areas to work week-about to ensure these areas are not left without a support system.

The centralised management system and availability of the clinical educator positions, have contributed to development and implementation of the Intern Level Framework which provides a structured and consistent learning, development and support process for interns across the state.

Although use of the resource is managed through MSQ, the Pharmacy Professional Development Working Group also plays an important role in oversight, monitoring and development of systems and processes.

Case Study 3: Podiatry

Podiatry recognised a need to be innovative in using their resource allocation of 1.3 FTE HP3.5 to get the maximum benefit from it. Through the Podiatry Statewide Steering Committee, the four directors from across Queensland designed a model to support regional and metropolitan areas.

In Brisbane, negotiations with QUT enabled development of a joint 1.0 FTE HP4 position between RBWH and QUT to i) respond to a gap in pre-entry training through establishing a high risk foot clinic at QUT and ii) collaborate between QUT and QH on pre-entry course content, development of systems to coordinate clinical placement processes, and student needs. Although establishing such a model has taken time, the Podiatry Steering Committee believes this has been time well invested.

In Rockhampton, a 1.0 FTE HP3.1 new graduate position was created to free up the Director to provide pre-entry clinical education. A recent review of this model determined that the new graduate role will be changed to a 0.5 FTE HP4 clinical educator position. When a Masters program in podiatry starts at Central Queensland University in the near future there is a desire to establish a joint 1.0 FTE HP4 position between QH and CQU using a model similar to that used in Brisbane.

Use of the clinical education resource is overseen by the four QH directors of podiatry through the Podiatry Steering Committee. A Podiatry Clinical Education and Training Advisory Group has also been established which includes representation from stakeholders outside QH.

Case Study 4: Social Work

The discipline of social work identified that not enough students were taking up placements and not enough staff were providing supervision. Their model has developed slowly. Many positions have only been in place in the last 12 months and are only being made permanent in 2011. Their focus to date has been primarily on pre-entry students. The Initiative resource provided them with a HP6 program manager, three HP5 clinical education specialists and 13 HP4 clinical educators (not all full time). Each clinical education specialist is responsible for multiple districts. Their role is to develop specific portfolio areas, standardise orientation and induction handbooks and other internal process and procedure documents, draft service agreements, provide individual mentoring and professional support to the clinical educators in their districts, and help social work departments incorporate clinical education into their existing service. The clinical educators undertake student recruitment, coordinate placements, liaise with universities and establish peer-based learning opportunities for students. Departmental social workers interview students, select those suitable for placement and provide field education.

2.5 Take up and governance of resources

In almost all disciplines the clinical educator positions have been readily filled. One of the smaller disciplines reported that, due to the specialist skills required, they are still in the process of recruiting someone for the role and may need to look interstate or overseas. Another small discipline noted that because clinical education is a new role for their profession there are not many people with well-developed skills in this area, or experience that would set them up for a specific clinical education role.

While the original funding for clinical educators was based on full-time equivalent positions at HP3.5 level, most disciplines decided to set these positions at a higher level because of the skills and expertise required. Eighty-one per cent of participants in the survey are employed at HP4, 15 per cent at HP5 and only four per cent at HP3³. As a result, the resources are spread more thinly than may have originally been intended.

There is recognition amongst those involved in the Initiative that a unique combination of skills and personal attributes are required for these positions. Some interviewees questioned whether they had the best applicant pool in the first round of advertising for these jobs and whether greater clarity about the intent and parameters of the Initiative may have increased competition for the roles.

In terms of governance of the resources, AHCETU was seen by many interviewees as serving an important role in preventing the devolution of the resource to districts. Concern was expressed that if this was to occur the resources could easily be absorbed into general district operations and priorities. However, some warn that having the governance held too tightly within AHCETU also presents a risk. If the unit is lost (due to restructuring or resource rationalisation) there is potential for the entire Initiative to dissolve. The need to ensure an appropriate balance between bureaucratised central office processes and adequate resource availability on the ground was reinforced.

2.6 Congruence with original Initiative intent

Overall, the resource appears to be rolling out in line with the original intent in terms of being used to support clinical education for pre-entry students and support for new graduates.

- Nearly 70 per cent of AHPs responding to the survey now receive support from a clinical educator.
- Nearly half of clinical educators who responded to the survey have seen a moderate to large increase in clinical education to pre-entry students over the past two years.
- More than half of clinical educators who responded to the survey have seen a moderate to large increase in support for new graduates.
- Thirty per cent of AHPs who responded to the survey say they are providing more clinical education than they were two years ago, and 30 per cent of these people say the increase is due in part to the support from designated clinical educators.
- Twenty four per cent of AHPs who responded to the survey are providing more support to new graduates than they were two years ago. 'Improved coordination for new graduate support' and 'support from a clinical educator' are cited as the most common reasons for the increase.

The workload management intent of the Initiative is also being addressed, with the larger disciplines, in particular, feeling much more able to balance their responsibilities in this area with their existing workloads as a result of the additional resources. The survey data indicates that satisfaction levels in providing pre-entry clinical education and new graduate support are relatively high. Sixty per cent of those who have provided clinical education to pre-entry students in the past two years and 65 per cent of those who have supported new graduates rate their satisfaction levels in these areas as high to very high. This contrasts with anecdotal reports that there was significant dissatisfaction prior to the introduction of the Initiative due to high and increasing workload pressures. The industrial action taken by a range of AH professions, in the context of concerns about balancing the workload demands of pre-entry clinical education, client caseloads and client safety, is evidence of this previous dissatisfaction.

³ It is possible (but cannot be confirmed) that these HP3 participants were new-graduates who completed the survey based on the fact that they were filling a role funded by the Initiative.

There are, however, some deviations from the original intent of the Initiative that are worth noting:

- The support for new graduates has not received the same priority as the clinical education of pre-entry students in discipline models and implementation. Some believe this is because of the pressure to take on increasing numbers of student placements as more universities put on undergraduate programs and existing programs increase their student intakes. Managing student placements is an immediate workload issue that cannot be ignored or deferred.
- Some disciplines do not take on students at all, so they are unable to support pre-entry clinical education directly. However, in most cases they are satisfying the intended focus of improving support to new graduates. Additionally, if the overarching aim, articulated through the Initiative program logic, is to contribute to sustainable, safe and higher quality clinical practice, these disciplines are meeting this objective by raising the profile of their profession and offering scholarships and cadetships in order to attract a sustainable stream of high quality new graduates.

There have also been a number of added benefits of the introduction of the resource. These benefits go beyond the original intent of the Initiative. Discipline representatives cited the following:

- Allowing professionals to keep up with the latest thinking and research through the increased presence of pre-entry students and new-graduates and better connections with universities.
- Allowing services to progress research projects of interest by better using the resources of pre-entry students and new graduates.
- Using the Initiative to implement formal arrangements to meet registration requirements for new graduates.
- Allowing facilities to justify the provision of low-demand services to their communities because they serve the dual purpose of giving students the breadth of clinical skills they need, as well as assisting clients in need.
- Giving some small disciplines an identity and governance structure within allied health which previously did not exist.
- Strengthening links within disciplines across the State.

Innovative practice... “Added benefits”

In Townsville, the speech pathology clinical educator runs sessional clinics for clients with needs that are less frequently seen. Clients with these needs would not typically have access to services locally due to low demand. Up to four students participate in the clinics at a time. The clinical education resource enables multiple needs to be met:

- Clients with less common conditions can see a local speech pathologist;
- Students have the opportunity to gain specific skills without travelling long distances; and
- The clinical educator has an opportunity to practice clinical skills that many clinicians may not have the chance to.

2.7 Change in activity

The introduction of the clinical education resource has occurred in tandem with increases (in some cases significant increases) in the numbers of days of pre-entry clinical education provided. The activity reports provided to AH CETU by districts clearly demonstrate growth.

As shown in Table 3 below, the most dramatic increases in the number of days of pre-entry clinical education provided have occurred in the large disciplines of pharmacy, psychology, the medical radiation professions and social work.

Three small disciplines have not seen increases in pre-entry clinical education. It should be recognised, however, that for a small profession, a significant proportionate increase or decrease in activity could arise out

of seemingly small changes in the work environment, such as a single position being vacant for a period of time or an increase in staffing.

It is important to acknowledge also that variables other than the clinical education resource may have influenced the outcomes presented. For example, the pharmacy model only uses the clinical education resource to support new-graduates, and yet, data indicates an increase of over 1,000 per cent in the number of days of pre-entry clinical education provided from 2008 to 2010. This increase could be due to unrelated efforts or to data collection issues. Some districts may not have started collecting data until 2010.

Table 3: Change in student placement days 2008 to 2010 by discipline

	Student days provided 2008	Student days provided 2009	Student days provided 2010	% change from 2008 (or 2009 if 0 in 2008)
Audiology	0	264	301	14%
Clinical Measurements	1,827	2,340	2,983	63%
Exercise Physiology	356	617	952	167%
Medical Physics	0	0	0	0%
Medical Radiation Professions	4,973	4,150	15,706	216%
Music Therapy	432	295	406	-6%
Nutrition and Dietetics	3,544	10,065	9,493	168%
Occupational Therapy	9,302	14,127	14,392	55%
Orthotics and Prosthetics	171	105	129	-25%
Pharmacy	0	247	3,118	1,162%
Physiotherapy	12,740	21,665	22,321	75%
Podiatry	0	321	335	4%
Psychology	0	2,286	8,647	278%
Rehabilitation Engineering	0	45	24	-47%
Social Work	0	4,111	12,848	213%
Speech Pathology	3,219	6,201	5,103	59%

The districts that have achieved the greatest increases in the number of days of pre-entry clinical education are Mt Isa, Central Queensland, the Sunshine Coast and Metro North (excluding RBWH). The only district that experienced a decrease in days of pre-entry clinical education was South West, where 18 per cent fewer days were provided in 2010 than in 2009. However, this is not significant. Given the small numbers in the South West, the 18 per cent change is equivalent to about two student placements. See Table 4 below.



Table 4: Change in student placement days 2008 to 2010 by QH district

	Student days provided 2008	Student days provided 2009	Student days provided 2010	% change from 2008 (or 2009 if 0 in 2008)
Cairns and Hinterland	2,407	3,794	4,452	85%
Cape York	0	0	0	0%
Central Queensland	912	2,463	3,547	289%
Central West	0	220	340	55%
Children's Health	1,353	2,453	3,910	189%
Darling Downs - West Moreton	3,923	5,705	10,070	157%
Gold Coast	2,983	4,727	7,420	149%
Mackay	792	1,111	1,791	126%
Mater Health Services	2,599	4,195	6,770	160%
Metro North (excluding RBWH)	2,621	7,092	10,888	315%
Metro South (excluding PAH)	4,246	6,939	8,598	102%
Mt Isa	117	320	575	391%
PAH	4,479	5,603	5,650	26%
RBWH	5,360	7,698	12,409	132%
South West	0	262	215	-18%
Sunshine Coast – Wide Bay	1,397	3,871	6,801	387%
Torres Strait and Northern Peninsula	0	0	0	0%
Townsville	3,132	6,003	7,599	143%

Data collection for new graduate positions began in 2010. As a result it is not possible to make an assessment of change in activity resulting from the introduction of the Initiative and therefore this data is not included in this output report.

3.0 How deeply is change occurring?

3.1 Leadership

The importance of leadership in the area of pre-entry clinical education and new graduate support was a strong theme in discussions. Those involved in the Initiative believe it is critical for discipline directors and directors of allied health to provide support to clinical educators in their roles and to set the culture and expectations for all staff in the area of pre-entry clinical education and supervision of graduates.

On the whole, clinical educators felt they were getting the support they needed from senior management and that a culture of clinical education is being encouraged from the top down. Pre-entry clinical education is a standing agenda item at many discipline meetings, AHP staff are usually being granted approval and time to undertake training and are encouraged to take on pre-entry students. Forty-five per cent of clinical educators who responded to the survey said they received training or support from their profession senior and/or the Director of Allied Health. One Director offers a reward program for staff who become involved in clinical education.

Experts advocate the use of rewards for supervisors of students, including financial incentives (cash or payment for professional development opportunities), luncheons, journal subscriptions, support groups, field educator of the year awards, and letters of commendation. Material and non-material benefits have been found to promote commitment to the supervisory role, with the non-material benefits considered of greater relative importance (Speers, Strzyzweski & Ziolkowski, 2004).

There were scattered examples where leadership of the Initiative was seen as inadequate. Approximately 7 per cent of AHPs whose departments do not provide clinical education felt this was at least partly due to



inadequate support from senior management. Twelve per cent said it was because they were not supported to balance their workload. Twenty-two per cent of AHPs felt there was a need for better recognition by management of the value of pre-entry clinical education and new graduate support.

A number of interviewees spoke of the challenges they experience as HP4s in advocating regarding the importance of clinical education to those in positions more senior to them. One clinical educator spoke about other clinical educators leaving their roles because they felt powerless to influence senior managers who hold the power to open doors for effectively fulfilling the expectations of their roles. There was also a call for discipline directors to be more supportive in relation to the additional clinical pressures generated when supervising pre-entry students or new graduates. The surveys indicate that support from leadership to take time out to attend training emerged as a problem for some individuals. Eleven per cent of survey participants said they had not undertaken any training in relation to clinical education because they were not supported by senior management or their discipline director to do so.

AHCETU is seen as playing a strong leadership role in the area of training and support. The presence of a structure around clinical education has enhanced the status of this function with management, which in turn has been reflected in expectations of staff. Fifty-five per cent of clinical educators who responded to the survey believe that the centralised management and coordination of the clinical education resource by AHCETU is a strength of the Initiative.

One systemic issue emerged in relation to leadership. While AHPs are receiving messages about the importance and value of clinical education through their discipline directors, in some instances there is a gap in communication with District Managers. District Managers (or other relevant senior managers) may not have a direct link to AHCETU and in some instances are recognising clinical education priorities. As a result, staff can receive mixed messages or gaps in information flow can occur. As an example, during the interviews it was identified that one small discipline did not receive their annual clinical education resource funding when it was transferred to the district. The district administrators were not aware that this discipline was eligible for the funding because the profession does not use the money to fund designated clinical educators. There were other instances where discipline directors were limited in their capacity to service their area because they were not able to access funding for clinical education costs beyond the FTE allocation, such as for travel.

3.2 Organisational culture

A supportive organisational culture is a critical success factor of clinical education programs. Students have been shown to be much more positive about their clinical education experience when they have perceived the organisation's management and other staff, within and across disciplines, to be enthusiastic about providing a learning environment for them (State of Victoria, 2007; Walker & Grosjean, 2010).

In many disciplines, AHPs consider that clinical education and new graduate support has been embedded in their professional culture for a long time. In others, the Initiative has played a significant role in putting clinical education at the forefront of people's minds and advancing this function as an important role that needs to be undertaken.

The data available from this output evaluation does not tell us whether organisational culture in relation to clinical education has improved in the last two years, but the current situation looks positive:

- eighty per cent of AHPs who responded to the survey agree or strongly agree that their team values the role of providing clinical education to pre-entry students and support to new graduates.
- seventy three per cent of AHPs who responded to the survey agree or strongly agree that they have a responsibility to provide clinical education to pre-entry students. Only seven per cent disagree or strongly disagree with this proposition.
- sixty four per cent agree or strongly agree that they have a responsibility to provide support to new graduates, with only ten per cent disagreeing or strongly disagreeing.

The project team heard reports that in some disciplines Queensland Health is now considered to be a highly attractive employer by interstate professionals due to the investment in and value placed on clinical education which in turn is interpreted as a valuing of the profession itself.



The remaining sense of unwillingness around clinical education by some is attributed to views that:

1. clinical education is the responsibility of universities;
2. resources are still not sufficient to meet the additional workload demands; and
3. not everyone has the professional or personal strengths and qualities required to be a good educator as well as being a good clinician.

In relation to this last point, the literature suggests that the desire and willingness to be a supervisor is an important attribute for supervisors (Speers, Strzyzweski & Ziolkowski 2004). But, the project team also heard that this perspective 'should not be a cop-out' for those who are less inclined to participate in these roles. It was suggested that some may hold this position in the absence of appropriate training, adequate support and positive experiences. If these opportunities and experiences are provided, initially reluctant professionals may be more likely to build confidence, interest and capacity to contribute effectively to pre-entry clinical education.

One stakeholder made a related point stating that it was not necessarily cultural change that was needed – but experiential change. If people experience less pressure and start having positive experiences in providing pre-entry clinical education and new graduate support, they will be more inclined to want to contribute to others' learning. Where this is starting to be achieved, this was thought to be because of the workload relief provided by the clinical education resource.

Innovative practice.... “Managing up”

Exercise physiology had trouble attracting students and graduates because they do not have their own dedicated discipline management structure to negotiate with universities and districts. They realised they needed to promote their discipline internally to get needed growth within the discipline.

As well as providing a centralised student placement arrangement, the clinical education resource was used to generate awareness of the discipline at a higher level so that it is considered in workforce planning and funding.

3.3 Training and support

Training for supervisors is considered essential if students are to have positive clinical education experiences and capacity for clinical placements is to be increased. Training leads to supervisors feeling better prepared for their role and better able to manage challenging learners, a concern frequently raised by supervisors and an area in which they often request support (Speers, Strzyzweski & Ziolkowski, 2004). Training has been found to not only improve the confidence of supervisors, but also prompt new supervisors to volunteer (State of Victoria, 2007).

Ninety per cent of clinical educators who responded to the survey had received training or support in the past two years to assist them in providing clinical education to pre-entry students and support to new graduates. This was in contrast to AHPs, where only 52 per cent of participants had received training or support in this area the last two years. This figure presents some concerns if considered in light of feedback from one stakeholder that all supervisors should have initial supervisor training and a refresher every year. But it is probably not surprising. Canadian research found that allied health supervisors often had minimal formal training in education or teaching and the approach they adopted tended to be based on their own experiences and preferences (Walker & Grosjean 2010). Nevertheless, students expect their supervisor to have appropriate skills. Research has found:

"Proper preparation of a (clinical supervisor) is one of the most important factors related to the success of the (clinical education) experience, yet most do not feel adequately prepared for their role, particularly in the areas of teaching and evaluating" (Yonge, Myrick, Ferguson & Lughana 2005).

Overall, 99 per cent of clinical educators who responded to the survey believed the training they have received in the past two years has significantly improved their ability to provide effective support for clinical education to pre-entry students and support to new graduates. In contrast to the clinical educators, only a third of AHP participants expressed the opinion that the training and support they have received has contributed

significantly to their effectiveness in these roles. This implies that, in relation to AHP skill development in pre-entry clinical education, the impact of the clinical education resource provided through the Initiative is not yet benefiting all professionals.

AHCETU has introduced a range of training and support opportunities relevant to pre-entry clinical education and new graduate support. Many of these sessions have been delivered in multiple locations to improve access to training for regional and rural areas. These include:

- annual clinical educators interprofessional forums – provides professional development workshops as well as networking opportunities;
- annual interprofessional forums for clinical educators that provide professional development workshops as well as networking opportunities;
- annual discipline specific clinical educator forum;
- Teaching on the Run training;
- videoconference series addressing a range of topics;
- advanced clinical educator workshops;
- intranet site with resources; and
- provision of post graduate scholarships focussed on clinical education.

Survey findings indicated that 63 per cent of clinical educators and 20 per cent of AHP participants had accessed AHCETU training in the last two years. The training and support provided by AHCETU was highly regarded by interviewees.

A number of professions reported being able to access introductory and advanced training about pre-entry clinical education from universities. Thirty-seven per cent of clinical educators and 26 per cent of AHPs survey participants had received such training from universities.

AHP participants in metropolitan, regional and rural areas indicated they access training and support to a similar extent. Even so, 53 per cent, 48 per cent, and 58 per cent, respectively, had not accessed training in the previous two years. This figure was substantially higher for AHP participants in remote areas, where 73 per cent had not accessed training in the previous two years.

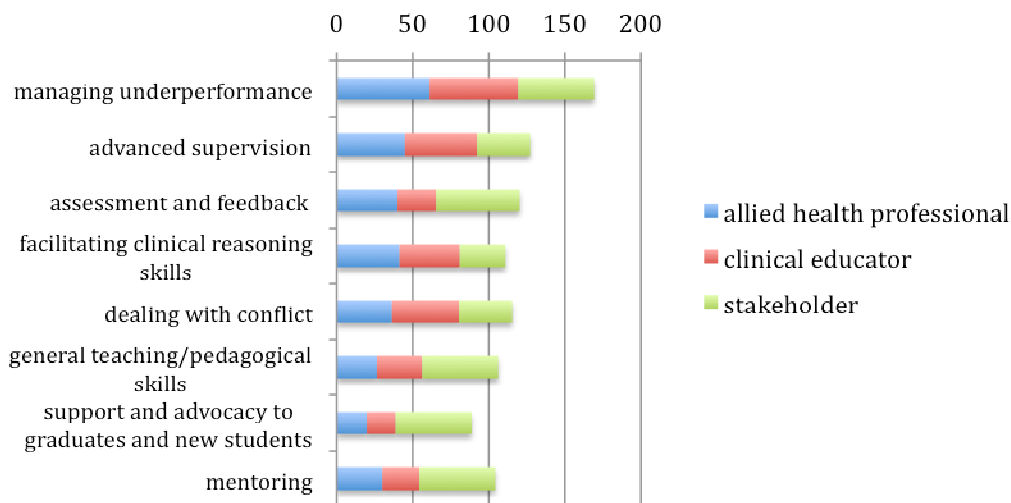
Despite the similar patterns of access to training for metropolitan, regional and rural AHPs, interview findings indicated that training access for professionals outside metropolitan areas remains an issue. The introduction of videoconferences by AHCETU is strongly supported. Even so, professionals in some areas would like access to increased opportunities for face-to-face training but are limited by their travel budgets and the challenge of taking leave from departments that do not have adequate staff to provide effective cover during staff absences. Universities do not routinely offer such training outside of their main faculty location (e.g. Brisbane, Gold Coast, Townsville, etc.). One interviewee suggested that universities should collaborate to ensure that training regarding pre-entry clinical education is coordinated and provided across the State.

The other key barrier to accessing training and support that was cited in the survey responses was inadequate time. Seventeen per cent of AHP participants said that this was why they had not accessed training.

Participants in all three surveys identified a range of skill gaps that need to be taken into account when developing training programs. The most significant gaps are displayed in Chart 1 below. The figures may be reflective of the relative importance of different skills for different groups involved in the Initiative. All groups agreed that Queensland Health staff needed greater skill development in managing underperformance. (Note that all stakeholder responses except two were from universities).



Chart 1: Perceptions of skill needs in relation to clinical education and new graduate support



Survey responses from over a third of clinical educators and AHPs cited infrastructure as an area where more support is needed. The interviews revealed that a significant barrier to taking on pre-entry students and new graduates was office accommodation and access to computers. A number of clinical educators and discipline directors interviewed indicated that they can not take on any more students because there is insufficient space at their facility.

Another barrier identified by a number of interviewees was the availability and stability of supervisory staff. People organising placements have trouble planning around leave arrangements and staff movements.

3.4 Workload balance

The supervisor's job satisfaction can have a very significant affect on the success of the learner (Barrett & Myrick, 1998 cited in Speers, Strzyzweski & Ziolkowski, 2004). Thus, in addition to training, supervisors need to feel well supported.

There is a strong message that the introduction of the clinical education resource has taken the pressure off staff in a number of areas. Clinical education is now something that clinicians can give more focussed attention to and undertake in a more systematic way.

However, burnout from the amount of pre-entry clinical education undertaken is still considered an issue in some places. There is research to support this view which suggests that this risk needs to be recognized and strategies put in place to avoid or deal with such a situation should it arise (Speers, Strzyzweski & Ziolkowski 2004). Some disciplines (as a whole) or discipline directors within individual workplaces mitigate this risk by rotating responsibility for providing clinical education amongst their staff.

A quarter of participants in the AHP survey believe their team does not have appropriate workload management processes in place to provide high quality clinical education. This compares to 44 per cent who believe appropriate processes are in place. Similar figures were found with regard to AHPs' perceptions of workload management processes to support new graduates. Clinical educator participants were more positive, with about 61 per cent believing appropriate workload management processes are in place.

Representatives from some of the larger disciplines expressed anxiety about increasing pressure to take on students as a result of the Health Workforce Australia initiative which aims to increase supply of clinical education and is due to begin in 2013. Concern was expressed that QH facilities have already reached saturation point and these larger disciplines are unsure how any further increase could be accommodated. There was an acceptance that new models would need to be developed. Universities see significant potential for new models that can increase capacity as well as allowing students to enhance service delivery. There were also words of caution in this regard. Some of the models that have been trialled, aimed at increasing

throughput of students, were not viewed favourably. One experience of 'peer learning', for example, caused additional stress for supervisors because students competed with each other for learning opportunities, rather than supporting each other.

Some interviewees consider that the effort going into training students needs to be planned more strategically. Concern was expressed that increasing numbers of universities are commencing new allied health courses, which require student placements. This is occurring without sufficient consideration of the longer-term impact on QH AHPs' ability to provide clinical education. Even though Queensland Health is not solely responsible for student placements or employment of graduates, practitioners are feeling the pressure. The project team repeatedly heard concerns about students being trained for jobs that do not exist, even though there is community need for new positions to be created. The surveys revealed that only half of AHP participants believe that current planning for the provision of pre-entry student placements and graduate support takes account of current and future workforce needs.

3.5 Recognition and career path

The profile and status of clinical education as a career is considered to have improved as a result of the Initiative. Interviewees believe that more people are considering clinical education as a legitimate career path. Some people divert into a clinical education role to acquire a broader set of skills as they progress through the HP levels and some see clinical education as a specialist area of focus in its own right. The reviewers heard that in a number of disciplines the designated clinical educator positions are in strong demand, with early career clinicians seeing the positions as something to aspire to.

As noted above, discipline directors and directors of allied health are generally helping to raise the status of clinical education amongst clinicians. As yet, however, recognition processes for good practice or high achievement in this area are rarely applied. A couple of instances of reward arrangements are just beginning in some districts, in disciplines including social work and medical imaging.

The surveys indicated that 64 per cent of AHP participants think that clinical education is a recognised and valued career path, while just over ten per cent think it is not. Clinical educators themselves are slightly less positive with 53 per cent thinking clinical education is a recognised and valued career path and 21 per cent thinking it is not.

3.6 Quality and evidence-based education

The literature indicates a number of factors that are critical to the quality of a clinical education training program, including: educators' level of clinical experience, teaching skills, preparation and willingness for the role; attitudes towards students; recognition of educators' commitment to the role; fair distribution of workload, provision of adequate physical infrastructure to support clinical education, and, student exposure to a range and breadth of experiences (Speers, Strzyweski & Ziolkowski, 2004; State of Victoria, 2007; Walker & Grosjean, 2010).

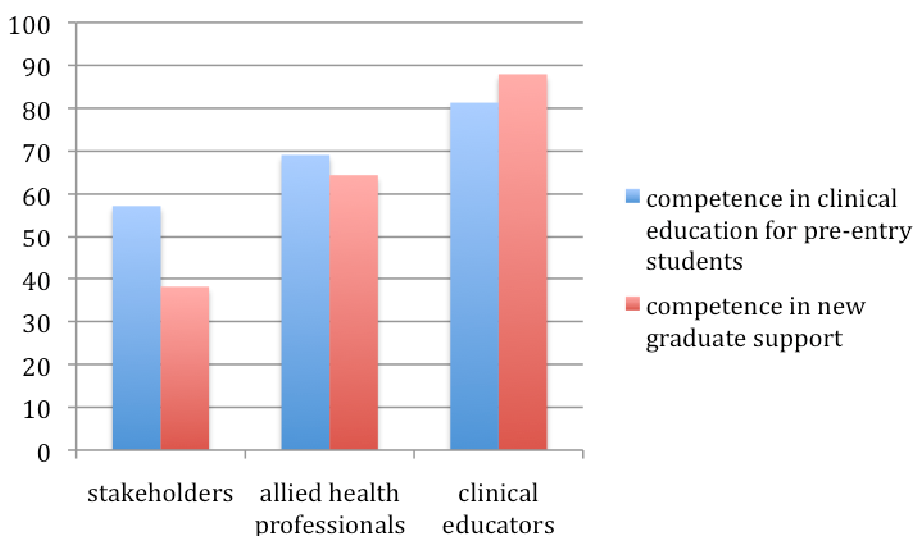
There is recognition that the first couple of years of the Initiative's implementation have focussed on determining and refining models, recruiting to people to the clinical educator and new graduate support positions and establishing strategies to improve coordination of and increase capacity to provide pre-entry clinical education and new graduate support.

Many disciplines feel they are now in a position to put a much stronger focus on mechanisms to both enhance and measure quality. That is not to say that quality improvement activities have not been occurring in parallel with increases in activity. In fact, several discipline representatives told the project team that QH is being seen by students as a preferred employer due to the quality of their pre-entry and new graduate clinical education experiences. However, there is more room for improvement in this area and an explicit interest has been expressed to pursue this more proactively.

Some disciplines, including audiology and speech pathology have formally agreed that it is time to focus on the quality of education and support and have introduced new key performance measures to reflect this. One stakeholder made the point that formalising quality processes is now more important than ever because of the sheer numbers of students involved - 'it is harder to contain the experience'.

In perceptions of competence in providing pre-entry clinical education and support to new graduates, 89 per cent of clinical educators felt that they were competent. A smaller proportion of AHP participants considered themselves competent, with 69 per cent indicating they are competent in providing pre-entry clinical education and 63 per cent indicating they are competent in providing new graduate support. The lowest level of assessment of competence came from stakeholder participants. Fifty-seven per cent indicated QH AHPs are competent in providing pre-entry clinical education and 38 per cent said QH staff were competent in providing new graduate support (note that 20 per cent of stakeholders said they did not know whether QH staff were competent in providing new graduate support). See Chart 2 below.

Chart 2: AHP and clinical educator perceptions of their own competence and stakeholder perceptions of QH staff competence in providing pre-entry clinical education and new graduate support



Clinical educators use information gleaned from the following sources to shape the pre-entry clinical education and new graduate support programs:

- sharing of good practice through clinical educator networks at local and state levels;
- sharing of research through collaborations with universities;
- attendance at conferences; and
- attendance at workshops provided by AHCETU.

Some disciplines have accessed additional resources from AHCETU to undertake specific research projects in relation to clinical education or new graduate support. Some have published articles and made conference presentations to share their learnings gained through application of the clinical education resource.

Innovative Practice... “Evidence based training and support”

Pharmacy partnered with Medication Services Queensland to combine resources and establish a clinical education model for supporting pharmacy interns. One component of this model involved development of the ‘Intern Level Framework’ that provides a formalised and comprehensive system of training and support. The framework was modeled on an international, evidence-based approach to training and skill development. Medication Services Queensland facilitates the overall implementation of the Framework and the clinical educators support its implementation at a local level. The Framework is now being adapted for use nationally.

Despite these activities, only 56 per cent of AHPs believe their knowledge in relation to clinical education is up-to-date and evidence-based. Many stakeholders hold a similar opinion with only 38 per cent thinking that



the models of clinical education used by QH are up-to-date and evidence based. These views contrast with the views of clinical educators themselves, 81 per cent of whom believe their skills are current and evidence based.

Only 27 per cent of clinical educator participants say they undertake research around clinical education as part of their role and 19 per cent say they undertake research around new graduate support.

These statistics indicate that there are currently unrealised opportunities to:

- successfully transfer clinical educator knowledge to the broader workforce;
- promote the rigour of the programs and processes developed by clinical educators; and
- build a stronger research capacity into the clinical educator's role.

3.7 Collaboration and stakeholder involvement

In many instances the Initiative has been a catalyst for significant collaborative efforts, within disciplines, between disciplines, across regions and between QH and external stakeholders, particularly universities. The clinical educator survey revealed that building shared ownership and responsibility for clinical education is seen to be a strength of the Initiative by 40 per cent of participants and opportunities to learn from and collaborate with other professions was seen as a strength by 52 per cent of participants.

Most disciplines have set up steering committees or advisory groups to oversee implementation of the clinical education resource. Many disciplines have Clinical Education and Training Advisory Groups (CETAGs) which meet regularly (usually once a month by teleconference and face-to-face once or twice a year) to share best practice and resources around clinical education and training broadly. Since the Initiative was established, these groups have taken a strong interest in pre-entry clinical education new graduate support and monitor progress with the Initiative. The AHCETU Program Managers have been instrumental in establishing and maintaining these groups.

Networking and sharing is also occurring across disciplines. The clinical educator survey indicated that 17 per cent of clinical educator participants provide clinical education to students in other professions and about 10 per cent educate staff in other allied health professions regarding clinical education and/or new graduate support. Interviewees advised that, at the local level, clinical educators often get together to share resources. In some places, clinical educators share office space in order to explicitly promote cross-fertilisation of ideas. Some facilities provide interdisciplinary training sessions for staff.

The relationships with universities vary widely across disciplines. In some disciplines the universities have been involved since the Initiative began and university representatives contribute to the way the resource is used. There were examples of strong, mutually beneficial arrangements whereby universities provide mentoring and information sharing about clinical education, and in return QH clinical educators help in designing and presenting university courses, including through adjunct lecturer positions. Joint research projects around clinical education have also been established in some disciplines. In other places, relationships with universities are very poor, with no formal meeting processes or arrangements for collaboration. This is clearly seen to be a limitation of the Initiative in these circumstances. Through the interview process some university stakeholders described the current arrangements as being less effective than they were prior to the introduction of the Initiative. The stakeholder survey data backs this up, with half of those surveyed saying that better communication and liaison with universities is needed.

The evaluation revealed the occasional example of collaboration with external stakeholders other than universities. Some disciplines collaborate with professional associations to ensure clinical education meets their requirements. One discipline collaborates with private sector clinicians by providing learning experiences for their new graduates that are only available in QH facilities.

The QPSU indicated that in most, but not all, instances, a Union representative had been involved in the development of each of the discipline models. Some concern was expressed, however, that there had been far less involvement from Union representatives in the discipline reviews that had recently been undertaken by a number of disciplines.



Innovative practice... “Local-level collaboration”

At Toowoomba Hospital, all Clinical Education Coordinators for the allied health disciplines are co-located. Because they all sit in the same office it is easier to jointly develop generic tutorials, share delivery of training to ease each other’s workload and, importantly, facilitate improved knowledge of other disciplines.

4.0 How is change being measured?

4.1 Activity data collection

All disciplines appear to be collecting data to provide to AHCETU in order to monitor progress with the Initiative but many are not confident in the quality of the data. Some said the data definitions were unclear and some admitted that they only provide the data to demonstrate that they are meeting requirements. They do not have much faith in the accuracy of the data.

A number of discipline representatives indicated that they would like to get feedback from AHCETU on the data they provide. They reported that data is sent to AHCETU from their district and they do not get to see the state-wide trends for their discipline. AHCETU advises that the data is uploaded on QHEPS for all staff to view and practitioners are advised of this through newsletters. The issue may be related to communication or it may be that disciplines would engage better if the data is synthesised and analysed so that key trends are highlighted.

Overall, the sense was that data collection and reporting on the Initiative needs to be improved. It needs to be:

- based on standardised, agreed definitions;
- systematically collected;
- centrally analysed with the results fed back to disciplines; and
- better linked to workforce planning.

4.2 Monitoring and feedback

Most disciplines said they seek feedback from students through surveys at the end of placements to find out how the placement suited their needs and how it could be improved. A smaller number survey staff and new graduates about their experience of supervision or support. Feedback is used to improve their programs and has been found to improve quality. There was little evidence of any formal feedback processes occurring with universities, apart from through their involvement in Initiative governance committees in some disciplines.

Innovative practice... “Acting on student feedback”

When they finish their placement, the students at one university write to the hospital which supervised their placement to thank them for the opportunity. But this is not simply a thank you letter. The students reflect on what they learnt and note what worked well in their placement and how their placement could have been improved.

These letters are reviewed by the clinical educator and used to improve student placements.

There was strong support for better and more formalised and standardised student and staff feedback processes. In most instances, where feedback processes are in place, they are initiated and managed within individual disciplines, at a local level using their own processes and surveys, limiting the opportunity for systematic, state-wide analysis and quality improvement.

4.3 Reviews

About half of the disciplines had formally reviewed the models in place for use of their clinical education resource. Some representatives had not considered carrying out a review and some felt it was too soon to do so as they were still in the early stages of implementation.

The reviews usually involved a process of bringing together the key stakeholders in the Initiative (clinical educators, discipline directors, AHCETU program managers and, in some cases, universities) and discussing what the clinical education resource had achieved and how it could be improved.

The reviews seem to have led to 'tweaking' rather than any wholesale changes at this stage. The types of changes made include reallocating clinical educator time across districts or facilities, changing the key performance measures to better reflect quality, and adjusting processes to improve effectiveness. There was strong support for regular reviews of the Initiative. However, the point was made that it is very hard to move resources around to better meet different geographical needs once people have been appointed into roles.

5.0 Conclusions

To what extent has the Initiative contributed to safer, more sustainable and higher quality clinical practice?

On the whole, it can be said that the Initiative has already had a positive impact on the provision of pre-entry clinical education and new graduate support. It has achieved a lot in a short time and there is support and optimism for it to continue to develop and evolve.

There are significant variations across disciplines in terms of the depth and breadth of implementation to date. This should not be seen as a weakness of the Initiative, or of the efforts of individual disciplines. It simply presents a challenge in terms of central monitoring and evaluation. This evaluation takes an overarching perspective, providing a broad view on progress and challenges.

The main strengths of the Initiative so far have been:

- The designated positions and statewide focus applied through AHCETU which has raised the status of pre-entry clinical education and new graduate support.
- The flexibility in the design, which has allowed each discipline to implement the resource in a way that suits its unique needs.
- AHCETU's central coordination, support for training and contribution to establishing and maintaining clinical educator networks. This has been of particular value to the smaller disciplines, many of which have not had a governance or support structure within allied health in the past.

Areas within the Initiative that need a greater focus as it evolves further include:

- Communication – general communication to all AHPs about the existence and intent of the Initiative; discipline-specific communication on the role of and access to the resource; and communication processes between disciplines and districts in relation to clinical education.
- Collaboration – comprehensive and regular collaboration and building of partnerships with external stakeholders and associated disciplines and systems to facilitate this in every discipline.
- Data – standardised definitions, tools and processes for collection of activity data that can be used for central, local and discipline specific planning, and ongoing monitoring and feedback processes that are understood and used by all disciplines and districts, including means for seeking input from students, supervisors, graduates and universities.
- Quality – actively addressing issues of quality, including measurement and reporting on quality and ensuring evidence-based rigour around programs.
- Capacity – understanding the capacity of facilities to take on additional pre-entry student placements and what additional resources (e.g. staff, accommodation, infrastructure), if growth in student placements is to continue.
- Support in rural and remote areas – consideration of approaches within individual discipline models and within the Initiative generally to better support clinical educators and AHPs providing pre-entry clinical education and new graduate support in rural and remote areas.



Reflecting back on the areas for attention highlighted by the Ministerial Taskforce in 2006, there is no doubt the Clinical Education Workload Management Initiative has contributed positively to addressing many of the issues raised. This is particularly the case in relation to building commitment to providing pre-entry clinical education and new graduate support and improving both funding and coordination of clinical education. But, in the words of one stakeholder, “the Initiative needs to be seen as a beginning, not an end point”. There is ongoing work to do to evolve and develop the model to fully embed it in QH workforce planning systems and processes and make the most out of all the thinking, relationship building, system design, and people development that has been done to get the Initiative off the ground.



References

Health Workforce Australia (2011). Accessed from: www.hwa.gov.au.

Productivity Commission (2005). *Australia's Health Workforce*, Research Report, Canberra. Accessed from: www.pc.gov.au/projects/study/healthworkforce/docs/finalreport.

Queensland Health (2007). Ministerial Taskforce on Clinical Education and Training Final Report March 2007, Accessed from: www.health.qld.gov.au/clinedq/Documents/10CEO003.pdf.

Skerrett, R. (2004). Efficacy of clinical practice supervision in allied health and community nursing. *ACQuiring knowledge in Speech Language and Hearing* 6(3), 150-152.

Speers, A.; Strzyzewski, N. & Ziolkowski, L. (2004). Preceptor Preparation: An Investment in the Future. *Journal for Nurses in Staff Development*, 20(3), 127-133.

State of Victoria (2007). *Clinical Placement Innovation: Projects Report*, Victorian Government Department of Human Services, Melbourne, Victoria. Accessed from: www.health.vic.gov.au/workforce.

Walker, S. & Grosjean, G. (2010). Desired skills and attributes for dietitian preceptors. *Canadian Journal of Dietetic Practice and Research*, 71(3), 134-8.

Yonge O, Myrick F, Ferguson L, Lughana F (2005). Promoting effective preceptorship experiences. *J Wound Ostomy Continence Nurs*, 32(6), 407-12.

