



Submission to:



Health Education and Training: Clinical Education and Training

Discussion Paper 2

Clinical training – governance and organisation

Prepared by:

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Introduction

Speech Pathology Australia (The Speech Pathology Association of Australia Ltd) is the national peak body for speech pathologists in Australia, representing approximately 4,500 members. A speech pathologist is a university trained specialist, qualified to provide a variety of services to people with communication and swallowing disorders that may be present across the life span. Speech pathologists work across a range of clinical settings including health (hospitals, community health and rehabilitation); aged care; education (preschools, schools and early intervention); disability and private practice. The entry level training of speech pathologists has a dual pathway, that being through a four year bachelor program or two year graduate entry masters.

Speech Pathology Australia is recognised by the Federal Government of Australia, Department of Education, Employment and Workplace Relations (DEEWR), as the professional body representing speech pathologists in Australia. As such, the Association is acknowledged as both an assessing authority for those with overseas qualifications and an accreditation authority for university speech pathology degree programs.

General Comments:

New Agency

Speech Pathology Australia applauds the Council of Australian Governments (COAG) and the National Health Workforce Taskforce (NHWT) in their focus on addressing the significant crisis in providing adequate clinical training to the prospective health workforce. We are particularly pleased to acknowledge the additional commonwealth funding of \$500m for undergraduate clinical training and the funding of a new national health workforce agency. We support the overall role for the agency in the planning, coordinating, and funding of professional entry clinical training across all disciplines.

The overarching aims and potential role of the agency, as outlined on page 11, is supported in principle, however it needs to be considered that there is not necessarily a 'one size fits all' and that differences across disciplines can reflect the differences in clinical practice. 'Inconsistency' is referred to as a 'challenge' to clinical education governance (on page 7) but likely reflects the complexities involved and it may not be desirable to change this. The agency should look at innovative strategies and drive leadership and best practice, but not seek to centralise and control initiatives which otherwise can be most effectively delivered at a local level.

Funding

New structural arrangements that attach clinical training funding to students regardless of clinical placement setting should be explored comprehensively. While it is supported that attaching funding to students will minimise the possibility of it being absorbed into general university or clinical agency revenue and widens the potential scope of placements, determining a match of allocation to the differing curriculum may be problematic. What may be the 'critical value' that would influence supervisors to take students on placement will need to be considered. It may be useful to also explore options for funding to be increased for specific clinical educators who may be placed at specific clinical facilities/clinical schools or allocated to a cohort of students throughout their clinical training. Equity across disciplines with respect to funding subsidies and incentives for supervisors is a key to improving the capacity of placements for all professions.





Discussion Questions

1. What is your experience of clinical training planning, organisation and management?

Speech Pathology Australia as the peak body does not have a direct role in the planning and management of clinical placements for students, as this is the role for university speech pathology programs. However the Association maintains a keen interest and commitment to supporting adequate clinical education for entry level students, so that they meet requirements for practising membership of the Association upon graduation, and more broadly that the profession is underpinned by sound academic and clinical skills that meet the diverse and complex needs of clients with communication and swallowing impairments. Speech Pathology Australia also advocates a strong role for all practitioners with respect to training future clinicians – this is reflected in the Association’s position statement “Clinical Education – the importance and value for the speech pathology profession” (SPA 2005).

As the body that accredits speech pathology programs, Speech Pathology Australia does play an important role in setting and monitoring the competency levels for entry level practitioners, as determined by the Competency Based Occupational Standards (CBOS 2001) for the profession. This in turn directly guides the universities in the clinical education and placement experiences students require in order to meet assessment requirements that demonstrate competency. Essentially, to meet competency requirements students must undertake clinical placements across specified range indicators involving both adult and child caseloads for the various core areas of speech pathology practice. This does not occur only in health facilities, with the need for placements in other settings that reflects the profession’s areas of practice and caseloads, such as within schools and centres providing early intervention and disability services, such as autism and cerebral palsy centres. Speech pathology will not be alone in this arrangement. It is therefore of significant concern that the NHWT continues to only make reference to ‘hospital and health settings’ when discussing provision of clinical placements. This is a very narrow approach and there needs to be cross-departmental and cross-jurisdiction governance and support to truly address the issues surrounding clinical placements for all health professionals. The health system alone is unlikely to ever be able to meet the placement needs of all health professionals, and does not reflect the multiple contexts in which the health workforce practises.

With respect to the experience of speech pathology programs, I would refer you to the submissions from individual universities for details. However it is our understanding, that there is little in terms of a specific coordinated approach and rather it is generally based on the individual university schools and departments building relationships with placement providers. Much is dependent on the good-will of the already overworked clinicians in hospital and school based settings with, in the main, no financial compensation offered for taking students, unlike the situation for some other disciplines. Allied health programs generally have a far lower level of funding for clinical education than is available to medicine and nursing, and cannot offer the additional incentives and resources to clinical educators in the field. This is in the context of increasing intakes and the commencement of new speech pathology programs adding to heightened competition for available placements in some states.

With increasing workload demands and pressures, the capacity for taking students has diminished and we are aware of some concerning examples where acute teaching hospital clinics, previously having been a strong partner in providing student education, no longer offer placements. As the workloads and caseloads have escalated the capacity within workplaces to provide quality clinical education has significantly reduced and its place has been marginalised and not viewed by employers as ‘core business’.

Largely the approach to facilitate increased placement capacity is one of ad-hoc negotiations, which may also extend interstate and overseas. While there is general cooperation among speech pathology schools and departments, within and across states, competition for available placements is inevitable. However we would caution against an overly controlled centralised system, as often arrangements at a local level can be most effective.





Some examples of approaches the speech pathology profession has taken to maximise capacity and coordination follows:

- **In NSW** a Clinical Placement Consortium has been formed across the four universities providing speech pathology courses, to access and share clinical placements and clinical education workshops. This Consortium contacts speech pathology clinics on behalf of all the universities, and collates the results in an electronic data base. Despite this cooperative approach the number of offers of clinical placements to all universities has fallen over time, while the need for clinical placements has grown.
- **In Tasmania**, the Department of Education has established a single point of contact for liaison with the universities on the mainland and coordination of placement requests. To assist students in coming to Tasmanian placements they offer 6 weeks financial support covering travel, accommodation and car hire costs. This strategy is also tied in with employment recruitment to Tasmania with final year students who show interest in working in the state, 'fast-tracked' into employment vacancies upon graduation.
- **In Victoria**, La Trobe University Speech Pathology program implemented in 2006 a team placement model for the Graduate Entry Masters program, which was trialed in the Northern Health region. Teams of four students are placed together, with payment made to the facility who takes them. This approach works well, and has been copied elsewhere.
- **In Queensland** there is a cross-departments (health, disability and education) speech pathology Clinical Education Forum. This meeting involves representatives from all employing bodies, ie Queensland Health, Education Queensland, Cerebral Palsy League, Disability Services, NGOs ie Autism Queensland, the two Speech Pathology schools in Queensland (UQ and JCU) including student representatives, and is chaired by the Speech Pathology Australia Qld President. The aim of the group is to discuss clinical placement and recruitment issues with a focus on forming cooperative strategies from each sector.

Another reported successful model in Queensland is the recent establishment of multiple student unit supervisor positions in allied health to address clinical placement shortages in QLD.

So while there have been initiatives involving the educating bodies, placement providers, government agencies and the profession itself, there has been little that is a significant and sustained solution, with approaches largely ad hoc and piecemeal.

2. Examples of good practice and approaches

While I am unaware of specific approaches, one of the limiting factors is the lack of organisational and industrial support for taking students. In addition to the obvious funding incentives that need to be available, there needs to be a strong workplace culture that student supervision is an important and vital part of every clinician's work role. This needs to be built at the employer level and reinforced through industrial awards that recognise and reward a clinician taking on students.

Not specifically relating to models of coordination of placements, but a significant advance within the speech pathology profession has been the development of a nationally accepted tool of assessment of speech pathology student competencies.

"COMPASS®: Competency Assessment in Speech Pathology" (McAllister et al, 2006; Speech Pathology Australia) is a psychometrically validated competency based assessment tool that is used across participating Australian and New Zealand universities to assess speech pathology students'





competency against Competency Based Occupational Standards (Speech Pathology Australia, 2001) during field placements (McAllister et al, in press). Clinical competencies assessed include profession specific as well as generic competencies. The initial paper-based tool began its use in 2006 and in 2009 a web-based application “COMPASS® Online” was launched which provides online functionality to the processes of student placements and assessment incorporated in the COMPASS® tool. It is designed to electronically manage, collect, and store the competency scores for all speech pathology students in Australia and New Zealand undergoing placements (e.g. for the duration of their course).

Current research within the profession is also exploring the application of data benchmarking as a quality improvement process to identify strengths and weakness in learning and teaching practices, and indicate whether resulting curriculum changes are having a positive impact on student performance. It is also anticipated that benchmarking will assist in identifying areas requiring further research, which will specifically test hypotheses regarding teaching practices and student performance in the workplace as measured by COMPASS®.

The COMPASS® tool has been met with great interest by the profession locally and internationally. There has also been considerable interest expressed by other professions, with the speech pathology profession in Australia being regarded very highly for its innovation in the area of standardised, competency based assessment of students.

This also reflects the long standing approach of the speech pathology profession in regard to competency based learning and standards, rather than time based requirements.

3. Strengths and Weaknesses of governance models presented in the Discussion Paper

Speech Pathology Australia primarily supports a **‘facilitative model’** in that what is lacking currently is an even playing field. In addition to providing a focus on leadership, best practice and innovation, a facilitative model would look at specific government initiatives and funding streams that will support all disciplines equally. The agency has a role in providing the systems and resources to build capacity and enhance efficiencies but leave the placement arrangements to organisations at a more local level.

What could work alongside a facilitative role are some aspects of a **‘brokerage’** model. There would seem to be value in ‘someone’ outside the individual organisation having a broader knowledge of the training needs and capacity in a given area and work towards bridging the gaps. This may be especially appropriate at a regional level. Knowledge of the individual disciplines in terms of their specific education and practice models will be essential, however this model has considerable promise.

Other models appear to unnecessarily seek to control placement allocation at a centralised level, and would seem to be imposing infrastructure and complexities, especially in the **‘tendering’** model, that would not be practical for small sized services, which is often the case within the speech pathology profession. This model would also likely heighten competition which would be detrimental.

It is difficult to imagine how one body would be able to determine designated competencies across all disciplines and be able to allocate available placements as described in the **‘central allocation’** model. This seems to unrealistically simplify the process which has intrinsic complexities best understood by the individual professions.

Far more discussion with all stakeholders detailing the specifics in potential models is required, however from this point, it would seem that a **hybrid of the facilitative and brokerage models** may be most appropriate and is well worth further development.

4. Is there another model for clinical governance other than those already identified?

Unaware at present





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

Specifics to be considered include:

- Adequate clinical training funding for universities across all health professions
- Consistency across disciplines of funding subsidies and supports for students; and financial incentives and resources/training for supervisors
- Industrial awards to include recognition for student training
- Organisational/employer support for student supervision in the workplace – for this to be valued and seen as ‘core business’
- Placement management systems to improve efficiencies
- Development and fostering of innovative, best practice models

6. Are there other opportunities to improve the governance and organisation of clinical education in Australia?

Stakeholder consultation is vital to creating sustainable solutions. Sufficient time and resources need to be provided to ‘get this right’. We caution against quick ‘runs on the board’ as against meaningful and comprehensive consultation.

Conclusion

Speech Pathology Australia welcomes the opportunity to provide feedback on this important issue and we are committed to working with the NHWT and new agency along with the speech pathology schools and our profession to improve the current crisis in clinical education.

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