Response to Public consultation on the Development of the Australian Teaching and Training Classification by SA Health

While South Australia has worked continuously with the Independent Hospital Pricing Authority (IHPA) on the development of the Australian Teaching and Training Classification (ATTC) there are still a few points that we would like to reiterate.

The ATTC framework architecture as it relates to the two levels (Profession and Training Stage) is acceptable to some degree as a mechanism to establish a consistent base across each of the professions, however, in doing so it mitigates the unique differences between the professions and engenders a generalist proposition which narrows the broad spectrum that needs to support teaching and training of the different professions.

The Classification system's dataset which forms the fundamental cornerstone for a future funding model still gives rise for concern. A question still exists over the ability to collect all the requisite data across all the professional groups. In the past three years South Australia has endeavoured to submit data for teaching and training to IHPA, however these submissions have highlighted the confusion around what is required and whether it is even cost effective to collect the information. While further development of the model is forecast, this is predicated on improved data collection and analysis of the existing dataset to inform future versions. Given the consistent and perpetual challenges to collecting the ATTC data there is a risk that jurisdictions who are unable to collect the requisite data will be disadvantaged in the evolution of the model as they are unable to provide all relevant data to inform future modelling. IHPA is encouraged to consider delaying any implementation of the ATTC until all jurisdictions are positioned to provide the requisite dataset.

Along with data management issues, the rationale to exclude Continuing Professional Development (CPD) as outlined in the Paxton Partners 'Independent Hospital Pricing Authority Define Teaching, Training and Research and Identify Associated Cost Drivers for ABF Purposes Final Project Report (2014)' significantly disadvantages the professions of nursing and midwifery. Post-graduate tertiary and post-enrolment vocational education programs alone are unable to provide the extensive and diverse range of learning experiences that underpin and support safe and effective practice, enable improved practice and/or the development of new skills (Nursing and Midwifery Council, 2015). Teaching, training and learning pathways are not necessarily always needed to be provided through formal academic pathways, yet such pathways are a critical component in ensuring high quality healthcare is delivered by highly skilled and well trained health professionals.

Nurses and midwives, like the other members of the health professions, are knowledge workers and the teaching and training definition in the consultation document acknowledges this. The definition articulates the activities required for an individual and these activities are being compacted against the formal education pathway through universities and the vocational education sector. Due to this narrow interpretation of the definition via an education framework and thus the exclusion of a range of other teaching and training modes such as CPD and embedded training (bedside teaching) the richness of the definition is

limited, and the opportunity to obtain a broad national approach to teaching and training is reduced.

Due to its diversity and application, it is acknowledged that CPD is more difficult to identify and capture than the simplified ATTC two level structure proposed in the consultation paper; professional groupings and training stages (pre-entry, new graduate, post graduate/vocational and an unknown stage of training). However, IHPA is encouraged to reconsider the inclusion of CPD in future development of the classification.

1. Are the current variables included in the ATTC version 1.0 relevant to clinicians, health service managers, and other stakeholders?

While the Frameworks variables seem reasonable to support the ATTC framework as it is currently defined, it is only when trying to apply them across each of the professional groups and then undertake the relevant data collection that the deficits in the variables become evident.

Feedback from the nursing and midwifery professions is that the Framework appears to be geared more to a medical teaching and training model than a nursing and midwifery model whereby CPD is a significant component of teaching and training. While it is noted in the Paxton Partners (2014) final report that CPD is not a differential driver of training and teaching costs as it is required to be undertaken for clinicians across all hospitals, it still drives teaching and training costs for hospitals and health services in the broader context of teaching and training. CPD as suggested by Paxton Partners (2014) is a normal course of business activity. The same could be argued in regards to the ATTC's training stages as well: supporting undergraduate students and enabling clinical placements, the investment in infrastructure to support the transition of new graduates and the provision of opportunities to enable post graduate and/or vocational activities. All the training stages in the ATTC are aimed at ensuring that the health workforce is highly skilled and proficient within their relevant scopes of practice, all a normal part of business for the healthcare sector.

While CPD is not nationally or professionally consistent and may have different meanings within the different professions, is this a rational reason for exclusion as put forward by the Paxton Partners (2014) report? It can be argued that consistency exists in the training stages proposed in the ATTC, however great variability then exists as one delves into the academic classification terms within the training stages. Universities and vocational education providers do not have a nationally consistent approach to implementation of program curricula. Professional bodies set national curriculum standards but how these are interpreted and applied may be quite different between education providers and this can be a cost differential driver for hospitals either within a State or Territory and/or nationally. The final exclusion criteria used to rationalise the exclusion of CPD by Paxton Partners is that it is ultimately an individual's responsibility (not the health services) to support their own CPD. While not arguing that professionals have a responsibility to contribute to their own CPD, this statement also misses the nuance that service providers can build the capabilities and capacity of their workforce within a broader context of teaching and training beyond those elements in the ATTC labelled as embedded costs.

Although the rationale for the exclusion of CPD within the Framework is understandable at this current juncture, it limits the ultimate value this model could provide if it were more comprehensive in its approach to teaching and training.

CPD for nursing and midwifery is different to that classified as embedded costs within the ATTC.

While the term 'Vocational' and 'Vocational Student' will be interpreted by the nursing and midwifery profession to encompass the Enrolled Nurse there is no clear definition of the term. It is also suggested some further clarity be provided around the term and its linkages to pre-entry students, new graduates as well as post graduates that are referred to in the training stage.

It is unclear with the inclusion of pre-entry students in the training stage of the Framework, and supposedly the allocation of funding to this category, how this may link to any funding universities and the vocational education sectors may receive for pre-entry students from the Commonwealth in regards to clinical placements.

The words 'upon entering the workforce' imply the healthcare practitioner will have the necessary capability on employment, rather than acquiring such capability during employment as they enter the workforce as a novice practitioner.

There needs to be greater clarification of the training stage terms.

Concern remains over the definition of one of the proposed training stages as it questions the robustness of the data that, in future, is proposed to allocate a portion of the jurisdiction's funding. After three years of data collection, SA is still working to understand and identify the nursing/midwifery 'students' that would fit into the postgraduate/vocational student category. There are some interpretations that we could make to collect this data and from our perspective would be in line with the definition but do all jurisdictions interpret the data the same way? Ideally data systems should be currently available and represent resources over which management has discretion and therefore controls in daily operations. If data is not available, the ATTC is at high risk of not being available and the costs to remedy will be high.

As 2016-17 is the third year of data collection it would be prudent for IHPA to take this data and compare the changes over the years. For example does the data seem to be improving and more importantly is the coverage getting better? This should be undertaken before any further changes are proposed or implemented.

2. Are there any further considerations in relation to the proposed structure?

As indicated above, the main consideration to the proposed framework should be regarding the basic data collection. Can all jurisdictions actually collect this information and is it being collected consistently?

Given the exclusion of CPD from the ATTC framework, it could be suggested this is a first step to gaining national consistency over a selected segment of the broader teaching and training paradigm within healthcare, however, to give greater robustness to the Model the inclusion of CPD in its evolution would strengthen the Framework, providing a greater more comprehensive model for health service manager and stakeholders.

3. Are there other variables which should be considered in future versions of the ATTC?

Refer to previous comments related to Continuing Professional Development.

4. What support material would be beneficial for the ATTC?

Clear definitions to remove any ambiguity around terms such as vocational, as well as, what elements are comprised within the training stages.

5. What communication avenues and methods should IHPA consider in order to inform and engage stakeholders of the ATTC and future ABF for teaching and training?

It will be critical along with engaging peak bodies and educational institutions as outlined in the consultation document that significant communication is provided to jurisdictions. IHPA may consider work with each of the jurisdictions on their specific communication strategy.

It was noted that whilst the jurisdictions, professional colleges and education providers have been engaged in the national working group, national groups such as the Australian and New Zealand Council of Chief Nursing and Midwifery Officer (ANZCCNMO), National Nursing and Midwifery Education Advisory Network (NNMEAN), National Medical Training Advisory Network (NMTAN) have not been engaged in the development of the ATTC.

6. Are there particular aspects or areas of the ATTC that should be prioritised in its development, or aspects that should be developed at a later stage?

South Australia feels that the collection of additional variables should be delayed until the basic data collection is strengthened. Some of the proposed variables do have merit in being collected but if jurisdictions are still not able to capture the number of postgraduate students, for example, then collecting previous degrees is not going to be very robust or informative.

The priority for IHPA must be to achieve/produce a good robust baseline dataset upon which to base all future classification development work.

7. Are there any further considerations that should be taken into account when developing the ATTC?

The classification and funding principles should also strongly correlate to the NHCDC costing estimates so that funding systems compliment patient costing. There is concern that the initial costing study encountered significant problems and that there is a risk that these costs are skewed to represent hospitals that were able to contribute good data to the study.

Refer to previous comments related to Continuing Professional Development.