Te Whatu Ora Te Aka Whai Ora
Health New Zealand Māori Health Authority

Finding a place to learn in health

July 2023

An analysis of how we organise clinical placements for health profession students in Aotearoa

…and thinking about how to do it better…

To learn more about this project, please visit our webpage A new system for student placements

Have questions, comments or would like to engage with the project? Please send us an email at: placementmodel@health.govt.nz

Contents | Storyline

Introduction and summary

This paper outlines a current state analysis of clinical placements across our health and education systems and identifies key opportunities for improvement and consideration by health and education leaders.

This is not a decision document as the findings and opportunities impact across sectors and many organisations – it will inform more focused decision documents.

Summary

Why

Challenges

Gaining insights

We need to grow more health professionals within New Zealand, urgently and over the longer term. To do this we need to strengthen access to clinical placements for nearly all health professions and in a wider range of health settings.

To achieve Pae Ora (healthy futures) and honour Te Tiriti o Waitangi, a key focus of this work needs to address the lack of experiential learning within Māori communities and kaupapa Māori services within current health professional training.

Devolved and disjointed health workforce education practice has, across decades, created a bottleneck with student placements. Education and health providers say the unplanned, competitive, and ad-hoc approach to organising student placements is a key barrier to growing a workforce that reflects our community and addresses systemic inequities for Māori, Pacific and disabled populations.

Some poor-quality placement experiences, that may involve bullying and racism, and a lack of options in people's rohe are barriers to recruiting and retaining health workers in communities and shaping stronger health workforce pathways for Māori. These limitations contribute to the health education system's failure to graduate sufficient Māori or Pacific students (both populations have recorded higher attrition rates across most health education programmes for decades). This contributes to an ongoing lack of Māori or Pacific representation in the registered health workforce.

A cross-agency scoping team was formed towards the end of 2022 to engage broadly and develop recommendations for strengthening the clinical placement system. Key findings from this scoping work are outlined in this paper and include the following:

The sheer scale of operations demands a thought-out system

There are more than 21,000 pre-registration healthcare students in New Zealand who need to complete more than 290,000 weeks of placements every year in our health services. They also require clinical supervision from a stretched health workforce (see page 15). In addition, there are post-registration students, new graduates and international students who also need mentoring in the same healthcare settings. Yet we have poor visibility of where these students are or what localities or service settings are able to have more students. There is no sense of a fair or effective distribution of students (with the notable exception of 3,400 medical students who are allocated placements through a distribution system that seeks a fair balance).

A highly disaggregated landscape is now improving

The legacy of 23 Tertiary Education Organisations (now 11), 20 healthcare districts, as well as non-government and private providers, and over 20 health professions, has resulted in multiple and diverse ways to organise clinical placements. The approach has often been heavily reliant on relationship-based networks that appeal to a sense of duty (as there is no formal requirement for health services to provide placements). There has not been consistent policy for how education or health providers are responsible for funding and delivering experiential learning, despite it being an essential component of health education as set out by regulatory authorities.

The establishment of both Te Whatu Ora, Te Aka Whai Ora and Te Pūkenga significantly reduce the range of organisations and can bring a cohesive response to this challenge.

Opportunity

There is a broad consensus on the problem and solutions at a high-level

Education providers, placement supervisors, placement locations and data have definitively shown us the current organisation of placements is:

- highly inefficient and complex, hampering efforts for all providers to plan for the future, which is limiting growth in enrolment numbers for most health students
- inequitable where barriers to attending placements (e.g., personal, screening and travel costs) inhibit Māori, Pacific peoples, mature students with whānau commitments and those without independent financial means from progressing
- disjointed and lacks visibility, so it is hard to match students to placements where they're most likely to succeed or where they want to work – this is important for sectors with large shortages like community-based and rural practice.

There is an opportunity with new nationwide health system structures, tertiary education reforms and digital technology to make improvements. Some aspects of the system for medical students provide useful lessons (with clear planning timelines and fair distribution systems) but this model alone would not be effective tackling the sector-wide challenges.

An integrated programme of work is needed to address all parts of the challenge: to make quick and tangible improvements on immediate pressures; and to iteratively manage a multifaceted and sustainable change process.

Thinking about how to do better…

There are opportunities for improvement across four workstreams, to collectively deliver an equitable and efficient placement system that will:

- increase the number of available clinical placements by at least 10% over the next three to five years (across the whole health sector)
- improve the availability, range of, and student experience of placements and increase student retention by at least 8% (across all health profession education programmes) over the next five years
- embed experiential learning for health professionals within Māori communities and kaupapa Māori services.

The four interdependent workstreams need to be progressively and collaboratively implemented by Te Whatu Ora in partnership with Te Aka Whai Ora and the education sector. Some are already underway, many were heralded in the Government's *Health workforce plan 2023/24*, and some proposed work is yet to start.

The current state analysis outlined in this document will inform the business case of options to consider for a Student Placement System Project, to deliver the four workstreams – in the shorter-term and over the next three years.

Four proposed workstreams to strengthen and unify the Student Placement System[1]

Tahi

Investment in coordination infrastructure

To increase visibility of all potential placement locations and allow for more efficient matching of students to placements across the motu:

- Design and implement a digital tool for planning and matching all pre-registration health students to clinical placements, across the whole health sector.
- Establish a student placement hub to map, plan, and report on future placement capacity (using the digital tool) and act as an expert placement helpdesk.

Key requirements and options for this workstream have been scoped, the next step is confirming the business case. Once the development phase is underway it must include all impacted stakeholders and system users through co-design methodology.

Rua

Standardisation and streamlining of system

To reduce the administrative burden on education and health providers, increase fairness and free up clinical resources to supervise students well:

- Develop one standard clinical placement agreement with consistent and mandated requirements and timeframes, for all of Te Whatu Ora, and all education providers – it can also be used as a template for other health providers.
- Standardise and streamline business processes, systems and documentation to support clinical placement organisation.

This will mean planning information (numbers of students and numbers of available placements) is provided in a timely way (as required for the digital tool), and that there are consistent expectations on health services to provide placements.

Standard quality approaches to screening, student information, onboarding, assessment inputs and feedback will improve the quality of placements and reduce the administration burden on staff and students.

Toru

Increasing the quality, range and number of placements

To increase the number of quality placements, and to better include community and rural, kaupapa Māori and Pacific, aged residential care and private settings:

- Devise and implement strategies to reduce pressure on supervisors and increase coordinator capacity (in addition to other workstreams), such as:
  - promote the expansion of Dedicated Education Unit models and “clinical campuses” in health services across the motu, in a range of professions
  - expand infrastructure to develop the workforce outside of hospitals, e.g., clinical coaches that support placements in primary care and rural settings (aligned with priority health service investment).
- Extend options for placements to all areas, with wider timeframes, so that it is possible to match a broader range of student preferences, including use of education-led clinics. This initiative will make use of the digital tool.
- Develop consistent incentives and information to promote placements for public, private and NGO providers, this policy work will benefit from data produced in workstream tahi and may include rethinking payment approaches.

[1] **Timeframes:** Substantive components of the first two workstreams can be delivered within a year and are enablers of the second two workstreams. However, all four workstreams should be progressed together, with sub-initiatives prioritised as required and as resources allow (see Appendix C for proposed phasing).

Improving equity in placements

To lower cost barriers for accessing placements, to improve the cultural safety of placements and invest in eliminating bullying and racism in all clinical placement settings:

- Ensure priority for placement allocation is given on a needs-basis (e.g., learners with dependents get a choice of placement location first and cultural commitments are recognised), plus address cultural needs for Māori and Pacific students such as placements in an area they whakapapa to, or particular language or access preferences. This initiative will make use of the digital tool and improvements can be continually monitored.
- Improve the range of support available for students and address financial stressors. This means consistent pastoral care and financial support is provided to students, including through the investment in a Tuakana | Teina mentor programme across all placement sites.
- Implement anti-racism anti-bullying initiatives across all placement sites. This includes a third-party monitoring approach where Te Whatu Ora can target improvement at 'hot spot' areas with increased 'alerts' about racism, bullying or harassment for improvement.
- Establish a standard approach across Te Whatu Ora for employing health students in assistant roles, while they are studying. This enables flexibility to work around their studies, pause the role if needed and gain a better understanding of the health work environment.
- Bring regulators, education providers and health services together to do 'what it takes' to provide accessible, quality and relevant experiential learning for future health workers. This means looking at how to improve quality and access through 'earn learn' options, simulation options, interprofessional supervision and learning and recognition of prior learning.

Several of these initiatives are closely aligned with work outlined in the Health Workforce Plan 2023/24.

Background

Consistent language for this cross-sector discussion is a foundation step

Currently there are many different names for similar roles, situations or activities related to clinical placements. This is confusing when comparing data across the system or when trying to understand different perspectives on a similar activity. We addressed this in our current state analysis by developing a common language and set of definitions (**see Table A**).

Table A: Consistent terms to describe clinical placement system components

Term	What we mean - (description/definition)	Interchangeable sector terms
Key terms used in this report		
Clinical Placement	*A critical part of health profession education where students are placed in the field to gain hands-on experience.* Clinical placements help learners link theory to practice and build the knowledge, skills and attributes essential for practice as identified by the education provider and regulator. Placements occur in various health service settings. Some health professions are placed in non-healthcare settings.	Clinical Attachment; Clinical Practicum; Student Placement; Experience Practical Placement; Fieldwork Block; Work Experience; Work Integrated Learning
Clinical Placement Agreement	*Documentation that formalises the arrangements for clinical placements between an Education Organisation and Health Service Provider*. It covers terms and conditions, timeframes for renegotiation, and may include resources, induction, orientation and fees. Some details can be in schedules referenced in the agreement.	Clinical Access (and Training) Agreement (CAA); Contract; Deed; Relationship Agreement; Partnership Agreement; Memorandum of Understanding (MOU) Schedule (to one of the above)
Tertiary Education Organisation (TEO)	An education provider that educates health professions, including universities, subsidiaries of Te Pūkenga (Polytechnic or Institute), Wānanga, or Private Training Organisation.	Tertiary Education Provider (TEP); a range of provider names see Appendix A Table F for the range.
Health Service Provider (HSP)	A healthcare provider that provides clinical placements may include government and non-government health providers, and publicly and privately funded services.	Agency; includes all Te Whatu Ora health services; a wide range of health provider names see Appendix A for a range.
Regulator	This may be a Responsible Authority designated under the Health Practitioners Competence Assurance Act 2003, some are empowered under other legislation or contracts, some are a professional membership organisation.	Responsible Authority; Registration Body; Relevant Authority; Regulatory Authority; Council; Registration Board.
Key roles or functions referred to in this report[2]		
TEO Placement Coordinator	*Nominated contact for health service placement providers for arranging placements within education providers.* Links with multiple HSP Placement Coordinators and sometimes student supervisors for the allocation of students to placements. Manages pre-placement activities; clearance, checks, etc.	Clinical Academic Leader; Director of Clinical Education; Practicum Leader; Regional Coordinator; Clinical Lead(er); Clinical Placement Coordinator; Student Clinical Coordinator; Professional lead(er) or Teaching Fellow; Fieldwork Educator Coordinator; Placement Officer
TEO Student Supervisor	The TEO contact who links with the HSP student supervisors to check on progress, undertake assessments and provide feedback. Many	Clinical Educator; Clinical Academic; Clinical Lecturer or Teacher; Fieldwork Educator; Clinical Tutor; or Tutor

[2] People's exact role may not be reflected, and one person /position may perform more than one of these roles.

Term	What we mean - (description/definition)	Interchangeable sector terms
	attend on site during placements for some of the time each week.	
HSP Placement Coordinator	Nominated contact for TEOs within health providers, responsible for allocation of students to student supervisors within their setting. Links with TEO Placement Coordinator on pre-placement activities. Not all Health providers have a Placement Coordinator and the TEO Placement Coordinator may link directly with the student supervisor. There may also be a regional coordinator role across several providers.	Clinical Centre Leader; Clinical Placement Leader; Clinical Placement Coordinator; Clinical Practicum Coordinator; Clinical Practice Coordinator; Student Coordinator; DEU Coordinator
HSP Student Supervisor	The location-specific health professional with appropriate qualifications to undertake supervision of students on placement. They may set learning goals, provide formal and informal feedback, support self-directed learning and complete TEO assessment documentation. Day to day supervision may be carried out by different people, with a lead providing sign-out.	Placement Supervisor; Preceptor; Fieldwork supervisor (some TEOs use this term also); Teaching fellow, Supervising Clinician

How we do placements prevents us from growing the workforce we need

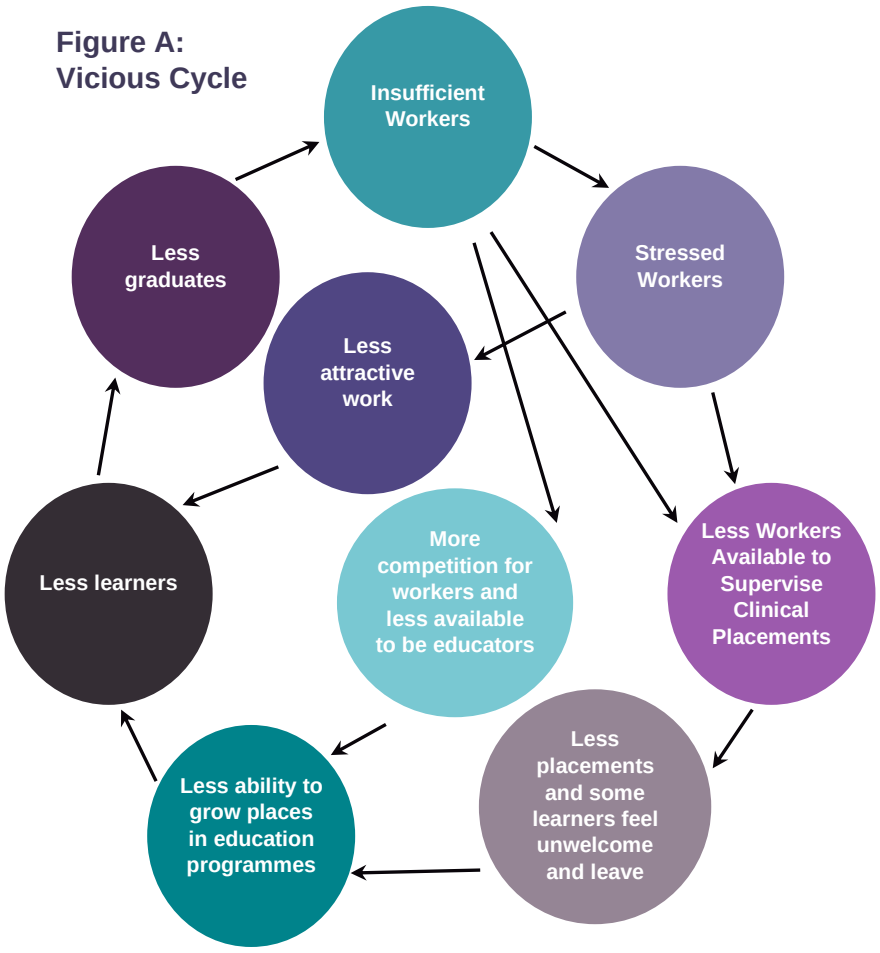
A joint Health Education engagement in 2022 with TEOs found that clinical placements, and the disjointed management approach, was the biggest barrier limiting the growth of more learners in health programmes (METIS 1302031 refers).

This barrier has evolved over several decades without strategic levers for government to centrally plan or commission training the health workforce (with some exceptions).

This has contributed to a workforce that doesn't meet our requirements in the number or diversity of people. We are also increasingly reliant on internationally qualified health professionals migrating to New Zealand.

The workforce shortages have also contributed to a vicious cycle (see Figure A) where it is not easy to increase the numbers of students due to a lack of access to suitable clinical placements, supervisors or educators. This is a complex problem created over decades.

Figure A: Vicious Cycle



The recent health and education system reforms provide opportunities to urgently address and fix these barriers.

A whole-system lens is needed to improve clinical placement systems

Te Whatu Ora, Te Aka Whai Ora, Manatū Hauora and TEC are working together

The Health Workforce Taskforce identified establishing a national student placement system as a priority for the health and education sectors. In October 2022 the Taskforce agreed on a draft scope for this work and targeted engagement with stakeholders involved in organising and delivering placements. This is to gain a robust knowledge of the current state and system requirements, and confirm the scope and work required.

Te Whatu Ora set up a scoping team in partnership with Te Aka Whai Ora, the Tertiary Education Commission (TEC), and the Data and Digital team to develop a work programme. An indicative timeline for this work was developed to include critical success pathways (see Figure B).

Draft scope and benefits of proposed system:

More visibility, planning and capacity

- Whole health sector including all HSPs, NGOs, Private, Rural, Primary Care, Aged Care, Māori and Pacific providers
- A centralised digital system with accurate reporting and planning data
- Expansion of settings, whole motu and wider timeframes

More equitable, transparent, fair, joined-up and efficient

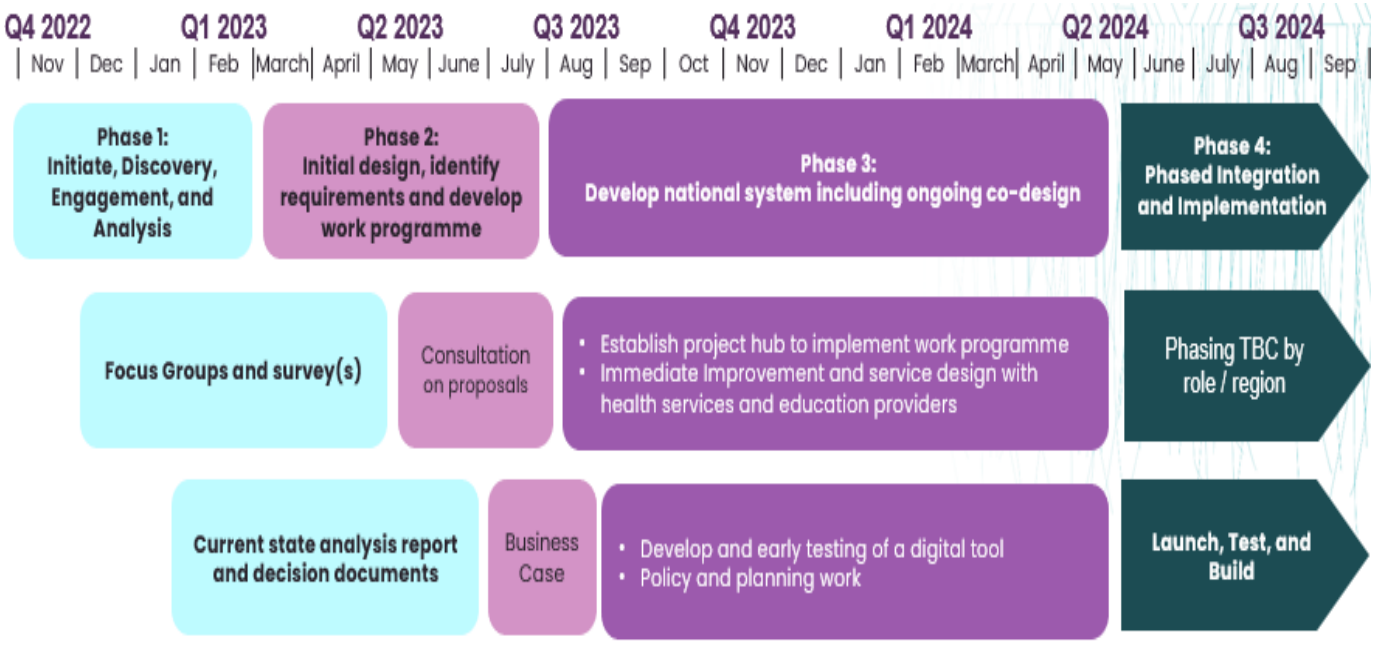
- Coordination resources and support for supervision
- Consideration of barriers for smaller health providers
- Consideration of barriers for students
- Addressing racism and bullying

Comprehensive but phased implementation

- Nursing, Midwifery and Allied Health - Medical later
- Pre-registration first
- Employed post-graduate or interns at a later phase
- Change management

Alignment with clinical learning innovation

Figure B: Indicative timeline for the work



This paper reports on Phase One

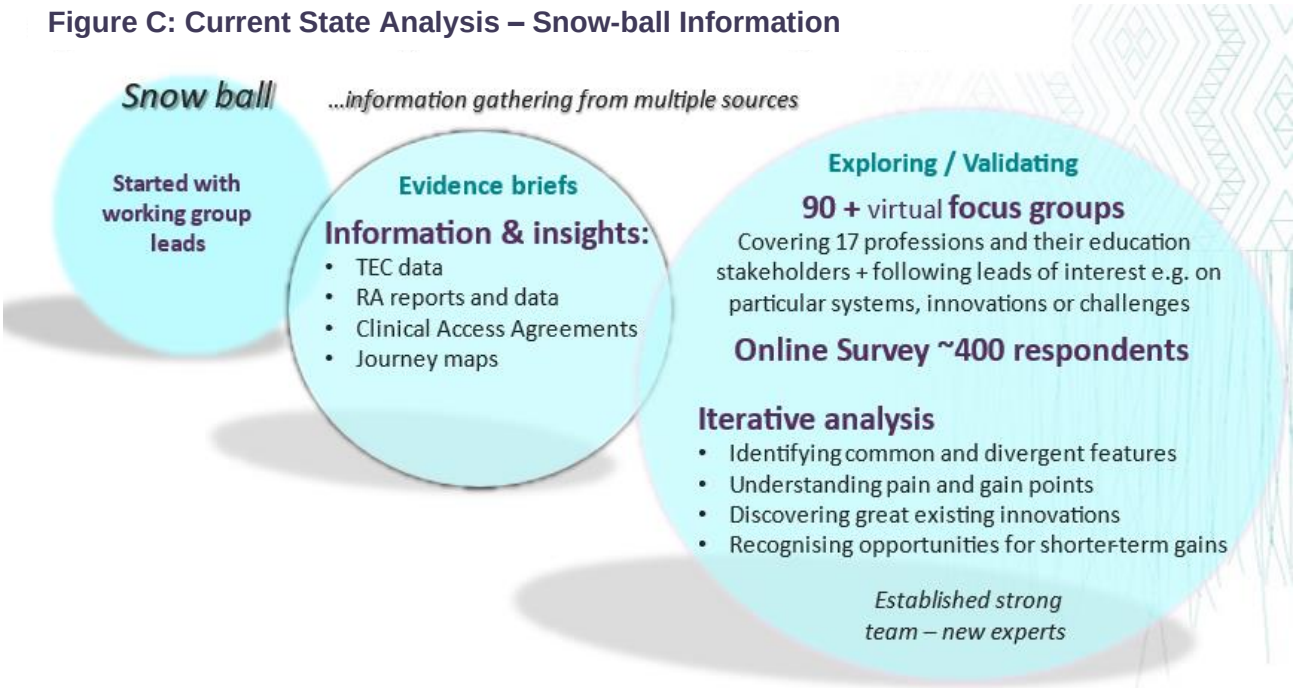
This paper provides a report-back to the many stakeholders who have engaged with us so far and generously provided their ideas and experience. It outlines the main findings and related recommendation for further work.

Method - how we built expertise and networks on student placements

Information gathering and engagement expanded iteratively

Our engagement process expanded like a snowball (see Figure C). We started the ball rolling by meeting with the Taskforce working group leaders who were subject matter experts for different professional groups (complemented by desktop research). We then followed leads as we found interested stakeholders, relevant evidence and data.

Figure C: Current State Analysis – Snow-ball Information



We established a website, project email address and database for updates as it became increasingly clear there was a strong desire for two-way engagement. We were not only building a comprehensive picture of student placements but also a coalition network of stakeholders that are interested in making change. We found the sector keen to engage, with many experts sharing good ideas for building a better system. We also heard broad agreement that change is needed.

We set out to know end-to-end processes for each area, profession, HSP and TEO

Between December 2022 and June 2023, the scoping team attended stakeholder meetings, held focus groups over Microsoft Teams, and sent out surveys. The aim was to gain knowledge of how placements currently work across a range of professions and areas, as well as understand varied perspectives within the system. It was important to hear from people directly involved in organising or delivering placements. See Appendix A for a list of stakeholder groups we heard from.

We wanted to fully understand what a joined up, nationwide system needs to achieve and what the impact of any change process might be. The engagement also aimed to identify what is out there now that we can build on, and what quick wins may be possible.

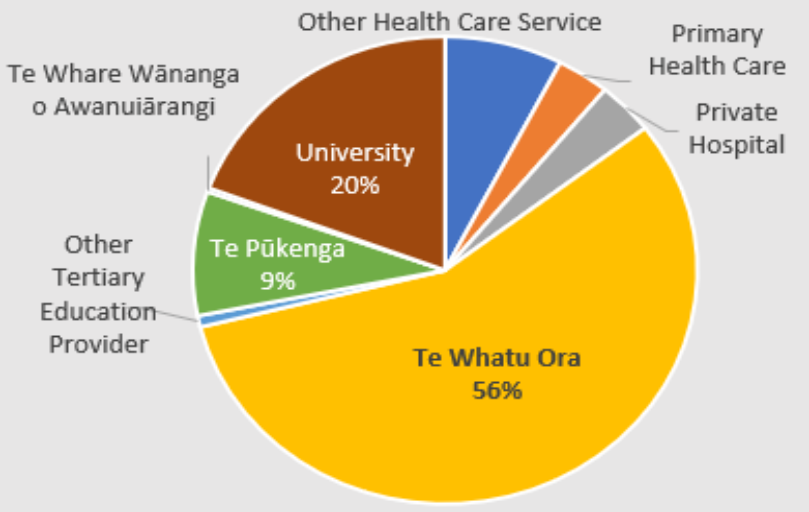
Across 100 + focus groups and meetings:

- 20+ involved nursing related participants
- 50+ involved allied and scientific health profession related participants
- 8+ included midwifery participants
- 8 discussed different digital tools currently in used in New Zealand and Australia.
- 20+ were a particular topic of interest (e.g., te ao Māori and students, Dedicated Education Units, innovative practice, regional models, and education planning)

Across about 389 survey participants (**see Figure D**)

- 29% (111) of respondents were from TEOs
- 71% (273) were from HSPs
- 97 respondents coordinated nursing clinical placements (of whom 68 solely coordinated nursing)
- 236 HSP respondents only coordinated one profession and one coordinated 10 professions
- 49 TEO respondents coordinated one profession, four coordinated eight to 10 professions.

Figure D: Organisations that survey respondent came from



Engagement was complemented by desktop research, data and a validation process

The scoping team has produced evidence briefs including 'journey maps' for 17 professions and other background information. The briefs were iteratively pulled together from various information sources including engagement with subject matter experts, analysing over 30 Clinical Access Agreements, examining the education standards set by the relevant regulator, data from the Tertiary Education Commission, Health Provider Index analysis and Te Whatu Ora, and relevant research evidence.

The evidence briefs are live documents we use to validate our understanding of the current situation, and regulatory requirements and placement organisation for each profession, as well as to collate relevant data to inform the findings in this report and the future system design processes. The validation processes include sending the briefs to Professional Specific Groups (PSGs[3]), Manatū Hauora Sector Reference Groups (SRGs) and the Taskforce working groups for comments and corrections. There is too much information to provide in this document, however we are happy to share briefs to people to view and/or comment on a particular profession.

Please email **placementmodel@health.govt.nz** with your request and we will send you the latest version. The professions covered include the following:

Anaesthetic Technicians	Medical Laboratory Scientists	Paramedics
Addiction Practitioners	Medicine	Pharmacists
Audiologists	Midwifery	Physiotherapists
Dieticians	Nursing	Radiation Therapists
Medical Imaging Technologists	Occupational Therapists	Social workers
	Oral Health Therapists	Speech Language Therapists

[3] The Allied Health, Scientific and Technical Working Group set up by the Health Workforce Taskforce, established 20 profession steering groups (PSGs) to make recommendations for a more sustainable workforce pipeline. The initial PSGs include anaesthetic technicians, sonographers, cardiac and clinical physiologists, medical imaging technologists, radiation therapists, oral health therapists, laboratory technicians and scientists, physiotherapists, speech language therapists, occupational therapists, dietitians, paramedics.

There are gaps in our engagement that will be addressed in the next steps

The rich engagement and analysis to date has given us a robust starting point. However, we discovered that the breadth of relevant information and interested stakeholders was too much to appropriately cover in our timeframes. In particular, so far we have not sufficiently targeted our engagement to address student perspectives, including Māori and Pacific students.

There has also been insufficient engagement with HSPs outside of Te Whatu Ora, including Māori and Pacific health providers, other NGOs, independent practitioners, primary and community health providers, aged care, and private hospitals and medical laboratories. We have at least spoken to some representatives from each of these groups. Some professions with smaller numbers of students have also not yet been considered in detail.

We have been able to address these gaps to a limited degree, drawing on some pre-existing research, related projects and through conversations with some subject matter experts from these areas, however this has not been comprehensive or fully representative.

Insight: ***It is important that any planned future engagement on student placement system options,*** as well as the proposed future service design processes (including co-design methodology) includes engagement with all impacted stakeholders to address gaps in the engagement to date. We acknowledge this takes time to do well.

There are also groups not yet considered fully that the system may include in future

There will be a need in future phases of the project to engage with medical student stakeholders, and post-graduate employed clinical placement stakeholders (such as Registered Medical Officers and Psychologist Interns), to explore the useful expansion of the system to wider groups.

There has been a limited view taken of the current approach for medical students so far (an evidence brief was developed). We found that there is a relatively well planned and resourced approach to clinical placements for medical students. Any growth of medical students must be considered by Cabinet to ensure funding is available for the future ten years to accommodate placement requirements (amongst other costs).

It was indicated in focus groups, and agreed by the scoping team and advisory group, that aspects of the system for medical students could provide a model for other health profession students.

Findings

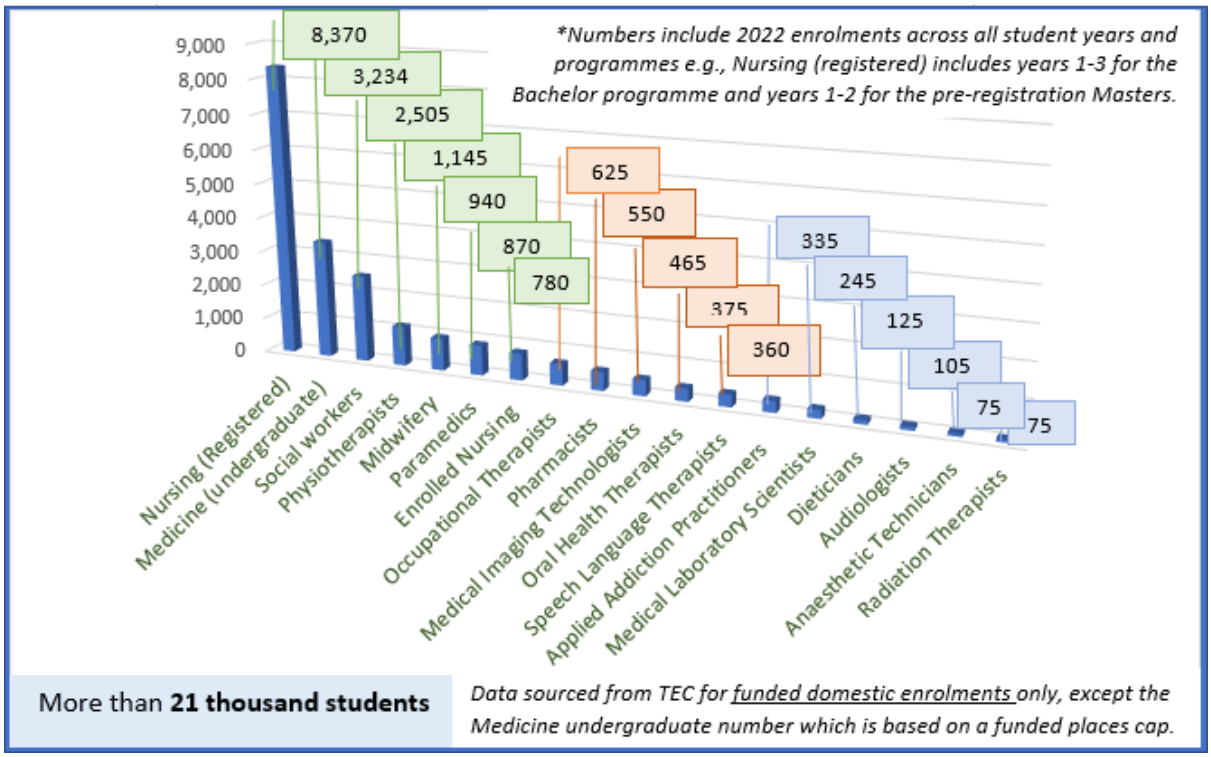
This section outlines the key findings from our engagement and investigations over six months

The sheer scale and variance of the current systems are remarkable

Over 21,000 pre-registration students require placements each year

We have not gathered data on all pre-registration health profession students but have a good understanding of those with larger student numbers requiring placements (see Figure E).

Figure E: Number of Learners enrolled in 2022 by health profession*



Health students require over 290,000 weeks of placements a year across the motu

- Nursing students combined (including enrolled and the degree/graduate programmes for registered nurses) collectively need to do at least **85,500 weeks*** of placement a year (based on Nursing Council requirements, some TEOs require more placement hours).
- Midwifery students collectively are required to do about **18,800 weeks*** of placement a year.
- The combined group of 15 Allied Health Professional and Scientific students listed in Figure E (comprising 7,855) have to do an estimated **78,550 weeks*** of placements a year (this estimate assumes an average of 10 weeks a year per student).
- A rough estimate of placement weeks that combined undergraduate medical students do each year is more than 105,000 weeks (based on an average of 30 weeks per student).

Not including medical or international students there is about **183,000 weeks*** of placements required each year, which our proposed new system needs to accommodate. The context for these placements also includes Competence Assessment Programmes (CAP)** placements, medical students, new-graduates, post-graduate students and interns all of which put pressure on supervision requirements with health services.

* These figures assume 40 hours a week – where number of hours is divided by number of weeks
**This is expected to reduce in 2024 with a different assessment model but some form of CAP will continue

The indicative numbers of placements each year are conservative estimates. There is no doubt these placements have a big impact on health services and the entire health system. However, with the exception of medical students, our visibility across the system is poor, and there is a lack of timely information about where these students are, or what localities or service settings would be willing and able to have more students.

There are numerous differences in how placements are organised, making it difficult to fully understand the system. Over the years TEOs, professions and HSPs have developed different approaches, with many hundreds of different Clinical Placement Agreements outlining relationships between TEOs and HSPs and a wide range of different timelines, payments, planning approaches, screening, allocation, on-boarding etc.

An unknown but significant investment in placements from TEOs and HSPs

The lack of a system-wide view and considerable variance means we do not know how much is invested in coordination across all HSPs and TEOs. However, from information provided in our surveys, we know there are at least 400 staff involved in coordinating placements. The actual number may be much higher, accounting for numbers not included in the surveys.

There are significant funds of at least $22 million dollars[4] transferring from TEOs to HSPs to pay for placements. There is considerable variance in the amounts recorded in the Clinical Placement Agreements, and in most cases the amount has not changed in two or three decades. The intention of these payments is no-longer clear – they are not sufficient to cover costs of clinical supervision, coordination or extra student costs. HSPs also use the funds in varied ways. This is what we heard from stakeholders – some of these funds:

- go into the bottom line of the service delivery – with no transparency of how it is spent
- are used to establish a professional development fund that HSP supervisors can access
- are used to directly support placements, by resourcing ‘Clinical Liaison Nurse’ roles
- are used to support student costs e.g. formally pooled to address rural transport costs or in the case of lead carer midwives, informally provided by the supervisor to a student.

Some variance is appropriate, and some is not, creating inefficiency and inequity

Different approaches for organising or delivering clincial placements are sometimes driven by distinct profession requirements (see international evidence in Apprendix B). However, there is significant variance within professions, reflecting different TEO learning philosophies and programme designs, or relationships with local HSPs.

Some professions have worked across TEOs to align their learning programme and placement timeframes or zones to maximse opportunities. However, many compete for the same placements, potentially overloading HSPs in one time period or area, while other time periods or areas are under used. There can also be a heavy use of relationships and networks by many TEOs to secure placements which may contribute to ad-hoc, disjointed and sometimes inequitable allocations, and overall tends to fail to make the best use of sparse clinical skills and resources.

Some TEOs altered their learning programme to better suit HSPs such as providing longer placements rather than several short ones. This innovation was appreciated by HSPs.

Professions, TEOs and HSPs were often unaware of the variable approaches

[4] This figure is a ballpark estimate based on an assumed average of $25 a day per student per placement. Some pay considerably more, and some do not pay at all.

Some participants in focus groups reported interest in learning from other participants and were not aware of the different ways placements are organised. The scoping team observed that some groups assumed the way they were doing things was how it was done everywhere. The many perspectives were enlightening. In particular, the approach to medical student placements seems to offer a model for other health profession learning.

System user perspectives are instructive

Learner perspective: "my placement allocation may not accommodate my needs"

In 2021, the Ara Manawa Team of the then Auckland District Health Board did a detailed qualitative investigation into the clinical placement experience for student nurses across the Auckland region. This covered placements in the three metro Auckland Districts taking students from five nursing schools. The insights are generally consistent with our focus group and survey findings but add a stronger student voice. Key take aways include:

Students appreciate a comprehensive orientation (but it does not always happen)

- A proper orientation in advance of a placement was found to be beneficial to both the students' confidence and likelihood of a successful placement. However, there was no standardised approach across clinical settings or districts.

"We got a big tour of the clinical area we were placed in before we were expected to start... we arrived on our first day knowing where everything was..." - student

"There wasn't really an orientation … it was left to the ward …they don't always have the time..." – student

Some students thrive and others 'just' survive <u>or leave</u> – personal circumstances and support, including financial aid, pastoral care and peer support make a big difference

- Some students feel unsupported, and that their circumstances are not adequately considered in allocating placements. A placement could include 40 hours of clinical rounds, up to 10 hours of paperwork in addition to other demands like part-time work and whānau commitments – it can be very disruptive.
- Research and focus group participants attributed high attrition rates to extra costs associated with placements, such as travel, parking, accommodation, screening and competing commitments. *These costs and pressures were considered a key reason people drop out.*

"You want to put up this front of a student who is positive and there to learn, while on the inside you're drowning … you don't necessarily want to ask for help..." – student

"I've got a really great group of students who all really look after each other..." - Student

"…some students require extra support that limits where they can be placed. More consideration could be given to students from equity groups to ensure they are well supported.." - *TEO*

- Costs associated with placements are seen as a major equity issue as it can inhibit Māori, Pacific, disabled and mature students, especially those with whānau commitments or without independent financial means from progressing with health programmes. Some, but not most, TEOs provide petrol/supermarket vouchers for those in hardship during placements.

There are concerns about inconsistency between theory and practice

- Some students reported different guidance on placement compared to the TEO education, and being expected to undertake tasks they have not been taught theoretically or via simulation first.
- Students heard that some HSP supervisors did not think TEOs had up-to-date clinical experience.
- Inconsistent learning requirements and expectations across TEOs and HSPs reduced certainty and confidence for students.
- Many HSP supervisors complain about the lack of clinical practice preparation prior to placements.

Interpersonal skills gained in placement and network opportunities are essential and motivational

- Students benefited from building relationships with potential colleagues, weekly teaching seminars and being part of staff morning teas.

  "…the placements where the staff seem well supported … the nurses were much happier and more willing to have students as they could rely on the other nurses to help out as well..."-student

"Networking opportunities are a really big thing … You figure out where you want to go..." - student

Feedback opportunities are important and are not always easy to provide or welcome

- Some felt unable to make complaints or discuss good practice in fear of damaging relationships and putting future job opportunities or the TEO in jeopardy. Other HSPs (especially where there was a Dedicated Education Unit approach) provided positive feedback systems.

"It was a good time to say thank you, get some feedback … She asked, 'what was one good thing, what was one bad thing, what was one thing that you would do in your next placement?'. ..a nice way to wrap it up..." - student

Many students experience increasing distress while on placement and mental wellbeing is a concern.

- This is not only due to the constant nature of having to perform while being assessed, personal stressors such as financial hardship, but for many they are experiencing situations they have not had exposure to previously, such as acutely unwell patients.
- There is a need for systems and processes in place to monitor and address this from both TEOs and HSPs. For example, Waikato use weekly education and support sessions for physiotherapy students. This gives supervisors dedicated time out from their student each week and allows students time for peer support.

"There should be robust processes for supporting and monitoring students entering potentially traumatic clinical placement environments". TEO

Education organisation perspective:
"competing for places with low confidence they will find enough"

The number of students that a TEO can enrol is limited by access to sufficient placements – and it can be a highly competitive process

- TEOs found it hard to know or confirm how many placements will be available in the future and noted that timeframes in Clinical Placement Agreements were not always adhered to (HSP Coordinators had the same complaint).
- There can be a heavy reliance on networks to organise placements which can lead to inequity and significant inefficiency.

"It is like the hunger games…" - TEO

"…we need standard and fair Clinical Placement Agreements with mandated time frames for data entry so we can plan with confidence " - TEO

We need more placements to be available

- There is no requirement for an HSP to take students and TEOs need to go with *'begging bowls*' it is hard because the costs of supervision are not covered and HSPs are often dealing with many other service pressures.

"It's really difficult because they always have more students than we have placements ..they have to negotiate between themselves who gets to go where." - HSP

It is challenging to match student needs, preferences, and circumstances with available placements

- Strong relationships between HSP and TEOs, and between TEOs and their students, are important for getting the matching right and for ensuring the success of the placements - so that all parties talk about and address any issues as they arise.
- *"It is particularly difficult to get the 'right fit' between student preferences and placement availability for the first rotation …when the individual students are unknown to me. It's easier to match supervisor: student learning styles and personalities as the year progresses"* - TEO
- Difficulty finding appropriate placements means that many students don't get the range of experiences that would optimise work readiness.

"…we need better incentives for HSPs to provide placements including in procurement with private and NGO providers…" - TEO

*"It is a **giant jigsaw puzzle** that will only fit one way… very time consuming and very difficult for the students" - TEO*

Pre-placement paperwork can be burdensome and inefficient

- "… we need s*tandardised paperwork for each student. Medical documentation should not be necessary because all students are screened and vaccinated for our course. Some HSPs / areas accept this, others require a lot of paperwork*..." TEO

"…while the hours are enough.. the quality of placements are the key to ensuring a workforce that is ready for practice"- HSP

Health service perspective: "too stretched to manage an extra workload with students"

Adequate supervisor numbers is the biggest challenge faced by clinical teams

- Service gaps and lack of senior staff in some HSPs mean there is no scope for placements.
- There can be limited capacity for placements due to a lack of clinical staff overall as well as the lack of staff who are qualified to be supervisors. Teams may include high numbers of recent graduates. Sometimes trainees are placed into qualified FTE vacancies, further diluting the number of qualified staff available for supervision.

HSPs under service pressures do not want to take on an extra administrative burden with placements

- Short placements and late confirmation or cancellations often do not work for HSPs. They do not accommodate the need for good onboarding and getting to know and trust students.

HSPs want TEOs to collaborate to coordinate placements better and align expectations

- Some TEOs plan across schools in an area and ensure consistent assessment processes and that placement times do not overlap. Other TEOs are very inefficient in their demands on HSPs.
- It would be useful to align learning expectations for students across TEOs for various settings. Some placement requirements are complex e.g. Emergency Departments and Intensive Care Units and it is unhelpful to have five different learning models / approaches.

HSP supervisors do not consistently get the support or training they require to do a good job

- Not all clinical teams get extra support or adjust case-loads to accommodate students.
- Concern was expressed about variability in support and training for supervisors.
- There are several approaches to supporting supervisors, including models such as 'Dedicated Education Units' which we heard good things about. However, many supervisors feel unsupported and unequipped, and that it is basically an *"unrewarding extra burden".*
- Allied Health PSG groups are recommending increased FTE for clincial educators.

"there are not enough places… coordinators are continually having challenging conversations with staff to take on a student" - HSP

" Longer placements are more useful than short stint placements"- HSP

"…admins are cheaper than clinicians and do admin tasks easily, to a higher standard and more quickly than a clinician can. Increase your admin pool to support your clinicians - reducing the burden of admin tasks … this then rolls over to them having time for students.." HSP

"Student placements .. occur in a cluster, and not spread through the year. It would be good to be able to have more of a spread, …" HSP

"placements should be spread across the sector and equally between regions and districts adjusting for hospital size"…"and be across the year not just in semester times" HSP

"…Supervision is time consuming and can be stressful - there is no remuneration or recognition attached to the role of supervisor. There needs to be funding and mechanisms to train senior clinicians across the sector". - HSP

"Recognise that having a student will slow the clinician down...This may mean increasing payments to private providers to offset the loss of income by seeing less patients" - HSP

"Student placements should not be based on the number of FTE in a team but in the skill and desire to teach. Some experienced clinicians are poor supervisors and students end up with a poor outcome or experience as a result" - HSP

- It is difficult for some private providers to accommodate the extra costs of having students within their business models, so many do not.
- Some private providers (including hospitals, aged residential care and Family Planning) indicated they would be keen to take more students but they are not asked, or the learning requirements are not flexible enough to fit with their servcies.
- Training to be a supervisor is inconsistent and variable, ranging from no training at all, to excellent examples of communities of practice supported by TEOs (e.g. an example in Social Work). When training is provided, there is a mix of TEO and HSP facilitated training. Expectations also differ between professions and sites.
- Some TEO programmes require placement supervisors to have/or be studying towards a specific qualification, or complete specific training. For example, MRI trainee tutors are required to sit an exam with the University of Auckland and obtain 100% to work as a tutor, and Anaesthetic Technician supervisors need to complete AUT's Introduction to Professional Supervision programme, available online.

"we need… a standardised training module re student supervision, cultural competency and more … each sector could add information that is relevant to their service. … ensure that all supervisors are receiving the same information…" HSP

A locality perspective on placements (rather than TEO programme focus) may allow coordinators to better consider local pressure and provide opportunities for interprofessional learning

- Many clinical areas host students from more than one profession or programme and there is a need to consider pressure in a particular locality, across all potential students when calculating capacity to accommodate students.
- *"… If all disciplines wished to maximise capacity without looking at competing requirements, we could run into bottlenecks..."* For example, medicine and nursing cut across most clinical areas, paramedicine students require clinical exposure outside ambulance services especially in Emergency Departments, peri-operative practice students require exposure in Post-Anaesthetic Care, PICC line insertion, sterile services alongside nursing and many more double-ups.
- Positive experiences were reported where an interprofessional placement approach is adopted such as where students share inductions, some learning experiences and sometimes accommodation (in rural settings). This model could be more enabled if the system allowed a cross profession view at a local service level.

Accommodating students with shared space and equipment in health settings can be problematic

"… practical challenges: lack of space and logistics to support student placements. Things like desk space, access to technology, and cars, equipment needed to do the job, are also challenges to overcome when considering taking on a student... smaller issues but ..really matter in the day-to-day experience for the supervisor and student when trying to provide a good scaffold for a quality placement." - HSP

- Many students share a desk with their supervisor or others. Some sites have set up a student common room set with IT access, etc. However, space is often very limited in health.
- Many clinical spaces do not comfortably accommodate a student to be present as well as a clinician, patient, and support person. This is for older facilities and new builds, where space for students is not factored into design.
- Access to IT devices is also important with many health services using e-notes and e-applications, and students are not provided access to devices. Oranga Tamariki now provide Social Work placement students with a device, and required IT access for the duration of their placement.

An equity perspective:
"a fully representative workforce is essential to improving health equity"

A new placement system provides an opportunity to prioritise improvements that make it easier for Māori learners to thrive and address inequity.

"A new placement system must address Whakamaua outcomes" HSP*

* Whakamaua is the Māori Health Action Plan 2020-25 a tool for the health and disability system to fulfil its stewardship obligations and special relationship between Māori and the Crown.

- A thriving Māori Health workforce is key to addressing longstanding inequity, institutionalised racism and poor Māori health statistics. However, currently 9% of the public hospital workforce are Māori compared to 17% of the population. There are increasing numbers of Māori health learners but attrition rates are worse than non-Māori and it will be many years before improved graduation rates impact overall workforce rates.
- We heard the current approach to placements contributes to inequitable outcomes when:
  - ākonga circumstances are not adequately considered, exacerbating financial hardship and academic stress resulting in high rates of attrition of Māori students.
  - placements are culturally unsafe and do not protect mātauranga Māori or Tikanga.
  - the current system, which often relies on networks, does not identify or address racism and discrimination wherever it is found.

"When I see my people come in Polynesian people, Māori people, who I know struggle with understanding the medical terms or even why it's important to take your tablets, I wanted to engage with them…trying to go that extra mile … I was told probably my third week to just sit there and shush…" student

There is low cultural competence in some settings and inconsistent cultural support

- Some noted the lack of acknowledgment of whanuangatanga within clinical systems. Cultural differences can clash with clinical practice, for example – students are uncomfortable giving instructions to kaumatua (elder patients) but are told by clinical supervisors they must.
- A focus group with Hawke's Bay stakeholders promoted the Tuakana | Teina system as effective for mentoring students and promoting cultural competence and feedback mechanisms across a service. They proposed regional cultural coordinators for students and supervisors. There are opportunities to improve the consistency in cultural support.

A new direction and focus on the Pacific health workforce is called for in Ola Manuia*

*Ola Manuia is the Pacific Health and Wellbeing Action Plan 2020–25

- Pacific health stakeholders told us that many previous attempts to grow the Pacific health workforce have not been effective. Currently, Pacific people make up approximately 3.5% of the regulated health workforce (where data is known) and about 7.3% of the non-regulated health workforces (March 2022) compared to approximately 7.4% of the whole population (Stats NZ).
- There is a need to grow the capacity and capability of the Pacific workforce to ensure equitable representation in the health system. A new placement system must proactively look for opportunities to help e.g., wrap around mentoring and pastoral care services for some Pacific students during placements (such as in midwifery) has positive results.
- Some settings work better than others. For example, a group of Pacific nursing students reported feeling *'unwanted', 'in the way' and 'slowing things down',* with placements in hospital. However, they also reported a better culture and very positive placement experiences in Aged Care.

A whole sector perspective: "we need change to make a fairer and joined-up system"

Intra and inter-profession conversations about clinical placements could be beneficial

- In the focus groups it became clear that not only does each profession, HSP and TEO have a different approach but they do not always know that it is done differently elsewhere and it was useful for them and us to hear discussions about the range of solutions people have implemented to common problems.

> *"It's not often that we get to have an open conversation with the other professionals involved in placements so we both found it quite helpful…" - TEO*

Effective pastoral care is critical but can fall through a gap

- Both TEOs and HSP have pastoral care responsibilities but with a wide variance in approaches it is not always provided, with both sectors expecting the other do more than they can.

Innovation is needed in experiential learning models across many professions

- Many focus group participants had ideas for how the model of clinical placements could be improved to better meet student and HSP needs. Achieveing this requires collaboration between the regulator, TEOs, HSPs and funders. Specific ideas included:
  - Expanding student-led clinic models, which could also be used to help meet unmet service need in some situations in collaboration with HSPs.
  - More simulation or virtual training options to reduce the demand on clinical placements.
  - Changes in ratios of supervisors to students in some professions, to allow more students per supervisor (there is evidence that students benefit from having peers).
  - Longer placements which allow HSPs to get to know and trust the student and can more easily build and use their skills. These are also much less administratively burdensome for HSPs.
  - Inter-professional placements and inter-profession supervision options.
  - Work with 'earn learn' options, including hiring students in 'casual' assistance roles.
  - Staircase from assistant roles and recognise prior learning to reduce placement hours.

The inability to plan or see across the whole system is a key challenge for both HSPs and TEOs

- Not being able to consider placements across the whole motu means there are missed opportunities to match students with placements where they are likely to succeed and find meaningful careers. This is particularly important for short-staffed sectors like primary and community-based care and rural practice.
- Not knowing how placements are distributed across HSPs, including all districts, localities, private, and NGOs health services means we can't ensure it is done in an efficient, effective and fair way.
- Low consistency in, and lack of visibility of, student experience of clinical placements makes it difficult to improve quality and student retention where it is most needed.
- Not all of the pain points described above can be fixed by a digital tool. However, a digital tool that allows whole system planning, allocation and visibility will enable us to address many of the issues identified and raise our understanding of the nature of other issues. This is why a great many stakeholders would like to see a nationwide digital tool implemented.

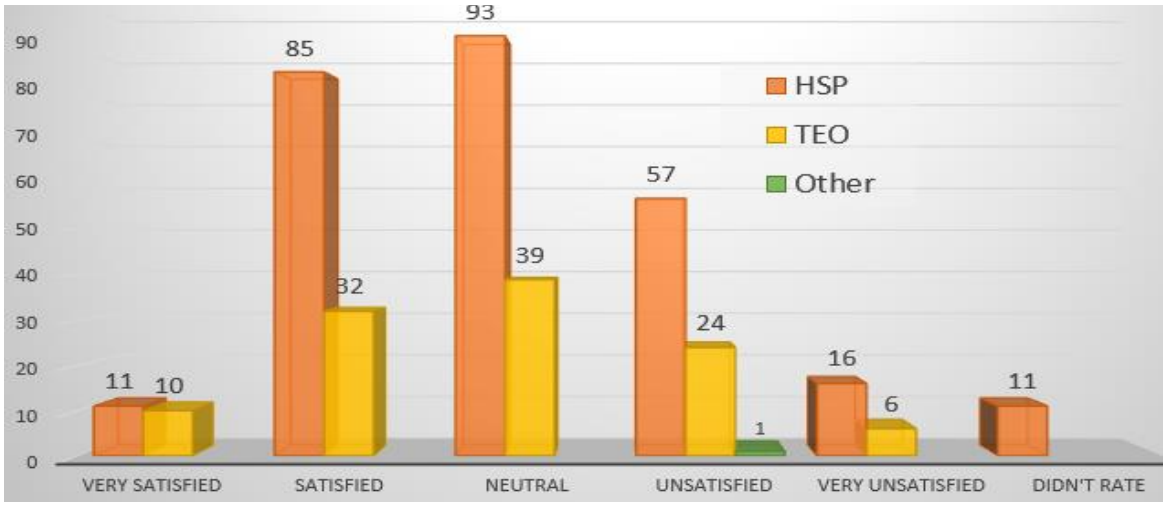
There are risks inherent in designing and implementing a new system that concern some stakeholders

- For some smaller professions coordination is relatively simple, and a new system may be too complex. There will need to be options to opt out and related rules in place.
- If a new system is too complicated, and not designed with users, then there is a risk that lack of uptake will make it ineffective. A robust change management plan will be required to bring all stakeholders on the journey through design, user testing and implementation processes.
- There are concerns that a nationwide system may exacerbate 'competition' and result in 'first-come-first-serve' allocations, and/or that an influx of students from other regions may take placements leaving local students without local placements. Adequate controls will need to be built into any new system to prevent these risks from manifesting.
- There is also a risk that if not implemented carefully a new system may break existing processes and relationships that are currently working well.

Many system users want to see improvements in how placements are organised

- Our survey canvassed how satisfied people were with current coordination of clinical placements. The majority were either neutral or unsatisfied. While 36% of respondents were satisfied, when reading the commentary, it is clear that many of those people were reflecting confidence in their colleagues and the job they are doing, or pockets of excellence (explored later). Many of those who are satisfied also raised significant issues about the current approach that they wished to have fixed.

Figure F: level of satisfaction with current coordination



- A survey of Professional Sector Group (PSG) members found 22% agree that there is adequate supervisory workforce to support training, with 18% neutral. 36% disagree that current clinical placements ensure work readiness, with 25% neutral.

We also heard broader workforce concerns related to student placement challenges

- Consideration needs to be given to the next phases in the student journey, and how Te Whatu Ora attracts, recruits, and retains future health professionals. Many programmes have a single-entry point (e.g., semester one start), resulting in an influx of graduates into the health market when they finish their programmes. Dual semester entry into programmes, and/or other methods of distributing the graduate pipeline across the year

would be helpful and would better meet the demands for workforce supply. This is because most Te Whatu Ora recruitment is 'vacancy driven', not allowing for anticipatory recruitment of graduates.

- Extend the voluntary bonding scheme to help attract students into hard- to- recruit areas.
- Retention of 'mid-career' health professions was mentioned several times. This group of health professionals are the ones often relied upon to support both students and new graduates.

"the key issue is not how many we are training it is why are we losing experienced clinicians and failing to recruit to mid-career roles who would be the successors for our "aging workforce". - HSP

Insights gained from innovation and practice

When we heard about positive models we set out to find out more to understand how these examples may inform the design of a new system. A snapshot of insights is offered below.

Oranga Tamariki uses HR tools and practices to onboard students

Oranga Tamariki use the same recruitment process for student placements as for staff they employ permanently. This includes an online application, interview, pre-placement checks and onboarding/induction. At present, this is for the Auckland region, involving 70 students each year across 21 sites. There is discussion around expanding this process nationally.

The approach implemented by the HR team also deploys planning and scheduling strategies. Placement dates and student numbers are discussed with all TEOs together in November of the year prior and an annual calendar is prepared. TEOs are encouraged to work together to maximise placement availablity and move placement dates when required.

Each kaimahi is allocated a laptop and the HR team hosts an induction day to assist with digitial set up and to sign off relevant policies. A powhiri takes place on the Friday before they officially start at their placement sites.

Feedback from 2022 demonstrated that 100% of students would recommend a placement to fellow students and 97% said they would come back and work for Oranga Tamariki.

Detailed placement feedback is shared with the TEOs, and any issues are addressed. A whakawatea is held as they finish their placements, bringing students togehter for a hui to farewell them and to share reflections. At this time all devices are returend, and hours are signed off by their supervisors.

Many students are employed on a casual basis by Oranga Tamariki while they study, e.g. into roles as drivers and support staff. Students may initially have a placement as a student, pick up a casual contract and then go on to permanent social work roles once they graduate.

Insight: ***Oranga Tamariki improved the experience and outcomes for TEOs, students and supervisors*** by managing social work placements using HR recruitment processes and strategies. It has taken the administrative burden from the supervisors, and also built a strong bond with students as their future workforce. The drivers for this innovation was a desire by HR to recruit from students and therefore provide an attractive and effective student placement experience.

A Bay of Plenty 'Clinical Campus' takes care of students and administration

The "clinical campus" model for student placements established in the Bay of Plenty is a single point of contact for clinical students in the region. The campus has been in place since 2012 and has evolved and improved over that time. The clinical campus includes ongoing learning and development for all staff as well as student placements for most students and

managing clinical trials and research. We are only describing the student placement aspects of the campus which is wider ranging.

The clinical campus is the one stop shop for under-graduate clinical placement organisation including all allied health students and medical students (years 4-6). It does not currently include nursing. The campus staff:

- manage contracts or other agreements with TEOs to ensure consistency in requirements for health and safety, immunisations, Vulnerable Children Act, Police checks, etc
- ensure all necessary paperwork and online training is completed prior to placement commencing
- do all the invoicing for placements
- maintain a student database so they know where any students are, at any time, and all their details (this was very handy during the pandemic)
- orientate all the students (face-to-face) which includes a tour of the hospital and an in-person "hand over" to their HSP student supervisor
- provide students with a list of possible accommodation in the area before they arrive.

The clinical campus concept started as a virtual model and morphed into a physical model over time. There are two physical campuses, at Tauranga and Whakatane hospitals. The campus also runs the Rural Health Interprofessional Programme for Whakatane (more on this below). They consist of meeting or teaching spaces (used for both students and staff), library, skills lab, shared kitchen, office space, equipment storage for teaching, a student lounge and locker room. The student facilities are important innovations offering better pastoral care and enabling informal networking between students from many different professions. Students undertaking community-based placements also have access to the shared facilities.

Insight: **'Clinical Campus' staff in the Bay of Plenty ensure students receive good pastoral care** and do all the administrative tasks. This leaves the HSP supervisors to focus on the clinical learning requirements. The service which evolved over time found that investment in pragmatic supports, with economies of scale across many professions, makes a positive difference to improving placement outcomes for all parties.

The Rural Health Interprofessional Programme could be built on

The Rural Health Interprofessional Programme (RHIP) offers a learning environment to understand rural communities that health professions can serve and how they can work across professions to provide the best health outcomes. It consists of seven rotations each year of a five-week block course for 10-12 health students from five to seven different professions (including allied health, midwifery, nursing and medicine) per site. Students are fully immersed in rural inter-professional environments.

Four days a week are spent in clinical placements in the hospital or community, and one day a week on training. We understand that positive learning outcomes may include:

- teamwork amongst professions
- understanding of rural communities, culture, and health disparities between rural and urban communities
- understanding of rural Māori health needs and inequities
- gaining insight into patients who live in remote/rural locations and their health
- preference to work in a rural location after graduation.

The programme commenced in 2012 in two sites: Whakatāne and Tairāwhiti. Over the last three years it has been expanded to include two new locations: the West Coast (first cohort

in 2021) and Hokianga (first cohort in January 2023). It comprises two similar programmes run separately by the Universities of Otago and Auckland (under a three-year contract with Te Whatu Ora). Both universities work with other TEOs to include a wide range of health disciplines in the programme.

Insight: **Evaluating and expanding RHIPs may be an ideal way to address a key area of demand.** By adding an additional cohort per year in existing locations and/or adding new locations, it would be possible to increase and improve quality clinicial placements in rural settings and ulimately to improve rural health outcomes.

Dedicated Education Units are effective TEO and HSP collaborations

Dedicated Education Units (DEUs) have been embedded in nursing student placements in Canterbury, Counties Manukau, Capital and Coast and Waikato hospitals for over ten years, with some other districts also having a smaller number of DEUs. They offer an alternative to the 'preceptor' model'[5] for nursing placements.

In a hospital context a DEU is often a ward or across two wards with two key support roles: the Academic Liaison Nurse (TEO) and Clinical Liaison Nurse (HSP). These jointly resourced roles are critical to the effectiveness of DEUs[6] and a minimum number of students are generally required to make them feasible. DEUs can exist in community settings such as district nursing or public health where there are a large nursing teams but are inappropriate with small teams. The DEU provides a clinical environment where students' learning needs are met through appropriate teaching and learning opportunities, with the principles of the community of practice theory.

DEU's provide structured orientation, allow for organised daily learning opportunities, monitor student attendance, and progress and encourage multidisciplinary staff to work with students. Clinical Liaison and Academic Liaison Nurses work together to support students and staff, and assist with assessments. DEU staff report high work satisfaction and the ability to be able to build rapport and trust with nursing students, whilst students report improved communication, access to staff and consistent assessment practices[7].

There is a centralised organisation structure for DEUs, with cross-sector governance. A health service may have a mixture of DEUs and preceptor placements. DEUs in New Zealand are generally established for nursing clinical placements, with a small number incorporating other professions, and this could be an area of further development.

We heard throughout the engagement that DEUs are working well and there is general support to expand them. There are also limitations; they only support large sites so cannot be used in all areas. There is also variable TEO support given the potential requirement for more staff resources than they currently provide. Focus group participants suggested a need to develop nationwide standards about the level of resourcing required as this can

[5] Preceptorship is a common model of support used in nursing when experienced professionals offer 1:1 guidance and act as a role model to students (or new staff member). Rostering students with one preceptor for the entire placement allows them to develop a cohesive working relationship, and results in a positive and effective placement. Challenges for the preceptor can include balancing multiple roles, with the additional work of preceptoring perceived as a burden, with little recognition given. Haitana J, Bland M. Building relationships: the key to preceptoring nursing students. Nurs Prax N Z. 2011 Apr;27(1):4-12. PMID: 21710910.

[6] Jayasekara R, Smith C, Hall C, Rankin E, Smith M, Visvanathan V, Friebe TR. The effectiveness of clinical education models for undergraduate nursing programs: A systematic review. Nurse Educ Pract. 2018 Mar;29:116-126. doi: 10.1016/j.nepr.2017.12.006. Epub 2017 Dec 16. PMID: 29272736.

[7] Dimino, Kimberly DNP, RN, CCRN; Louie, Kem PhD, APN, CNE, FAAN; Banks, Janet DNP, RNC-OB; Mahon, Emily PhD, MBA. Exploring the Impact of a Dedicated Education Unit on New Graduate Nurses' Transition to Practice. Journal for Nurses in Professional Development 36(3):p 121-128, 5/6 2020.

involve some complex calculations. There was also a proposal to create 'cultural' as well as 'clinical' DEUs building on the model with a cultural focus.

Insight: **DEUs are an evidenced way to enhance clinical placement support and increase capacity.** An expansion to more regions would create more national alignment, with the overall aim to improve clinical learning and capacity across the motu. Given the current reality of clinical environments with nursing workforce challenges, providing additional supports to nursing students whilst also supporting the staff who nurture students will be welcomed by the nursing workforce.

Placement costs for students increase attrition

In focus groups we repeatedly heard about some common challenges or barriers experienced by healthcare students, which lead to financial stress before and during clinical placements, for some this may lead to them dropping out of their course.

Pre-placement requirements lead to some students dropping out

Health provider requirements to prove immunity and/or obtain vaccinations are variable and inconsistently managed across TEOs and HSPs

Some TEOs cover the costs of obtaining an immunity record in the course costs, and contract student health services to manage the process, for others it is left to the student to organise and self-fund. This can come at a considerable personal cost to students who may need to consult their GP and pay for laboratory testing to gather information. The costs for this are estimated at $200-$300, though for some students this was reportedly higher.

For students who did not have childhood vaccinations in New Zealand, or who were born before 2005 their immunity record may not be easily accessible, leading to additional costs for laboratory testing. There is also variation in the required vaccinations across the different health providers, as evident in the clinical placement agreements. Focus group participants reported that some students dropped out rather than navigate these requirements or pay extra, and this would often be Pacific or Māori students, further exacerbating inequity.

Other pre-placement requirements also create financial stressors for students

Some programmes require students to complete a first aid course pre-placement, and for most a uniform or work appropriate clothing and footwear needs to be purchased prior to placements. They can require multiple uniforms to allow for laundry.

At least one TEO was so concerned about students dropping out before they do placements because of the costs, that they have arranged to meet these costs via the student fees and thus allowed students to pay over time (via their student loan etc).

During un-paid placements, student's life budgets are often stretched

Some placement opportunities go unfilled due to no suitable student accommodation

Away from home placements can come with significant travel and accommodation costs, especially in more isolated or rural sites, or in high demand urban sites with limited/expensive accommodation. Finding suitable available and affordable accommodation can be a challenge, with some placements going unfilled as there is no student accommodation.

To address this barrier for rural placements, the Rural Health Interprofessional Programme five-week placements in Hokianga, Whakātane, Tairāwhiti and West Coast cover costs for travel and accommodation and are therefore popular options for students to attend.

Additional costs may also be incurred for commuting, petrol, parking and childcare

Even if students are not required to travel for placements, shift patterns of early starts or late finish times can mean public transport is not suitable or safe for students to take so there can be additional vehicle related costs. Staff parking rates are often not available to students at placement sites, with students needing to pay the public rate of more than $20/day, or seek off-street, or private parking options. Some students with families will need to pay for additional childcare during placements and make arrangements for other dependents.

Reduced capacity to supplement their budget with part-time work

The most significant financial impact during placements is the decreased earning capacity compared with outside of placement times. The scheduling of placement days and shifts will often mean students are not able to continue their usual part-time work, particularly if the shifts overlap and the placement and work sites are not in close proximity. Research indicates some students have to choose between rent and meals, sometimes calling in sick to placements if they could not afford to attend. It is evident in the literature that financial stressors detract students from opportunities to learn and compromise their overall experience of being on placement.[8]

Insight: ***There is a need to address financial costs for students doing clinical placements.*** Students may use a mix of savings, family support, student loans, allowances, support from the Ministry of Social Development, scholarships, and part-time earnings to try and keep up with the financial pressures while studying healthcare. However, some cannot manage, and it leads to inequitable outcomes and retention rates in health professions. These issues particularly impact Māori, Pacific and disabled learners (see Page 47).

Student support via StudyLink is limited and can be inadequate

StudyLink can help students pay for their studies through student loans and allowances. However, StudyLink eligibility (for loans or allowances) has a lifetime limit (of about seven or eight years of full-time study) and notably does not accommodate part-time study.

A loan can be used to cover course fees and course related costs including living costs and is paid back over time via the tax system. It is interest free if you remain in New Zealand.

Student allowances have tighter eligibility constraints and how much they can get depends on age, other income (including parents' income if the student is under 25 years of age) and course type. Eligibility changes if you're over 40 (after which it will only cover around three years of full-time study). Students who are retraining in health, following previous study and students who are over 40 may not be eligible for StudyLink allowances and loans causing further financial hardship.

Digital systems demonstrate great potential

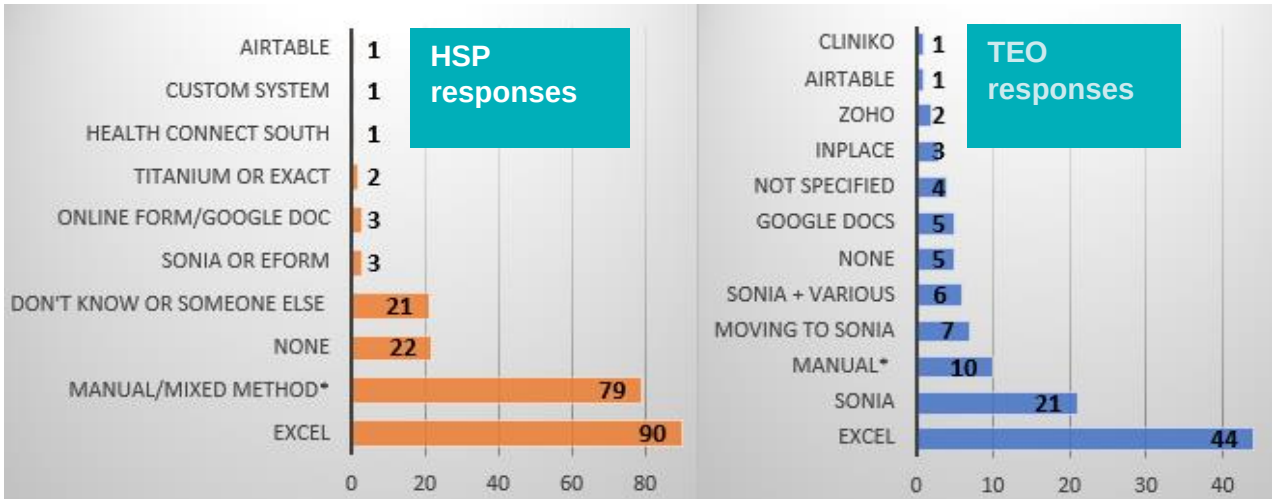
A range of digital tools are used across the motu

There is no consistently used digital tool for organising student placements in a joined-up way across New Zealand or across TEOs. However, a few regions or TEOs have implemented digital systems that effectively address their specific student and placement provider needs.

[8] Grant-Smith, D & de Zwaan, L (2019) Don't spend, eat less, save more: Responses to the financial stress experienced by nursing students during unpaid clinical placements. Nurse Education in Practice, 35, pp. 1-6.

Our survey asked what booking system respondents used and out of 384 responses the biggest response was Microsoft Excel (134) followed by a small number using Sonia (~30) and the majority listed 'other' (220) with a wide range of descriptions including: *'human thought'; 'different for each administrator'; outlook; wall planner etc.,* (**see Figure G**)

Figure G: Survey responses to 'what is your current booking system'



** "Manual/mixed method" includes: calendar, diary, email, phone, in person, other MS product (not excel) etc*

Digital tools, here and in Australia, show that our goals are achievable

We identified some sophisticated digital tools developed or purchased over the last few years to help organise student placements. Many have achieved success at addressing aspects of the challenges we have been identifying. This section outlines key features and lessons with the implementation of these systems with a few key insights highlighted.

A multiple platform system used by WITT (Taranaki, subsidiary of Te Pūkenga)

WITT integrated the following three purchased digital tools to create a digital placement system that assists with their nursing and other health courses:

- Airtable: a customisable online relational database and spreadsheet combination (similar to MS Access plus Excel) as a backend database. Access is limited to a few WITT staff, and others have read only access. The database and related apps were designed and built in-house, and are reliant on one person maintaining it, so potentially not scalable.
- Jotform: Online form creator–feeds some data to the database e.g., photo of records.
- Placement platform: Bubble.io. This website builder can pull info from wherever it is told to, in this case Airtable. It is the front end used by students.

The Airtable database contains information on students (populated by the student management system via automatic downloads), staff, placement facilities, programmes, placements (in negotiation, declined, confirmed) and clinical weeks. Negotiating placements occurs outside the system but once allocated students are linked to a placement on the database. Students interact via the web-app, they upload photos of signed timesheets and enter hours (which are audited) and access information about placements. They also upload tasks and contribute to discussions and receive feedback from the clinical lecturer. The HSP have read-only access that shows them details of students coming to a placement, other placement sites get an email. Student information and photos from the database are used to generate hospital IDs and logins.

Insight: ***Designed for and by the TEO meets their needs but not HSP needs.*** Feedback from students is positive. However, while it is an improvement for the HSP (they appreciate a live system to check) the interface is not smooth with low automation and formatting issues. The HSP needs to manually download each student registration form separately for onboarding, and they use separate excel sheets to coordinate placements at the hospital.

Desired future developments include providing all HSPs with frontend access/dashboard to see students and linking in preceptors to be able to provide feedback and assessment inside the system.

Student Placement Management Software – Sonia selected by some Universities

Sonia is used by the University of Otago for all its health programmes, University of Waikato for Nursing, and several other universities are investigating expanding the use of Sonia.

Sonia provides a customisable platform and the following applies to how Otago has configured it. All student information is stored and uploaded directly from the student management system. This includes pre-placement check information (health screening). It is possible for Sonia to export this information into a file to import into another system, however, there would need to be a mechanism for capturing permissions on sharing personal information, which might present a legal difficulty.

Insight: ***There is capability to efficiently allocate placements according to prioritised preferences.*** Students log in and select their top three, four or five preferences and add supplementary notes. For each profession, a separate placement group is set up in Sonia, with the placement sites available for that timeframe added. Within the system the placement officer can then see the preference rankings and notes, then Sonia can automatically allocate students to placements sites, based on the rankings. There is an ability to override this allocation. Otago have found Sonia is accurate in granting students (via an algorithm) their preferred placements, and in under two minutes.

HSP have access via a portal, and some are setup to go in and record student assessments. All the communication with sites can be sent directly from Sonia, so there is a record of communication.

Students enter via a portal and use it to access placement information, mark preferences and enter timesheets. There is little feedback from students, which implies that it is working for them.

Insight: ***It is important to provide support to fully make use of the functionality.*** The system is 'very configurable' and is not used in the same way, or to its full capacity, by all education programmes. University staff suggested that if there was a companion system on the HSP side that it would be easier for the full functionality of Sonia to be deployed. They acknowledge that some departments are still working their old systems alongside Sonia, if they had more time, they would work with them to show them how to use Sonia to its full capacity.

Some departments have seen a reduction in administrative time with the switch from complex spreadsheets to an automated process. The emergency management team have also found it valuable to be able to locate students at any given time.

InPlace Student Placement Software selected by some Te Pūkenga subsidiaries

Similar to Sonia, InPlace is 'off the shelf' software, offering a management platform for clinical placements. Otago Polytechnic have used InPlace for four years for health courses (Nursing, Midwifery, Occupational Therapy) – around 500 students in 1,600 placements a

year. It is also used by other faculties. Ara Institute of Canterbury started using InPlace in 2021 for Nursing and will roll out to other health programmes.

When Otago Polytechnic and Ara compared Sonia and InPlace in the market they felt they were similar, with some differences in functionality. They preferred the student interface of InPlace, and they felt the technology that InPlace is built on was more modern.

Insight: ***Key to success was implementing good business processes and standard operating procedures*** prior to installing InPlace. Once fully implemented placement organisation was improved, and coordination with the placement providers was streamlined.

Otago Polytechnic integrates the information from its student management system into InPlace and then groups student data into courses or placement groups, and adds HSPs. Placement requests are set up and students allocated. They manually allocate students to placements, although this could be automated with rules applied to allocation. Pre-placement requirements are uploaded and students can access placement information. Placement providers have access to view and accept placements, and the information can be used for invoicing.

Both organisations feel the main advantage of InPlace is having one central point of truth, and increased availability of data. It doesn't take away the challenges of finding more placements.

Similar to Sonia, we understand InPlace has a product which allows for collaborative placement coordination across TEOs and HSPs. This is used in ACT Australia.

Auckland implemented a common database system for nursing placements

This is used by Auckland - Te Toko Tumai, Waitemata and Counties Manukau districts (they have separate versions, but the same format and business processes agreed across five TEOs in the region).

A locked master spreadsheet has been developed that displays available placements in all clinical areas across the calendar year. The five local TEOs can view this, and in the window when it is unlocked, they put in placement numbers/year level requests into the available slots. Negotiations then take place between the TEOs to manage double bookings and keep to agreed student numbers. Once finalised and a minimum of four weeks prior to placements, the student names are shared from TEO to HSP via a master form that is used to arrange all required IT access and logins, security cards and ID. Late requests can only be considered if the TEO has identified a potential gap from the spreadsheet.

Insights: ***This cross TEO and HSP regional spreadsheet enhanced coordination and they see potential for more improvements.*** There is now much clearer information and data available which reduces the effort spent on planning, negotiating and administration, including invoicing (previously there was manual count across numerous multiple spreadsheets). They are now looking at how to link it to Trendcare (Safe Staffing tool that calculates how many nurses and the skill mix necessary to safely staff wards) to see if it can help guide how many students a clinical area can support.

PlaceRight Victoria is effective for a similar sized population as New Zealand

Placeright is a web-based information system, providing a standardised consistent and secure mechanism between education provider and health service placement providers. It was built in 2011 for the Department of Health Services Victoria, by a third-party provider. It is owned and funded by the department. Costs for development were $5.1million (total spend from 2011-2015) for development and initial costs – mostly development staff.

Placeright is now rolled out to 25 health professions and over 23,000 students a year, for all of Victoria and South Australia.

It offers three views 1) for the Department of Health system administration, where all data is entered on service providers, users, and where system support is offered; 2) for placement providers; and 3) for education providers.

Before a placement can be arranged a partnership must be agreed between the health service and education provider. From there placements can be offered and unlocked by health providers, requested by an education provider, and then published back to the education provider "in offer" and then confirmed. Once confirmed student names will be added against the placement, within a cut off four to six weeks prior to placement. Education providers upload student information, placement information can be added, and reports generated. Placeright can link with systems like InPlace or Sonia that education providers use, however, most TEOS find it easier to interface via spreadsheets with bulk uploads.

Insight: ***A driver for the system is that it manages mandated reporting on placements for the Government*** and related payments to HSPs by the Government per placement, in addition to the payments by TEOs to HSPs. The reporting helps the government with workforce planning and they also incentivise HSPs to provide placements in high demand areas with higher payments. A key strength is the ongoing dedicated staff that provide support, reporting and have managed a continuous improvement process for the system.

ClinConnect | HETI (nsw.gov.au) was built in-house in New South Wales (NSW)

ClinConnect is a web-based application that was developed by the Ministry of Health in NSW over ten years ago. It is now supported by eHealth and Health Education and Training Institute (HETI), eHealth providing the technical and development aspects and two HETI staff support the state-wide platform for all entities that use it, with governance provided by stakeholders within the Ministry of Health.

It provides a dashboard view of information by discipline; important dates, placement summary and links to policy directive, student compliance and verification necessities, and a proforma of the student placement agreement. ClinConnect allows HSPs to offer clinical placements within certain cycles that TEOs then apply for within a set timeframe. There are various pathways to request placements depending on the discipline preference, the most common being the request/approve/accept pathway, where the HSP must approve and accept the placement that is requested. This process takes place six months prior to placements, with some room for late requests up to 21 days prior (after that it is managed by HETI staff on a case-by-case basis). Placement hours are recorded in the system, however there is no payment made for placements. Students have a ClinConnect number and placement number to make searching within the system easier.

There is a requirement for the HETI staff to add in new cycle dates manually each semester. It does not interact with Sonia or other education-based applications and does not allow student access. ClinConnect can produce reports on many aspects of the data it holds.

Insight: ***There is no payment provided by TEOs to HSPs in NSW which simplifies the administration*** and makes it clear that educating health professionals is a joint responsibility between health and education.

HSPnet used in the northern region to manage RMO placements is inflexible

HSPnet https://hspcanada.net/ is a Canadian based integrated software package and is used by Te Whatu Ora, to manage Registered Medical Officer (RMOs – junior doctors including registrars) placements in the northern region. The system supports around 1500

RMOs. There can be up to 7000 placements (runs) per training year (usually four x three-month placements for Post Graduate Year (PGY) 1 and PGY2 and two x six-month runs for Registrars (but there is some variation).

RMO allocations take place annually, decisions on allocations are made by clinical staff, outside of HSPnet – data is then uploaded into the system and reports can be generated. A team administration staff support HSPnet and related processes around allocations.

HSPnet has been in use since 2013 and will be out of license at the end of 2023 and a replacement is being investigated. The system has been adapted to also hold recruitment/HR and training information in addition to the allocation function. There is no ability to make further adaptations to HSPnet, with limited improvements or upgrades in the past five years.

In 2014/2015 HSPnet was piloted by AUT University with Waitemata and Auckland DHBs to manage undergraduate physiotherapy student clinical placements. The Northern region team ran the pilot and undertook the evaluations. The DHBs rated their initial impressions on the extent HSPnet met their expectations and requirements as 'poor' and 'insufficient evidence' whereas AUT rated this as 'very good'. This reflected the three organisations very divergent views on the overall suitability of HSPnet – its ease of use, potential impact on workload, and the compatibility of HSPnet with existing workflow processes. Expansion of HSPnet was not implemented due to lack of support from the DHBs.

Insight: ***Off-the-shelf software may be inflexible for future improvements or expanded use.*** There is a need to upgrade HSPnet for ongoing use for RMO placements. However, this may not be feasible as the licence to use the software is expiring. Replacing the entire system is the preferred option.

International evidence on clinical placements

Worldwide, many governments and education providers want to train more health professionals to increase their domestic supply of healthcare workers and help to address the current global workforce shortages. Related increases in the number of learners are seen to place considerable pressure on health services to accommodate more clinical student placements within a backdrop of resource limitations, emerging healthcare system challenges and health crises, such as the COVID-19 pandemic. While this is not an entirely new challenge, the solutions are not clear in the international literature.

Fourteen post-2010 articles from like-minded countries were identified as having lessons that can be extrapolated with caution to the New Zealand context (see Appendix B).

The impact of placements on the health services has not been well quantified

Several researchers considered the impact on productivity and costs to health services of providing clinical placements. There is no clear consensus in this literature, however it is common for services to identify resistance from health professionals to supervise student placements, due to the perceived negative impact on their time and workload.

Several studies suggest clinical placements add cost to a health service provider by consuming supervisor time. One study estimated a supervisor spending 4.3 hours on average per week supervising a student, which directly results in a decrease in service provision. However, other studies showed students may have a neutral or positive effect on patient activity levels and clinical time during placements. Longer placements were identified as a key contributing factor to more positive impacts. This aligns with the preference

expressed from health services as they suggested longer placements to allow services to develop trust and confidence in a student.

The varied definition of productivity and other limitations of individual studies reduce the ability to generalise these findings.

Key themes for what needs to be addressed in all placement models

Several research studies explored the different models available for arranging clinical placement (see Table B) and no model is identified as superior in all circumstances. However, the following themes were identified in these studies as the most important considerations for any successful placement model:

- prioritisation of the development and nurturing of positive relationships between students, peers, and their facilitators, with the need for consistency and continuity
- students must be supported by experienced professionals and be facilitated to meet competence through individualised feedback
- provision of a specific orientation
- incorporate development of positive learning experiences and perceptions from students
- collaborative allocation of resources (from health and education) for sustainability
- the potential to offer a variety of models within settings and professions.

Table B: Student placement models

Traditional / Block placement 1:1	Block placement models integrate full-time clinical placements for periods of weeks within study periods. Apprenticeship style of learning underpins block placement models.
Collaborative/peer-assisted learning models 2:1, 3:1	Collaborative placement models emphasise the assignment of two or more students to a clinical supervisor. This uses peer learning and wrap around support for the supervisor who has the key role supporting the students.
Capacity development facilitator model	This model has an onsite facilitator from the university who works with clinical mentors and students to ensure promotion of teamwork and professional socialisation, mutual support, increased knowledge about appropriate learning strategies and improved organisational skills.
Dedicated Education Unit	The dedicated education unit are models that reflect specific units or wards within a hospital or ward that are dedicated for the clinical placement of students. Have dedicated onsite personnel from health and education to support the students and supervisors.
Hub and spoke model	The hub and spoke model refers to a bicomponent approach to placement provision, where a student is allocated to the primary ‘hub’ but will have the opportunity for secondary learning experiences (‘spoke’) related to the primary hub placement.
Student led (only some professions)	Students lead service provision within their settings under the guidance of their clinical facilitators.
Combination	Some studies reported a combination of established clinical placement models to enhance specific outcomes. Combination models in this review, reflect an amalgamation of established clinical placement models.

Each professional group appears to favour a specific placement model influenced by numbers, capacity, and availability of supervisors. Some placement models such as Dedicated Education Units and Capacity Development Facilitator model require additional resource and are impractical in smaller health service settings with lower student numbers, or where there are fiscal restraints.

Thinking about how to do better

This section of the report outlines the rationale for, and the key components and anticipated benefits of four proposed cross-agency workstreams to develop and implement an effective, efficient and equitable national student placement system.

A cross-agency work programme is required

Opportunities are organised into four interrelated workstreams

Based on the insights from our engagement and evidence it is clear that a range of interrelated improvements is required across the motu to deliver an effective, efficient and equitable student placement system. It is also clear that implementing this system is a critical success factor for growing the responsive, representative, and sufficient health workforce that we need to deliver Pae Ora.

Four workstreams emerged out of the opportunities for improvement that we identified in our analysis and engagement:

Tahi

Investment in coordination infrastructure, including the development of a fit-for-purpose digital tool and the establishment of a student placement system hub to make more placements visible and available and to make it possible to address a broader range of learner circumstances.

This work will be critical to the success of workstreams toru and wha and to the capacity for the sector to plan. This infrastructure will enable us to know (rather than estimate) the actual capacity and costs of student placements in New Zealand and to realise many benefits.

Rua

Standardisation and streamlining of clinical placement business processes will have many immediate benefits for sector in the shorter term. It is also critical to the success of the coordination infrastructure. Longer-term it should enable the promotion of best-practice standards for coordination and delivery of clinical placements.

Toru

Increasing the quality, number and range of available placements in particular, to better include community and rural settings, kaupapa Māori providers, Pacific providers, aged residential care providers and private providers. In the shorter term this workstream will find out what it takes to expand placement settings (including to wider timeframes) to enable more students to enrol as soon as possible. Over the longer term we want to see expanded experiential learning options and placement settings that meet future health demands, address more flexible ways of working and are attractive to Māori and Pacific learners. This workstream may include the expansion of DEUs for example.

Wha

Improving equity in placements by lowering barriers to access, removing bias and improving cultural safety. Urgent work to improve retention rates for Māori and Pacific should include ensuring their clinical placement preferences can be met as a priority. This enables learners to accommodate personal circumstances and meet cultural needs. We have also identified work to improve the quality of learning and the experience of students in placements which over the longer term should lead to a more representative workforce and more equitable health services. This workstream complements significant work identified in the Health Workforce Plan 2023/24.

Together, we believe these workstreams will achieve the desired improvements, with a focus on responding to current pressures, as well the need to stabilise and transform our approach to student placements in Aotearoa. See Appendix C for proposed phasing.

The proposed details and aims for each workstream are discussed in the following sections.

Tahi: Invest in a centralised digital tool, necessary but not sufficient

A digital coordination tool can help with most of the challenges we identified

The scoping team partnered with the Data and Digital team in Te Whatu Ora to determine the requirements of a student placement system and the potential of a new digital tool to address these requirements. This work draws on the engagement, evidence briefs, other evidence and data.

This preliminary mapping and design process determined that many of the key challenges (such as insufficient visibility of, or access to placements, inequitable distribution of placements, inability to adequately plan ahead and inefficient and duplicative administration processes) can be addressed at least in part through improved business processes enhanced by a digital tool (See Table C), and without a tool we cannot make significant progress. This section outlines how we drew this conclusion and next steps.

We identified six common phases | processes in the currently highly diverse systems

See Figure H which provides a common language to discuss the key processes and phases of a clinical placement system. **See Table C** for a description of each process or phase.

Figure H: Processes and phases in a student placement system

Once these processes were determined, co-design strategies, including the creation of multiple ‘personas’ were deployed to establish key pain and gain points for each user role, and how these roles may differ within themselves. The key roles are defined at the beginning of this report, e.g. HSP and TEO coordinators and supervisors.

The next step in the process was to create detailed ‘user stories’ within each of the six business processes. This included goal statements and fundamental steps needed to achieve those goals for each of our system users. This established a specific action flow for the future state, and helped determine what specific requirements we need from a digital system to enable this, as outlined in brief in Table C.

Table C: Key processes and phases in the Clinical Placement System

Term	What we mean - (description /definition)	Interchangeable sector terms
Plan capacity	Having visibility of, and planning capacity for, student placements in HSPs so we have the right number of placements, and they are fairly distributed	*Confirm available placements or supervisors; map or manage placements; 'enter agencies', 'providers' and 'sites'*
In the future we envisage this phase is where HSP's confirm what placements will be available in a prescribed future timeframe, and a proposed hub will use the digital tool to identify areas of concern (gaps) and find ways to accommodate additional placements in those areas. The hub may also divvy out a fair and equitable distribution of placement allocations. A digital tool can enhance planning, visibility and equitable distribution in this phase		
Register	Having visibility of the number of students registered for upcoming clinical placement and recording key student information and pre-placement requirement compliance.	*Enrol; student eligibility; enter or upload student data*
In the future we envisage this phase is when TEO coordinators receive information about incoming students and register them or update their information in the digital tool. This is also the process where evidence of students meeting pre-placements requirements (police checks, vaccinations, etc) are gathered / recorded. A digital tool can improve planning and efficiency in this phase		
Liaise & match	Matching specific students with appropriate placements as per requirements and preferences and as per agreed prioritisation factors/processes. Capacity to have needs-based allocation.	*Allocate, prioritise, accept; upload, negotiate, request, accept, approve; unlock; review; in offer; confirm*
In the future we envisage this phase is where the TEO coordinators place students into their allocations, unused allocations are freed up, and then placed into. There will also be capacity for HSP coordinators to see the range of professions that may be placed in the same sites. A digital tool can improve access, efficiency and equitable distribution in this phase		
Confirm & prepare	Ensure which students go where and when is understood by all parties. Ensure the HSP is ready to receive them. Ensure students are ready for their placement and meet pre-placement specific requirements. Schedule orientation.	*Onboarding, publish lists; accept and publish; roster produced*
In the future we envisage this phase is where students acknowledge/accept placements, and HSP coordinators implement all required pre-placement preparation and onboarding. A digital tool can improve efficiency and student and supervisor support in this phase		
Provide placement	Ensuring required activities are undertaken during the placement and recorded, including assessment and invoicing	*Attachment; practicum; fieldwork; work experience; work integrated learning etc*
In the future we envisage this phase is where the placement occurs and related timesheets, assessments and other details are recorded on the system. A digital tool can improve administrative efficiency and consistency in this phase		
Feedback & report	Ensuring feedback from all parties is captured and shared appropriately alongside effective reporting, complaints and quality processes and monitoring.	*Continuous improvement cycle*
In the future we envisage this phase is where students and supervisors provide feedback into the system, and the digital system produces reports based on the data it has gathered A digital tool can help ensure continuous improvement, effective planning, improved student outcomes, visibility and equitable distribution in this phase		

Prioritising and costing options for a fit-for-purpose digital coordination tool

The proposed future state system requirements were used to determine the various potential Information Technology (IT) development components, which were put through a costing and prioritisation process. This determined how much benefit each IT component adds compared to how much work and cost is required. The final output of this highly detailed process is informing the development of the business case for change.

Next steps and further system details and strategic decisions for considerations

Following confirmation of the business case, design work with Data and Digital will begin in full. Co-design workshops will need to be established between the designers and representative sector stakeholders, flushing out the specific details of the system and strategic decision-making questions. This process of system creation is anticipated to last for about eight months and then the system will be rolled out in tranches to specific roles, ensuring any issues are caught before being deployed nationally.

The following key questions will need to be addressed as part of the system design process.

Plan capacity	We will likely make use of a health system unique identity for health students to support planning: • How best can we accommodate Māori data sovereignty and privacy issues and how should it interface with education student numbers and the Health Provider Index (HPI)? Payments and incentives: • Should health funding or TEOs pay an incentive to HSPs (public and private) to provide placements? • Should we reduce administration costs by different funding methods? • Should TEOs have to pay for placements when cancelled with short notice (to prevent over booking on purpose)? When considering mandated timeframes for various steps should we require TEOs and HSPs to: • provide placement numbers / requirements 6 or 12 months in advance? • confirm specific students to placement sites 6 or 4 weeks in advance? Note - there will need to be an exceptions process for late additions. Agreeing numbers for placements: • Are placement numbers agreed then allocated at a 'whole of service' level or to a specific site/ward/speciality? • How do we map to ensure a fair distribution of placements geographically and across the sector?
Register	Student information: • What level of information do we hold in the system? E.g., demographics, iwi, preferences, health status, immunity records, police checks, screening, placement preferences, and for what purpose? • If a TEO is uploading student information, is there a requirement for this to be verified? E.g., proof of immunity. Do we link with verifying systems such as Aotearoa Immunisation Register - once fully implemented? • Should students access the system to keep their details up to date?
Liaise & match	Visibility: • Consider what access the different users have within the digital system, are users restricted to view only their profession and/or organisation and related placements? • Is there a system view by location (of all professions) – who requires this view? Note the proposed hub will have a national and local view to enable mapping, in particular, during the Plan Capacity phase - should this be shared, and with who? Prioritisation:

	• What type of preferences are required to be recorded/considered? E.g., does it include where they want to work, close to transport, convenient for accommodation, and related needs such as childcare etc? • What are the prioritisation rules, who decides these and how are they implemented E.g., does the proposed hub provide guidance for the TEOs to then operationalise, or do TEOs decide?
Confirm & prepare	Preparing supervisors • Is there scope for profession specific information to be available via the system at this stage, for example standard templates for assessment, best practice principles and supervisor support. Interface with students • Will there be two-way communication with students, will their confirmed placement information come from the TEO or the shared digital system? • Will inductions, and other onboarding matters be scheduled via the system?
Provide placement	Recording placement attendance: • Do we require the system to be able to record student attendance? • What frequency would be required? E.g., by day, week or month? Invoicing: • Do we want the system to be able to manage invoicing? • What frequency would the invoicing be required? E.g., monthly or by semester?
Feedback & report	Feedback and complaints: • Should the digital tool collect standard, formal and regular survey information from all users? • Should the system include a student complaint system, and/or third-party complaint/feedback monitoring? Monitoring and reporting: • What regular monitoring information and evaluation data would be useful? • How are reports managed by the system – what reports are required and for whom?

A ‘Student Placement Hub’ is envisaged for implementing the digital tool

Once the digital tool is launched it is envisaged a student placement centre of expertise will be established within Te Whatu Ora to manage the overall system and make use of the centralised digital tool.

Key functions for the hub could include: planning capacity with a whole system view, mapping placements, identifying gaps and finding solutions, providing system users guidance for prioritisation including to ensure equity, providing ‘helpdesk’ support to all digital system users with capacity to override if required, producing and sharing reports to improve system functioning and planning at all levels, stakeholder engagement, monitoring and evaluation, continuous improvement projects, refining functionality and more.

We’ll likely propose an interim hub to assist with work across all workstreams, to build and retain necessary expertise, and to design and establish the permanent hub as a key component of this proposed workstream.

Rua: Options to streamline, standardise and improve in the short term

In parallel to the development of a digital tool, there are a number of opportunities for improvement we can implement in the short term. Each opportunity is also closely aligned with the ultimate success of the digital tool and the details need to be scoped, confirmed and approved before being implemented.

Develop a standardised Clinical Placement Agreement and template

A review of current Clinical Access Agreements has been initiated. This has highlighted common areas in the agreements as well as unnecessary information that creates administrative challenges and differences. We propose a master agreement and memorandum of understanding is developed with Te Whatu Ora legal resources and in consultation with education legal representatives. The agreement would outline responsibilities for both parties, with mandated and consistent pre-placement requirements (such as health screening approaches) and standard timeframes for placement coordination processes (such as when students are registered or confirmed in placements). The master agreement would be supplemented with an annual schedule (as an appendix) for profession/programme specific requirements.

There are unique arrangements within some agreements, such as post-graduate papers offered in lieu of or in addition to placement fees. We recognise there needs to be flexibility to maintain some mutually beneficial and specific arrangements for particular organisations.

Address costs for pre-placement screening

Investigate government covering the cost of pre-placement health screening (including blood tests, immunity records, vaccinations and mask fit) for all health students. A consistent approach should also apply to other costs such as police checks. This project is about finding an effective way for the government to meet the pre-placement health screening costs for all students.

Standardise processes, systems and documentation to support placements

This work will be prioritised using what we have heard during sector engagement and recognise those areas in New Zealand that have already progressed some of this work. It could include:

- A standard policy for all pre-placements checks/screening being confirmed by TEOs or by Te Whatu Ora.
- A national standard or specifications for DEUs.
- Standard forms and processes for confirming students are ‘fit to practice’, and an agreed approach and documentation to ‘support plans’. A support plan guides a best-practice approach to provide support to students who are not reaching the required standard, and/or who experience health or other issues while on placement.
- Development of a template student placement feedback form, that could be used across the different professions with some required questions and the option to add specific questions.
- Standardised ‘placement profile’ – this is information about the placement that the provider completes and makes available to the TEO and student. It includes relevant logistical information such as parking and uniform, pre-reading and helps students to prepare themselves for the placement.

Consistent orientation and onboarding aligned with the legal requirements

The Health and Safety at Work Act 2015 and related regulations apply to employees, contractors, and students in TEO and HSP settings. The law require that workers and others

receive the highest level of protection from workplace health and safety risks, as far as is reasonably practicable. This includes risks to both physical and mental health. Student orientation needs to address these risks during the onboarding process, with assurances in place that this is being completed. Currently there are a range of approaches and resources. These could be reviewed and collated as a resource for all HSPs to ensure a quality approach and clarity about legal responsibilities.

Review payments from TEOs to HSPs for clinical placements and standardise

It is important to recognise that current payment amounts for various professions have mostly not been reviewed since the 1990s. A policy review of the settings for these payments is needed so the policy intentions for these payments can be articulated and accounted for in the respective Health and Education Votes. Currently money is transferring from TEOs to HSPs in ad-hoc, mostly inefficient and inequitable ways.

This project would also initiate work looking to establish a standardised payment approach for clinical placements in the Clinical Placement Agreements.

Toru: Increase the quality, number and range of placements

This workstream complements, and makes use of, the digital tool, standardisation and improvement processes. It involves exploring a range of service delivery and policy initiatives with the potential to increase the number and quality of available placements, especially in high demand service areas. There are opportunities to begin some proposed projects in this workstream immediately with pilots to expand places and using learnings. Some projects are closely aligned with actions in the Health Workforce Plan 2023/24, and some will need to inform future proposals for investment.

Devise strategies to reduce pressure on supervisors and increase capacity:

- **Ensure sufficient regional HSP coordinator resources in all areas**
  This can ease the burden on onsite HSP clinical supervisors by coordinating training and facilitating non-clinical education, allowing onsite clinical teams to focus on on-the-job training. An example of this is the Clinical Campus in the Bay of Plenty.
- **Establish and expand DEU models where appropriate (right service size)**
  DEUs in more health services across the motu and a wider range of professions will achieve the goals noted above regarding coordinator resources. DEUs have been proven to increase capacity for placements and improve the quality. This has funding implications for TEOs and HSPs that need to be explored and addressed.
- **Investment in supervision**
  Investigate ways to increase supervision within areas of high workforce demand, including pathways for supervision training and looking at supervisor release time, backfill, lower caseload, advancement opportunities and other incentives or support for services to take on students. This could include providing additional FTE.

Increase placement options by using the whole nation and whole calendar

This project needs to establish processes for extending options for placements to all areas with wider timeframes, so it is possible to match a broader range of student preferences (addressing variable personal circumstances), and make more placements available.

According to our survey 74% of TEOs currently already place some students outside their region and sometimes it is a requirement. However, there are many reported challenges about ensuring it meets student needs and preferences at this stage. The digital system presents a great opportunity for learners to find placements that meet their preferences in a

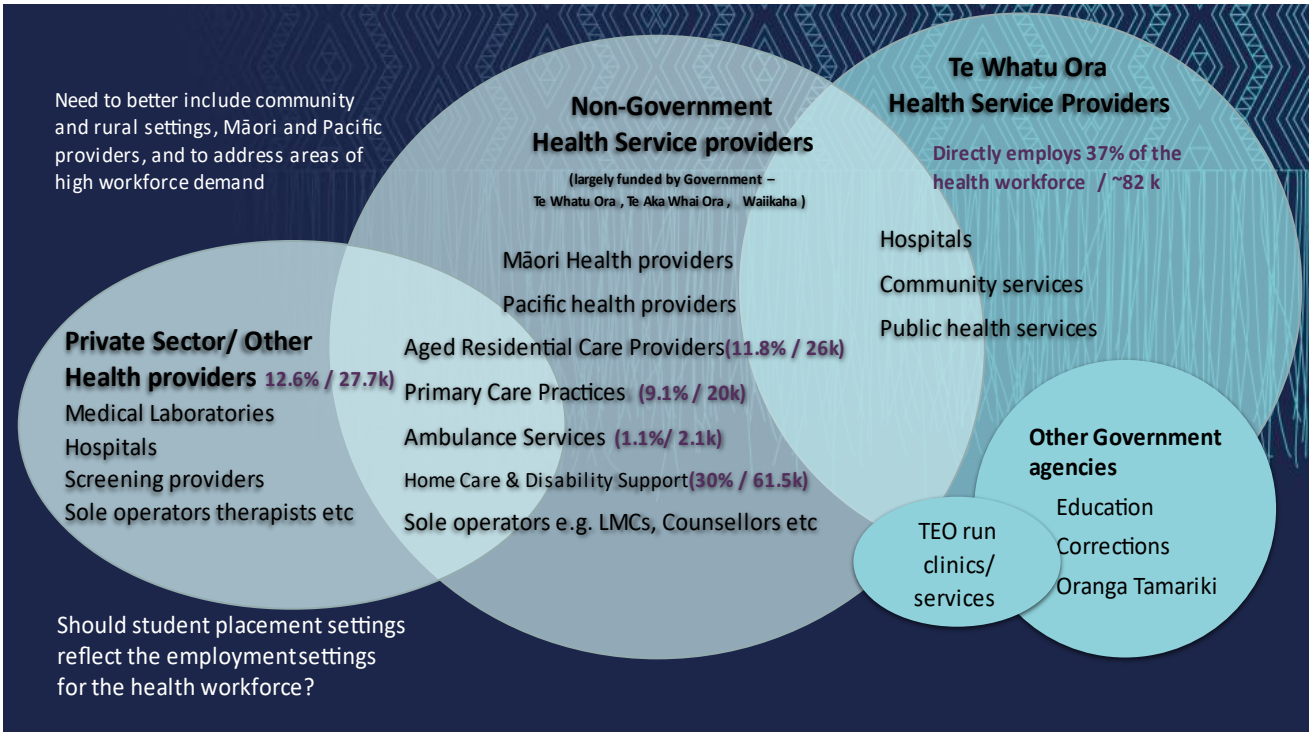
broader range of areas (not just where the TEO has pre-existing relationships). For example, places where the student has whānau support, or where they know they want to work, or alternatively in some cases they may prefer to be placed away from home as they don't want to work with patients/clients they already know.

Part of this project will explore options for providing placements outside the academic calendar and in weekends etc. While these timings are not always appropriate for the HSP, TEO or student, in some situations they may work. Therefore, removing barriers will help to broaden options.

Expand clinical placement settings and mapping fair distribution

There are a wide range of learning settings for health profession students (see Figure H). However, we know anecdotally that placements are not distributed in a way that matches where graduates want to work when they complete their courses, or that addresses the key areas of demand. We have also heard there are parts of the health sector that could accommodate students for clinical placements, but have not had a request to do so, or they would require extra support to establish quality clinical placements.

Figure H: Clinical Placement Settings



We will get an accurate view of how placements are distributed when the digital system is in use. In addition, a view of the whole system and increased visibility of placements, as well as services becoming aware, may help to broaden the range of placements available. One part of this project is establishing a way to calculate and allocate a fair distribution of students. This would build on the approach currently used for medical students.

There is also a need for targeted initiatives to be designed and implemented to expand the settings that can offer student placements. These are outlined here:

- **Develop incentives for under-used private, aged care and NGO services**
  Several primary care, NGO, community service groups and the Aged Residential Care sector have expressed a strong interest in supporting students in a more coordinated and

sustainable way. We need to examine how to promote and expand these placement settings, while acknowledging their current immense workforce pressures.

We heard the lack of monetary incentive, and/or perceived burden of paperwork for the private sector are factors that influence their decision to offer clinical placements. Addressing these issues could open further placements.

- **Expand TEO-led clinics**
  There are some student-run clinics (Physiotherapy, Oral Health, Speech Language Therapy, Audiology) based at TEO student campuses. This model could be expanded to deliver low cost or free healthcare to areas in our communities with unmet need, while offering supported clinical placements.

- **Expand rural health placement options**
  There is an opportunity to partner with a broader rural health workforce programme to improve and increase clinical placements in rural settings. This may involve evaluating, improving and expanding the Rural Health Interprofessional Programme (RHIP) outlined earlier in this report. It will also be important to bring a rural lens to all the other activities in this workplan, such as ensuring the proposed digital tool accommodates the needs of rural localities.

  Te Whatu Ora, Te Aka Whai Ora and Manatū Haurora plan to work together with a wide range of rural stakeholders, to co-design an integrated approach to rural health education and training. This work will focus on improving access, coordination, and alignment of education and training pathways in rural settings – clinical placements will need to play a role.

- **Partner with service expansion that has the potential to expand training settings**
  From 1 July 2023, the “Early Actions” workforce development funding is expected to support workforces who will be forming Comprehensive Primary Care Teams, including pharmacists, physiotherapists, care coordinators as well as further allocations for GPs, nursing, and paramedic roles. The project is prioritising Māori and Pacific workforce development and will be flexibly applied to support skill enhancement and working to top of scope for professionals.

  A portion of this funding is also being proposed for practice-level support for rural practices to host students/trainee placements and/or meet supervision requirements such as for Nurse Practitioner and Pharmacist Prescriber training. Often, they do not have the size or capacity to host placements.

  It would be useful to work alongside this project and look for opportunities for supporting these newly enhanced teams to take pre-registration student placements. It would be mutually beneficial as the long-term goal is to build this community workforce.

Wha: Improve equity with a stronger focus on learner needs

Enrolment and retention for Māori and Pacific learners in health needs to improve

Although enrolment rates have increased for Māori in some health professions, their completion rates remain low (see Table D) compared with other ethnicities. Pacific learners do not have good enrolment or retention rates for most health professions.

Table D: 2022 cohort-based qualification completion rates for TEC funded learners[9]

Health profession education programmes	Māori	Non-Māori and Non-Pacific Peoples	Pacific Peoples	Overall
Audiology	"S"	96.2%	"S"	96.4%
Medical Imaging Technician	80.0%	89.5%	"S"	88.3%
Medical Laboratory Science	"S"	84.1%	"S"	82.7%
Midwifery	51.1%	62.9%	52.9%	59.0%
Nursing (Registered) Degree level	60.3%	71.5%	57.2%	67.6%
Nursing (Registered) Grad entry	"S"	80.0%	N/A	81.8%
Enrolled Nursing	37.5%	66.9%	61.8%	60.0%
Occupational Therapy	58.6%	75.4%	40.0%	71.2%
Oral Health Therapy	88.9%	92.1%	60.0%	85.7%
Pharmacy	"S"	97.1%	"S"	94.7%
Physiotherapy	76.9%	89.8%	"S"	86.2%
Radiation Therapy	N/A	70.6%	"S"	66.7%
Social work	40.9%	52.3%	50.0%	48.1%
Speech Language Therapy	88.9%	83.6%	"S"	84.4%

An integrated approach is required to fix this situation with speed. TEOs are aware of these metrics, and improvement will come by focusing on all aspects of their programme design and pastoral support.[10] This will complement the work to address the costs of placements to students, as noted below. In addition, health-led or health-education partnerships that enhance the pastoral support during clinical placements need to be considered in alignment with the work by TEOs. This includes the following initiatives:

- **Prioritise cultural preferences related to placements of Māori students**
  It's important we focus on enabling Māori students who would like to work with Māori providers, or do their placements in an area they whakapapa to, or work with Māori tikanga methods, to meet these aspirations as part of their experiential learning.
- **Offer pastoral care with the Tuakana | Teina mentor programme**
  We need to connect the Tuakana I Teina mentor programme underway in Te Aka Whai Ora to students in placement settings. This could mean that regional cultural coordinators work with students and supervisors to establish a mentor programme.

[9] Table D contains data provided by the Tertiary Education Commission, 2023. The 2022 cohort-based qualification completion rates provided are based on the intended qualification required for registration within each health profession in 2022. Note: Data is for TEC funded learners only. Figures provided in red identify results where the numerator or denominator is between 5 and 10. Care should be taken with the use of these values. Where numerator and denominator values are less than five, the value has not been provided. These suppressed values can be identified by a "S". For more information please see: Methodology Guidelines

[10] A model for achieving this is the Ōritetanga Learner Success Framework which has been rolled out by the Tertiary Education Commission. It aims to realise system-wide equity in the tertiary education sector. Large tertiary education providers are required to submit Learner Success Plans which outline how they will implement organisational change to achieve equity at their organisations.

- **Expand other effective pastoral support options**
  There needs to be cultural and pastoral care for student placements across all districts. Many localities have 'homegrown' approaches that are successful (such as a local hub for students along with inclusive whanaungatanga). This good practice can be used as model for other areas. This project is about identifying and mapping these to identify gaps and areas for investment and upskilling staff with the knowledge.

Improve the range of support available for students to address financial stressors

The number one barrier for many Māori and Pacific students completing placements and graduating as health professionals is financial hardship. This can include having to absorb costs associated with pre-placement requirements, decreased earning capacity during placements, parking, transport and accommodation costs for out-of-town placements.

We heard the following ideas during our engagement to mitigate the financial impact of placements on all students. Some have a broader remit and will need to sit outside this workstream, but related work will be closely aligned, and the impact should be monitored:

- The government (HSP or TEO) covers the cost of any immunity screening or vaccinations required for pre-placement screening, either through fees, or as a cost to Te Whatu Ora, with vaccination requirements standardised (noted in workstream 2).
- Ensure priority for placement allocation is given on a needs-based system, so those with need (such as dependents, family circumstances) are given a choice of placement location first (a component of workstream 1 and needs to include the development of agreed business processes and decision criteria).
- Work with rural placement sites to establish affordable accommodation options for students, consider who would fund this (a component of workstream 3).
- Make the range of full financial support options visible and available to students (key aligned work that sits outside this programme of work).
- Investigate the potential for the health sector to provide a stipend for students during placements and/or in their final year (key aligned work that sits outside this programme).
- Create options for casual student employment in health services while studying (below).

Options for casual student employment in health services while studying

Explore a standard approach across Te Whatu Ora for employing health students as healthcare assistants (and other assistant roles) while studying. Create and promote a student labour pool or 'bureau' to support this with employment rules that allow students time off as required to complete clinical placements. For example, a midwifery student would be provided the flexibility to be on call as required to attend births as part of their clinical placements. Also develop options that specifically suit Māori and Pacific learners.

The approach would enable flexibility to work around their studies and to pause the role if needed (assistant hours would not count as clinical placement hours). The role does not need to be in their own health speciality area, but it is likely any work in a health setting will help a student get a good feel for the health sector, in addition to providing financial support.

Innovate with clinical placement models to enhance experiential learning for students

The development of education programmes, and the clinical placement component of this over the last several decades has been strongly influenced by key policy drivers of the regulators and TEOs. Given the failure to achieve more equitable education or health outcomes there needs to be a shift in the design of these programmes to better meet the needs of Māori and Pacific students. It is likely this will improve quality outcomes for all students and HSPs.

This project is about working closely with regulators, TEOs, profession bodies and other stakeholders to understand how a programme might innovate with experiential learning to improve the quality of placements and outcomes for students and HSPs. This is likely to involve looking at how we might enable:

- 'earn learn' models of education
- recognition of prior learning and related staircasing/or bridging between different professions as well as from unregulated roles (such as assistants and technicians) into regulated roles
- simulation/virtual experiences as a component of learning
- interprofessional learning and supervision options.

The case example could involve working with the TEO and Pharmaceutical Society to implement changes to support Māori into pharmacy technician roles.

Case example provided as a submission:

A pharmacy technician pathway could be a rapid solution option to develop patient facing Māori healthcare workers. - Technicians are patient facing non-registered healthcare workers that carry out a vital role in ensuring safe and sustainable supply of medicines to patients. With additional training they can also vaccinate and check and sign off dispensed prescriptions.

Technicians can work/earn while they study towards qualification which is much more accessible than university courses. It is an excellently placed entry level pathway into healthcare, which is supported by trained pharmacist at the frontline who act as preceptors.

Community pharmacies can provide pharmacy technician placements in every single community across New Zealand so it has the ability to scale very fast. This model can also free up the pharmacist workforce to be able to step into more clinical roles.

Investment in anti-racism and anti-bullying initiatives

This project is about developing and implementing a monitoring approach across all student placement sites to flag 'hotspots' where there is an increase in 'alerts' about racism, bullying or harassment. This will then provide Te Whatu Ora with reports and the ability to target areas for training and improvement.

The idea is for third-party monitoring to be anonymous and not undermine natural justice principles. Students and staff would be encouraged to provide information to provide clarity for where investment in cultural competence and safer healthier workplaces is needed. This should include staff training to reduce racial microaggressions and enhance cultural sensitivity. This approach has been developed, tested, and implemented by Auckland Medical School with success. This initiative must be thoroughly informed by the experiences and needs of Māori and Pacific learners.

It would need to be accompanied by standard HR complaints services, to allow students and staff to take formal action through serious complaints. There would also need to be an alternative option for people who may usually not speak up or make a formal complaints due to the risk to their future, or the time and mental and emotional energy it takes.

Scope, phasing options and benefits

Next steps to establish a student placement system work programme

A business case with the costs and benefits of relevant options for a student placement system work programme is being developed. It's also important that we have further consultation on the proposed workstreams to finalise key aspects of the way forward. The project team will also continually engage as this work progresses. Appendix C is a draft version of how the workstreams may be phased.

We envisage an initial launch of a digital tool and hub will be followed by a learn | build process with detailed phasing yet to be determined. The project will test ideas and assumptions related to the implementation and phasing with system users.

The scope is constrained by the size of the endeavour

It is proposed at this stage that the system covers:

- all of health sector - (not including health placements in other sectors such as corrections, defence, and education although this extension could occur in future)
- all health professions that need clinical placements - (not including medicine initially)
- pre-registration placements.

Opportunities for further expansion or enhancements would require further scoping work. For example, the system could iteratively expand to include medical students, placement management for paid interns (including Clinical Psychologists), Registered Medical Officers, new graduates and medical specialist training. Similarly, there may be opportunities for other sectors that do placements with health students (such as for social workers in Corrections, Education, Oranga Tamariki and Social Development) to be included.

Expected benefits, outcomes and impacts of a new system

Table E outlines high-level intervention logic about our expectations of the proposed work if implemented. The benefits of the digital tool include:

- Automatic reporting, visibility of the upcoming workforce, and information on how to address upcoming shortages, oversight of whether equitable distribution is being achieved, and international student placements.
- Knowledge and mapping of placement capacity by locality and profession alongside knowledge of where the students are to help planning activity.
- A streamlined and fairer coordination process which enables HSPs and TEOs to organise placements without a complex web of relationships, without network-based bias and without as much administrative burden or duplicative work.
- A simplified process will lead to more placements being offered and taken. Easing of the bottleneck to enable TEOs to enrol more students into clinical placements.
- A centralised place for external and internal student placement queries. The proposed ‘hub’ will be able to respond accurately to queries and provide perspectives available only through having student placement knowledge in-house.
- Capacity to monitor and prioritise placement preferences for Māori and Pacific learners which can help with student costs and cultural needs and improve completion rates.
- The proposed ‘hub’, to form a student placement centre of expertise that will progress other related pieces of work to advance clinical placements in New Zealand and promote best practice.

Table E: Logic map and anticipated benefits and impacts of this new system

Issues	Objective	Outputs	Outcomes /Benefits	Impacts
• Insufficient health workforce and insufficient workforce diversity perpetuating systemic inequities for Māori, Pacific and disabled populations. • Not training enough health professionals in Aotearoa. • Training providers can't increase enrolments because clinical placement opportunities are not visible or accessible. • Poor student placement experiences and inadequate support for clinical supervision. • Duplicative and inefficient effort including by clinical and educator staff placement coordination. • No national view of student placement capacity –or where students are in health system -prevents effective planning.	Te Whatu Ora and Te Aka Whai Ora partner with the Education sector to build a nationwide, whole health sector, **student placement system:** To support TEOs, health providers and students to connect with placements across the whole motu. To prioritise students in placements and address institutional racism and other barriers for Māori To enable planning and workforce forecasting.	**1) Centralised coordination infrastructure** Related service design and business process support that ensure more, and a wider variety of, placement opportunities are visible and accessible to TEOs and students. Accurate reporting capabilities and data management. Established hub to map, plan and report on future placement capacity and act as an expert placement helpdesk. **2) Standardisation and streamlining of system infrastructure** Efficiently and fairly meeting costs of placements, with reduced administration and consistent expectations, support and documentation for all system users. **3) Increasing the quality, number and range of available placements** Increased quality placements, including in community and rural settings, kaupapa Māori and Pacific providers, aged residential care and private providers and effective support for supervision. **4) Improving equity in placements** Lower cost barriers to accessing placements, improved cultural safety of placements and investment in eliminating bullying and racism in all clinical placement settings. This will include financial support, pastoral care support and options for casual student employment.	• TEOs are able to plan and enrol more learners with confidence on how many placements are available • Easily accessed and understood system • Available, accurate, and live record of where our future workforce is in each profession pipeline • Preferences can be matched including for a more diverse cohort of students and in a more diverse range of settings • Less duplicative administration for both TEOs and health providers and improved use of existing placement options • Improved collaboration, reducing competition, bias and network driven inequity in the system • Support for underused providers to take students and fairer distribution including private providers • Support for clinical supervisors - especially in smaller and providers short of staff • Elimination of bullying and racism • Development of prioritisation systems, monitoring and evaluation that addresses equity and health needs e.g. Māori students that whakapapa to a particular area or students with dependents • Expanded experiential learning options and placement settings that meet future health demands, address more flexible ways of working and are attractive to Māori and Pacific learners • Dashboard reporting for regions and visibility of student locations across the Motu • Uniquely identifiable health workforce available for wider workforce uses	• More learners and graduates through the system • Student retention increases as quality placements are available and attractive • Better representation for Māori and Pacific peoples amongst students and graduates and the overall health workforce • Growth of opportunities to educate in service areas and communities currently under used • Freeing up resources allocated to organising student placements – more for clinical supervision and student support • Improved reputation of Aotearoa's Student placement system • Improved forecasting planning, capacity building, and risk management for the health workforce to enable the strategic intent of Pae Ora – to embed Te Tiriti o Waitangi, and enable distribution of a workforce based on population needs

Assumptions to quantify benefits

It is not possible to precisely quantify the benefits. We are making the following assumptions.

The digital system and standardisation processes will:

- enable better forward planning and confidence for HSPs and TEOs (across more than 16 professions, 23 TEOs, 20 districts, many more health services and thousands of placement sites)
- significantly improve efficiency of student placement coordination for both TEOs and HSPs
- enable visibility of a wider range of placements, in broader settings and timeframes than was possible when it is mainly managed by personal networks and varied Clinical Placement Agreements limited to agreement partners.

Through these improvements we assume that once the minimal viable digital product is implemented, we will be able to increase the range of clinical placements available/visible by at least 10% per annum.

With approximately 18,000 students currently getting placements, across nursing, midwifery and allied health, this amounts to placements for about **1,800 more students per year**.

The broader workplan will:

- provide more support for coordination and clinical supervision, including expanding programmes such as DEUs which are proven to increase capacity and quality
- over time increase incentive for private and other providers to offer placements.

Through these improvements we assume that this will also over time increase the range of placements HSPs can make available. The quantum, however, depends on the level of resources put into clinical supervision.

To illustrate, we can assume based on research a 30% increase in placement availability in a ward when a DEU is established.[11] Therefore, we can assume a ward that currently takes 10 students per annum will be able to take 13 if a DEUs is established.

Hypothetically, if 15 hospitals (of the requisite size) are enabled to establish new nursing DEUs in 10 wards (that currently take 10 students a year), then we can assume there will be an increase in nursing placements by 20 (hospitals) X 10 (wards) X 3 per year = **450 more students per year.**

Based on these estimates we will have places for **~2,250 more students per year.**

The broader work plan also seeks to improve retention through being much more responsive to student needs, in particular Māori and Pacific students.

If we reduce attrition over time by 8% with better pastoral care and support during placements as well as meeting the preferences of students with the highest needs (such as whānau commitments) then there will be an additional **~1,500 graduates per year.**

There will also be a positive cycle in play as improvements from the digital system and broader workplan deliver more graduates, workforce shortages and pressure will decrease. This should mean more senior staff are retained and more clinical placements sustained.

[11] Studies show that DEUs can increase the number of students on placements by up to 30% compared to a preceptor Model. This is achieved with a more structured and integrated Learning experiences. DEUs also contribute to better nurse retention.

Te Whatu Ora Te Aka Whai Ora
Health New Zealand Māori Health Authority

Appendix A: Key stakeholders and those we have heard from

There are diverse and numerous organisations with a stake in clinical placements. This appendix gives a sense of who the stakeholders are and who we heard from so far via our focus groups, submissions and surveys. In addition to our advisory group, that includes clinical, workforce and policy leaders from Te Aka Whai Ora, Te Whatu Ora, Manatū Hauora and the Tertiary Education Commission, the scoping team heard from:

- people from all 17 professions and 11 TEOs outlined in Table F on the next page as well as many, but not all, of the 80 TEO education programmes requiring clinical placements.
- people in Te Whatu Ora services, other HSPs as well as sector associations that are interested in clinical placements, including those listed below:

Te Whatu Ora districts

- Southland
- Otago
- South Canterbury
- Waitaha Canterbury & West-Coast
- Nelson Marlborough
- Capital Coast
- Hutt Valley
- Wairarapa
- Whanganui
- Hawkes Bay
- Mid-Central
- Taranaki
- Bay of Plenty
- Tairawhiti
- Lakes
- Waikato
- Counties Manakau
- Te Toka Tumai, Auckland
- Waitemata
- Te Tai Tokerau

Te Whatu Ora Groups:

- Directors of Nursing
- Directors of Allied Health
- Directors of Midwifery
- Addiction workforce hui
- Regional Workforce Directors

Other health providers

- Canterbury Health Labs
- Central Otago Health
- Crest Private Hospital
- Family Planning
- Grace hospital
- Hato Hone St John
- Lead Maternity Carers
- Mahitahi Hauora
- MedLab South
- Mercy Hospitals
- NZ Blood Service
- Oceania Healthcare
- Ormiston Hospital
- Pacific Radiology
- Pact Group
- Path Lab
- Pegasus Healthcare
- Platform-
- ProCare
- Ryman Healthcare
- Southern Cross - Hospitals
- St Georges Cancer Care
- Wellington Free Ambulance
- Whai Oranga o te iwi health centre

Workforce Taskforce groups:

- Allied Health Group & Professional Sector Groups
- Medical Group
- Midwifery Group
- Nursing Pipeline Programme steering group

Professional groups/ associations:

- Aged Care Association NZ
- Aotearoa NZ Association of Social Workers
- Council for Social Work Education in Aotearoa NZ
- Council of Deans of Nursing and Midwifery (Australia and NZ)
- Dietitians Board
- Institute of Medical Laboratory Science
- National Centre for Interprofessional Education and Collaborative practice
- Nurse Education in the Tertiary Sector (NETS) (Aotearoa NZ)
- NZ Anaesthesia
- NZ College of Midwives and Midwifery Employee Representation and Advisory Service (MERAS)
- NZ Nurses Organisation
- NZ Private Surgical Hospitals Association Inc
- NZ Universities Students Association
- Pharmaceutical Society of NZ
- Regulatory Bodies convened for a regular Manatū Haurora meeting
- Social Workers Registration Board
- Te Kaunihera Manapou - Paramedic Council
- Universities NZ: Planning Directors

Other

- NSW Clinconnect team
- Victoria State Place right team
- Oranga Tamariki placement lead
- 3 high schools that offer placements

Table F: Health Education Programmes by Tertiary Organisations

	South			*Central*			*North*		*All*		
Profession student #	University of Otago	University of Canterbury	Victoria University	Massey University	University of Waikato	Te Whare Wānanga o Awanuiārangi	University of Auckland	Auckland University of Technology	Te Pūkenga*	Te Wānanga o Raukawa	Te Wānanga o Aotearoa
Nursing 9150									*Numerous * (13)*		
Medicine 3480											
Social work 2505									*Numerous ***		
Physiotherapy 1145											
Midwifery 940									*Wintec, Otago Polytechnic. Ara*		
Paramedicine 870									*Whitirea*		
Occupational Therapy 625									*Otago Polytechnic*		
Pharmacy 550											
Medical Imaging Technology 465									*Ara, UCOL, Unitec*		
Oral Health Therapy 375											
Speech language therapy 360											
Addiction Practice 335				Maybe in future				Maybe in future	*Numerous **		
Medical Lab Science 245											
Dietetics 125											
Audiology 105											
Perioperative practice 75											
Radiation Therapy 75	Wellington Campus										

* Note **Te Pūkenga** includes:

- *Ara Institute of Canterbury,*
- *Universal College of Learning UCOL*
- *Manukau Institute of Technology MIT*
- *North Tec*
- *Otago Polytechnic*
- *Whitireia NZ*
- *Southern Institute of Technology SIT*
- *Waikato Institute of Technology WINTEC*
- *Eastern Institute of Technology EIT*
- *Nelson Marlborough Institute of Technology NMIT*
- *Western Institute of Technology at Taranaki WITT*
- *Toi Ohomai Institute of Technology*
- *Unitec*

(note there are other Te Pūkenga institutes that do not provide health programme

Appendix B: Summary of international evidence on placement models and costs

		Research method	Brief synopsis of findings re costs and models	Citation
Australia	All professions	Economic evaluation based upon a pilot of an interprofessional student clinic based in Australia.	This study investigated the cost effectiveness of a student-led interprofessional clinic. It demonstrated that this model yields substantially higher costs per day of student clinical education than the conventional immersion in a hospital setting model. Economics are only one factor of many in the consideration of the effectiveness of an educational intervention. Possibly improved patient outcomes and prevented hospitalisations could make this system economically viable from a societal perspective, however trial data is needed before this could be satisfactorily factored into this equation.	Haines, T., Kent, F., Keating, J. (2014). Interprofessional student clinics: an economic evaluation of collaborative clinical placement education. *Journal of Interprofessional Care* Jul;28(4):292-8.
		Literature review	There is no research able to quantify the costs and benefits of clinical placements on health service organisations. Some literature estimates the time supervisors spend directly supervising students – as 4.3 hours on average per week. This can be understood as a cost to the health service provider as it results in decreased service provision. Benefits include recruitment of future staff and students contributing to service provision if placements are of sufficient length.	Bowles K, Haines T, Molloy E, Maloney S, Kent F, Sevenhuysen S, Tai J. (2014) The costs and benefits of providing undergraduate student clinical placements for a health service organisation: *An Evidence Check rapid review for the Health Education Training Institute (HETI)*
		Literature review	Some studies demonstrate student placements in clinical practice cause an increase in practitioner workload and lengthen their workday. Clinical educator workload and time spent at work increased when a student was present with time management being the predominant challenge practitioners faced. These perceived limitations are balanced by the benefits described by supervising clinicians. Providing clinical education can enrich both the practice, and the practitioner, and the advantages should be highlighted when offering or considering the expansion of clinical placements.	Waters, L., Lo, L., & Maloney, S. (2018). What impact do students have on clinical educators and the way they practise? *Advances in Health Sciences Education* Vol 23, 611–631.
	Nursing	A participatory action approach and evaluation	A new supported preceptorship model was developed by education and health. Features included: creation of a learning community, increased IPE opportunities, changes to the clinical timetable, development of a clinical preceptorship program, support by a full-time clinical facilitator and development of common; clinical objectives, skill sets and a clinical evaluation tool. The model was associated with a 58% increase in students and a 45% increase in student placement weeks over the four-year period.	Barnett, T., Cross, M., Shahwan-Akl, L., Jacob, E. (2010) **The evaluation of a successful collaborative education model to expand student clinical placements** *Nurse Education in Practice* Vol 10 (1) 17-21.
		Descriptive study using; questionnaire survey with qualitative thematic analysis.	Study purpose was to assess the implementation of standards by Australian Nursing higher education providers as set by accrediting and regulating bodies. A finding in this study was the lack of standardisation across the placement/clinical coordination roles and activities across higher education providers. There are multiple clinical placement models used by higher education providers and their placement providers. Lack of uniformity in the definition of a preceptor or those guiding principles to assist professional registered nurses in their role as preceptors. *"A central placement system may be useful, standardisation helpful… better admin support".*	Osman, A., Bradley, L., Plummer, V. (2023) Evaluation of resource allocation for undergraduate nursing professional experience placements coordination in Australian Higher Education; A cross-sectional study with descriptive qualitative thematic analysis. *Nurse Education in Practice,* Vol 67, Feb.
	Allied	Quality review on the impact of the initiative on placement capacity and workload	This paper describes implementation of a clinical placement capacity building initiative within health services developed from a unique opportunity to provide funding through an industrial agreement. The Initiative enabled a co-ordinated response to meeting placement demand and enhanced collaborations between the health and education sectors for five allied health professions.	McBride, L., Fitzgerald, C., Morrison, L., Hulcombe, J. (2015) Pre-entry student clinical placement demand: can it be met? *Australian Health Review* (39) 577–581.

		Research method	Brief synopsis of findings re costs and models	Citation
		Systematic review with meta-analysis. (For Dietetics, Occupational Therapy, Physiotherapy and Speech Pathology)	Data showed students may have a neutral or positive effect on Allied Health patient activity levels and clinical time. Most studies were on Physiotherapy and saw an increase by 2 patients seen per day when seen in conjunction with students – placement length was a contributing factor, and this aligns with the preference for longer placements. The limitations of individual studies reduce the ability to generalise these findings.	Bourne, E., Short, K., McAllister, L., Nagarajan, S. (2019). The quantitative impact of placements on allied health time use and productivity in healthcare facilities: A systematic review with meta-analysis. *Focus on Health Professional Education: A multi-professional Journal.* Vol. 20 (2), 8-40.
Canada	Allied	Scoping review (Physiotherapy Occupational Therapy)	Overall, the 14 studies included in the review suggest that the supervision of students does not have a negative impact on productivity. However, the productivity measures varied in the type and methods which limit comparisons. This variability, along with the experience of stress by clinical educators as they attempt to satisfy multiple roles may account for the discrepancy between the perception and actual measure of productivity.	Coleman J, Knott K, Jung B. Impact of physical therapy and occupational therapy student placements on productivity: a scoping review. *Can. Med. Ed. J* 2021 Sep.15;12(4):98-110.
South Africa	All profession	The purpose of this scoping review was to describe what is known on clinical placement models used in undergraduate health professions education – research from Australia, UK, and USA.	Most research in the field of clinical placement models focuses on evaluating outcomes associated with the implementation of clinical placement models. Specific professions favour one clinical placement model over the other. These decisions are influenced by the placement purpose, the number of students, and availability of supervisors. Some clinical placement models also require extraordinary resources. Dedicated education units (DEUs) aim at creating an 'ideal' clinical environment to facilitate authentic learning. However, procuring additional resources to create an ideal clinical environment may be a challenge, as additional resources may be impractical in some settings. Medicine and Nursing report more clinical placement models that accommodate many students, while professions with a smaller number of students, dominated reports on collaborative models that allow for more intimate supervision. No single clinical placement model exists as the panacea for undergraduate health professions education.	Nyoni, C.N., Dyk, L.HV. & Botma, Y. Clinical placement models for undergraduate health professions students: a scoping review. BMC Med Educ 21, 598 (2021).
United Kingdom	All	Mixed methods literature review	Several placement models were described, including the traditional 1:1 model as well as 2:1, 3:1. The hub and spoke, capacity development facilitator, collaborative learning in practice (CLIP) and role emerging placement models were also discussed. There is a considerable paucity of high-quality evidence evaluating differing placement modules.	Millington P, Hellawell M, Graham C et al (2019) Healthcare practice placements: back to the drawing board? *British Journal of Healthcare Management.* 25(3): 145-153.
	Nursing	Integrative review	The main models of undergraduate nurse clinical education identified were: traditional or clinical facilitator model; the preceptorship or mentoring model; and the collaborative education unit model, with no ideal model identified. Four common elements across the models: the centrality of relationships; the need for consistency and continuity; the potential for variety of models; and the sustainability of the model. Effective implementation and support of a given model are central for success.	Forber, J., DiGiacomo, M., Carter, B., Davidson, P., Phillips, J., Jackson, D. (2016) In pursuit of an optimal model of undergraduate nurse clinical education: An integrative review *Review Nurse Educ Pract Nov*;21:83-92.

Appendix C: Draft phasing of proposed work programme ambitions

Workstreams	Short-term - respond - pilot – learn - build *within year one*	Medium-term - expand - stabilise *within year two*	Longer term - transform *year three and beyond*
Tahi Coordination Infrastructure	• Develop and launch a digital tool for planning and matching students to placements, across the whole health sector, whole motu and whole calendar year. • Establish interim hub to map, plan and report future placement capacity and provide expert helpdesk.	• Roll-out the digital tool and support to whole health sector in phased way with change management. • Develop detailed analysis and mapping tools, and a network of stakeholders and structures for managing the student placement system.	• Permanent hub established. • Ongoing analysis of data and feedback to understand equity outcomes, gaps and future needs – to enable planning and continuous improvement.
Rua Streamline and standards	• Develop one standard clinical placement agreement with consistent and mandated requirements and timeframes, for all of Te Whatu Ora, all education providers (and template for other health providers).	• Standardise processes, documentation and systems to support clinical placement organisation. • Develop standards and expert practice knowledge for student placements.	• The hub provides a centre of expertise for all health and education sector participants to promote and ensure best practice in clinical placements.
Toru Increase the number and quality	• Pilot expansion of nursing placements (800 additional places) and find-out what support is required – this includes extending placements to all districts, with wider timeframes, and under-used settings including community placements. • Pilot the expansion of DEUs including clarifying funding sources across education and health. • Develop investment proposals (and related policy on placement funding and support for supervision).	• Promote the expansion of DEUs (or similar). • Expand locality based and interprofessional placement opportunities, particularly in rural settings and with comprehensive primary care teams. • Create incentives to encourage under-used private, aged residential care and NGO services to provide clinical placements.	• Regulators, education and health work together to expand innovation of experiential learning options, such as: ○ new earn / learn models of education, ○ interprofessional learning and supervision ○ education-led clinics ○ infrastructure to develop the workforce outside of hospitals, e.g., clinical coaches in primary care and rural settings. ○ more 'recognition of prior experiential learning' to enable staircasing /or bridging between different professions as well as from unregulated roles (such as assistants and technicians) into regulated roles. • More student support funding to health students (may include grants, allowances, scholarships and bonding options) while they complete clinical placements.
Wha Equity	• Engage with students (with a focus on Māori and Pacific learners) and Māori and Pacific providers to refine overall plan and the following actions:. • Develop process to ensure priority for placement allocation is given on a needs-basis (e.g., those with dependents are given choice of placement first) plus prioritise cultural preferences such as Māori students who wish to work where they whakapapa to (making use of the digital tool). • Develop anti-racism and bullying initiative across all clinical placement sites. • Develop support for placements in Māori and Pacific providers.	• Ensure government covers cost of pre-placement health screening for learners. • Establish a standard approach across Te Whatu Ora for employing health students in assistant roles, while they are studying. • Work with Te Aka Whai Ora and other agencies to implement: ○ pastoral care and financial support for priority students through the investment in a Tuakana | Teina mentor programme across all clinical placement sites ○ the anti-racism and anti-bullying initiative across all clinical placement sites.	