# QUEENSLAND HEALTH WORKFORCE STRATEGY FOR QUEENSLAND TO 2032

# CONSULTATION PAPER

University of the Sunshine Coast submission

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# Contents

## Executive Summary

The University of the Sunshine Coast (UniSC) welcomes the Government's initiative to develop a 10-year health workforce strategy.

It is imperative that Queensland Health and universities form a true partnership to maximise the sustainable delivery of a contemporary health workforce, including to reduce our reliance on interstate or international recruitment. This kind of partnership means a joint commitment to, and responsibility for, ensuring equity, accessibility and social justice in the education, training and career pathways of the current and future health workforce.

### Recommendations

UniSC provides the following recommendations in response to the Consultation Paper. The context for these recommendations is outlined in the body of this submission.

*General*

1. Queensland Health undertake a targeted consultation process with the tertiary education sector on opportunities to develop a stronger and more equitable partnership model.

*Focus area - Supporting and retaining the current workforce*

2. Queensland Health acknowledge the important role that universities play in supporting and retaining Queensland's heath workforce via both student employment and workforce upskilling.
3. Queensland Health consider how to better support workforce postgraduate study opportunities, including by widening eligibility for the Queensland Training for Research Active Clinicians (QTRAC) pathway to regional health services and universities as well as developing programs that expand PhD scholarship opportunities.
4. Queensland Health develop more clearly defined career progression pathways within and across disciplines, including exploring advanced practice pathways and corresponding programs of education and the expansion of notation and endorsement of Eligible Midwives.
5. Queensland Health ensure workforce planning both recognises and supports the health workforce's professional responsibility and expectation to help educate the future workforce.

*Focus area - Building new pipelines of talent*

6. Queensland Health undertake, in consultation with education and training providers, an end-to-end review of the current student clinical placement model, to address significant issues including increasing provider costs, placement availability and quality, variable student experience and student financial burden ('placement poverty').
7. Queensland Government and Queensland Health take a more holistic view of the potential unintended consequences of Fee-Free TAFE for Enrolled Nurse (EN) on university nursing programs and the future health workforce skill mix.
8. Queensland Health scale up 'transition to speciality practice' programs across disciplines in areas of need, including aged care and mental health.
9. Queensland Health ensure new talent pipelines are developed in consultation with universities and carefully consider the system wide impact of any changes.
10. Queensland Health fund graduate clinical researcher internships for outstanding graduates to undertake a 50:50 clinical and research graduate year to consolidate clinical skills and undertake honours research in areas of identified need.

*Focus area - Adapting and innovating new ways to deliver*

11. Queensland Health prioritise further research by universities to continue to build acceptable alternatives to clinical placements, such as simulation and the use of telehealth consultations.
12. Queensland Health consider new ways to deliver conjoint appointments for clinical specialists to co-design and teach into university courses.

## 1. Introduction

The University of the Sunshine Coast (UniSC) is pleased to provide a submission in response to *Queensland Health Workforce Strategy for Queensland to 2032 – Consultation Paper*.

We welcome Government's initiative to develop a 10-year health workforce strategy, particularly the acknowledgement in the Consultation Paper of the need to "improve partnerships with education and training providers as well as professional bodies to build workforce capability and capacity". We were also pleased to see reference to the important issue of student placements, an area ripe for improvement through greater collaboration between education and training providers and Queensland Health to explore all opportunities to improve the student placement experience and cost burden for both students and education and training providers.

Regional universities like UniSC play a critical role in addressing the current maldistribution of Queensland's health workforce as they provide an accessible pathway for local students to gain nationally accredited health qualifications and in many cases those students go on to work with public or private health providers in their local regions. It is imperative that Queensland Health aims for a true partnership with universities to maximise the sustainable delivery of a contemporary health workforce to reduce our reliance on interstate or international recruitment. This kind of partnership means a joint commitment to, and responsibility for, ensuring equity, accessibility and social justice in the education, training and career pathways of Queensland's health workforce.

This submission is structured around the Consultation Paper's three proposed focus areas:

1. Supporting and retaining our current workforce
2. Building new pipelines of talent
3. Adapting and innovating new ways to deliver.

UniSC would welcome the opportunity to elaborate on any aspect of our submission. If this is of interest, please contact Mr Jason Mills, Head of Government Relations on jmills3@usc.edu.au.

### 1.1 About UniSC

UniSC was founded in 1996 after Sunshine Coast residents campaigned for locally provided tertiary education opportunities. As the first greenfield university to open in Australia since 1975, we have helped unlock the innovation, productivity and potential of our regional communities through the contributions from our alumni, current students and staff and our research capability and impact.

Consistent with our mission to improve access to higher education in underserved locations, UniSC has strategically expanded our footprint into more regional communities, encompassing five campuses from Moreton Bay to the Fraser Coast. We collaborate closely with all levels of government, regional leaders, industry, and other partners to ensure our programs, research and support services align to create greater opportunities in all the areas we operate within.

Health programs are UniSC's most popular offerings, particularly nursing, but also a wide range of allied health courses. In 2023, approximately 40 per cent of UniSC's total enrolments were in health programs, with 3,500 students completing a nursing degree. Following an extensive review of Queensland's health workforce challenges to inform UniSC's future health education offerings, in 2024 we are pleased to be introducing a Bachelor of Medical Laboratory Science (Pathology) and a Master of Dietetics, with a Bachelor of Physiotherapy scheduled to commence 2025.

On the world stage, UniSC is recognised by The Higher Education (THE) Impact Rankings as a global leader in climate action, clean water sanitation, life on land, and life below water. This ranking comes alongside the Australian Research Council's recognition of UniSC as a producer of world-class research in 26 speciality areas, including environmental science, medical and health sciences, neuroscience, technology, and psychology.

## 2. Response to Consultation Paper

### 2.1 Focus Area One - Supporting and retaining the current workforce

Universities have an important role to play in the development of Queensland's current heath workforce through staff upskilling, advanced training, professional development, and postgraduate pathways in response to workforce demands.

Universities also play an important role in supplementing the existing health workforce as many students already make up a component of the workforce in different roles while they are studying. For example, the Queensland Health nutrition assistant workforce is largely made up of nutrition and dietetic students.

Education offerings regardless of level of award should be co-designed to ensure they are fit for purpose, mutually beneficial and sustainable. They should also be affordable for employees who wish to participate and gain further qualifications so they should be supported through professional development awards and funding.

Opportunities for postgraduate study need to be strengthened, including widening participation in the Queensland Training for Research Active Clinicians (QTRAC) to regional health services and universities. Additionally, there is a need to develop programs that expand PhD scholarship opportunities and actively support clinicians in nursing, midwifery and allied health disciplines.

Career progression pathways need to be clearly defined within and across disciplines and articulation between career levels defined and programs in place to better support those making upward career transitions for example allied health assistants, nutrition assistants and enrolled nurses.

Advanced practice pathways and corresponding programs of education need to be explored including Physician Assistants, Nurse Practitioner and expansion of notation and endorsement of Eligible Midwives.

Existing health workforce and recent graduates need ongoing professional education to work to their full scope of clinical practice and in transitions to other roles in health services education, administration and higher management functions. Expert clinicians do not necessarily make good managers and appropriate postgraduate education should be required for transitions to other areas of practice.

Health staff need to recognise their professional responsibility and role expectations for the education of the future workforce and this needs to be factored into workforce planning so that time is made available to staff for them to teach and support students and novice staff. The professional responsibility for education is not just an expectation of universities, it is a professional requirement and an expectation of program accrediting authorities. This should be underpinned by clinical education professional development to upskill staff to be effective teachers in the work environment and to build capacity.

## 2.2 Focus Area Two - Building new pipelines of talent

Building the nursing, midwifery and allied health workforce requires a fresh look at how student placements are undertaken if we are to increase in the capacity and quality of placements in health services. Current placement barriers which need to be addressed are increasing education and training provider costs, placement availability and quality, variable student experience and the student financial burden ('placement poverty').

*1. Institutional costs*

Health Workforce Australia (HWA), via the Clinical Training Funding Programme, delivered a dedicated Commonwealth funding programme specifically for clinical training for nursing and allied health disciplines. When HWA was disbanded in 2015 the legacy of universities paying health services for student placements remained and this cost impost is rapidly increasing as health services continue to lift the fees they charge universities for placements, far above CPI and often poorly justified. Health services changes for student placements also vary across disciplines, which is not equitable, and the way health services use the payment varies, with little accountability to demonstrate that those funds are directed to student education.

Health and education and training sectors are all funded by governments, so funds afforded to tertiary education providers have become an income stream for health services. This is not good public policy and use of taxpayer money and is becoming increasingly unsustainable for universities given Commonwealth funding for health programs has not kept pace with placement costs.

Further, complex contractual arrangements are required for each health service or individual placement provider, and this comes at a substantial, albeit hidden cost, to the health and education providers. Efforts need to be directed towards a single standard contract for all disciplines, health placement providers and tertiary education provider.

*2. Availability and quality*

Availability of appropriate placements is often constrained by the capacity of clinical care providers to provide the required level of supervision, clinical experience, and assessment. Most clinical facilities are busy and complex workplaces, however training and education must be key features of their work. Without this, and without providing health students with appropriate learning experiences, there will be a shortfall in the healthcare workforce, compounding the problem.

While the National Placement Evaluation Centre NPEC measures the quality of clinical placements through student evaluations, enabling timely feedback to education providers, there is an absence of quality assurance and accountability from health services to tertiary institutions.

*3. Student experience and financial burden*

While students are provided with learning opportunities, they also report clinicians who are unprepared or who are reluctant to teach and regard them as a burden. A cultural readjustment needs to occur alongside upskilling the health workforce to participate in clinical education[1].

There is a lack of recognition of the direct and indirect contributions that students make to the health workforce. Contributions include assisting staff with their workload through direct patient care, technical and non-technical tasks and indirect contributions include exposing health service staff to new perspectives on routine care practices, and modelling evidence-based practice at the

[1] Maher, J, Pelly, F, Swanepoel, E, Sutakowsky, L and Hughes, R. (2015), Nutrition and dietetics placement experience. Nutrition & Dietetics, 72: 156-162. https://doi-org.ezproxy.usc.edu.au/10.1111/1747-0080.12163

bedside[2]. In addition, many disciplines require final year and Honours students to undertake projects in health services that contribute to practice improvement and health outcomes.

There is evidence to show impacts when students undertake projects that do not require ethical approval (such as primary prevention community interventions; community/stakeholder consultations; communication; peer support; partnership projects; consultancy work; reviewing workplace policies; undertaking quality improvement projects; audits; establishing evidence-based practice). A study conducted in Queensland in public health nutrition and food service management demonstrated a reduction in the supervisor's project time and increased occasions of service for individual patient management[3].

Importantly, students experience what is commonly referred to as 'placement poverty' when undertaking compulsory placements given their reduced capacity to earn while on placement and the increased cost of attending placements, including accommodation and transport. This particularly impacts students from disadvantaged background and mature age students who commonly work part-time jobs. There is also an assumption that students working on placement should provide 800 to 1,000 hours of free labour. This is not equitable with other professions or with the VET sector where payment on placement is commonplace.

Supernumerary placement should be maintained in order that students can immerse themselves in learning experiences, so a cost-of-living allowance is recommended over payment for work-based placement.

Fee-Free TAFE will support the Enrolled Nurse (EN) pipeline, but there needs to be broader consideration as to the impact of this on university programs and the future workforce skill mix. This approach may have a detrimental impact on the Bachelor of Nursing (BN) program entry cohort and potentially threaten the financial viability of university programs. It could ultimately result in a workforce with an unbalanced skill mix, and workforce dilution which will place more pressure on RNs, so RN retention may be impacted. Furthermore, we have known since 2005 that there are lower mortality rates in hospitals with higher levels of nursing education after adjustment for patient and hospital characteristics[4]. Arguably a future focussed approach would be to offer transition programs to support EN graduates into BN programs and better support BN student cohorts with fee reduction, training stipends, and undergraduate student paid positions.

Transition to speciality practice programs should be scaled up across disciplines in specialty areas of need. Students who are interested is specialist nursing roles could be recruited in third year and supported in their final placement in that clinical area with training to equip them for specialist practice in a graduate year. UniSC's Transition to Practice Program[5], which provides BN students with an interest in a career in aged care with a final placement that incorporates hands-on-learning of clinical care for elderly residents for aged care, could be extended to other specialities such as mental health nursing.

[2] Gerdtz, M et al. (2021) Entry to practice programs in nursing: contributions to learning, direct patient care and health systems. Report for the Council of Deans of Nursing and Midwifery Australia. The University of Melbourne July 21st 2021. https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0009/3961836/Entry-to-Practice-Programs-in-Nursing-Full-Report.pdf

[3] Ash, S, Martin, EK, Rodger, S, Clark, M and Graves, N. (2015), Student and supervisor productivity change during clinical placements: a cohort study. Nutrition & Dietetics, 72: 163-169. https://doi-org.ezproxy.usc.edu.au/10.1111/1747-0080.12093

[4] Aiken LH, Clarke SP, Cheung RB, Sloane DM, Silber JH. (2003) Educational levels of hospital nurses and surgical patient mortality. JAMA. 2003;290(12):1617-1623. doi:10.1001/jama.290.12.1617

[5] https://anmj.org.au/final-year-university-placement-helps-transition-to-aged-care-career/#:~:text=The%20'Transition%20to%20Practice'%20program,clinical%20care%20for%20elderly%20residents

New talent pipelines should be developed in partnership and consultation with universities and the impact of system wide changes carefully considered. The impact of new roles and models of care also need to be recognised. For example, a shift towards malnutrition care by nutrition assistants can result in positive patient and health service outcomes (e.g. reduced mortality, decreased length of stay, and reduced food waste[6]).

Funded graduate clinical researcher internships should be available to outstanding graduates to undertake a 50:50 clinical and research graduate year to consolidate clinical skills and undertake honours research in an area of identified need for the health service.

### 2.3 Focus Area Three - Adapting and innovating new ways to deliver

Evidence around acceptable alternatives to clinical placement is lacking and where it exists there is limited funding for education research to advance practice. For example, gold standard evidence provides conditional support for substitution of clinical practice with well-resourced, high-quality simulation-based education across healthcare professions. We know that outcomes are similar when simulation replaces clinical practice[7]. But funding is required to conduct further research to determine how much clinical practice can be replaced with simulation.

Universities are well positioned to undertake research in new models of care delivery and new models of education delivery, and we are exemplars of collaborative research in our region. However, one of the recurring issues is that evidence is disregarded in decision making by health services. For example, collaborative research conducted in Caboolture by Craswell et al[8] has not influenced decisions made around clinical supervision in the region.

New ways to deliver must include conjoint appointments for clinical specialists to co-design and teach into university courses. There needs to be a sophisticated partnership model for employment that supports clinical and academic (teaching and research) pathways for conjoint appointees.

New ways to deliver health services include models of care that extend beyond the hospital doors into the primary care services in the regions and communities. For example, in midwifery this should include practising in any setting including the home, community, hospitals, clinics or health units as outlined by the International Confederation of Midwives (ICM), thus working to their full scope of practice[9].

[6] Rushton A, Edwards A, Bauer J, Bell JJ. (2021) Dietitian assistant opportunities within the nutrition care process for patients with or at risk of malnutrition: a systematic review. *Nutrition & Dietetics*. 78: 69–85. https://doi-org.ezproxy.usc.edu.au/10.1111/1747-0080.12651

[7] Bogossian, F, Cant, R, Cooper, S, Levett-Jones, T, McKenna, L, Ng, L, & Seaton, P. (2019). Locating 'gold standard' evidence for simulation as a substitute for clinical practice in pre-licensure health professional education: A systematic review. *Journal of Clinical Nursing, 28*, 3759-3775.

[8] Craswell, A, Cockroft, G, & El Haddad M. (2024 under review) Partnering with clinicians supporting nursing students' clinical placement at a regional hospital. Journal of Nursing Education.

[9] Stone, NI, Thomson, G, & Tegethoff, D. (2023). Skills and knowledge of midwives at free-standing birth centres and home birth: A meta-ethnography. *Women and Birth, 36*(5), e481-e494. https://doi.org/10.1016/j.wombi.2023.03.010