



Independent Hospital Pricing Authority (IHPA)

Teaching, Training and Research Costing Study

Public Consultation Paper

Response from the

Australian Orthotic Prosthetic Association (AOPA)

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INTRODUCTION

The Australian Orthotic Prosthetic Association (AOPA) is the peak professional body representing orthotist/prosthetists in Australia. An occupation summary of the vital work orthotist/prosthetists typically conduct in the Australian workforce context is provided as Appendix 1. AOPA membership represents 70% of the practicing profession according to the Australian Bureau of Statistics 2011. AOPA has an important role in self-regulation, standard setting and the provision of expert advice and representation in relation to the profession.

AOPA self-regulate the profession via the enforcement of:

- minimum education requirements (further detail: <http://www.aopa.org.au/membership-information/guidelines-for-applicants>)
- mandatory continuing professional development and
- adherence to standards and codes (<http://www.aopa.org.au/publications/standards-and-codes>)

AOPA is used for credentialling purposes by private health insurance organisations, many facilities, both public and private who employ orthotist/prosthetists directly and state funding agencies to determine the appropriateness of an individual to provide services within the Australian healthcare system.

AOPA is pleased to provide this submission to the Independent Hospital Pricing Authority (IHPA) for Paxton Partners to consider in their costing study. As a relatively small profession in the unique position of having only one education provider, understanding the integrated learning model the educator has developed in conjunction with Victorian public health facilities will be vital in ensuring the sustainability of teaching and training within the orthotic and prosthetic profession.

Within this submission AOPA have answered the consultation questions deemed relevant to the profession only. Further information can be gained by contacting Jackie O'Connor as per the details on the cover of this submission. AOPA look forward to being consulted more directly as part of stage three as outlined in the Project Methodology Summary.



RESPONSE TO CONSULTATION QUESTIONS

2. Are there any specific T&T activities (refer to step 1 of the T&T costing methodology) that should be captured as part of the costing study?

Appendix 2 of this document has been previously submitted to Paxton Partners for this particular project via Allied Health Professionals Australia (AHPA). In answering the questions posed by Paxton Partners, this document details the activities undertaken by orthotist/prosthetists to assist with the teaching and training of undergraduate and postgraduate students and new graduate employees where clients/patients are and are not directly involved.

Whilst all activities outlined in Appendix 2 are important to the current University curriculum being able to achieve the desired learning outcomes, AOPA see it as particularly vital that the 16 week practice placements occurring for all fourth year students, which are categorised by the consultation paper as embedded teaching and training, are captured within the costing study.

3. How important will it be to capture embedded T&T that occurs in conjunction with patient care?

Recommendation 1 of the Definitions and Cost Drivers project stated that “any further work conducted by IHPA on T&T be undertaken on the basis that the term ‘teaching and training’ describes:

“the activities provided by or on behalf of a public health service to facilitate the acquisition of knowledge, or development of skills. These activities must be required for an individual to:

- attain the necessary qualifications or recognised professional body registration to practice;*
- acquire sufficient clinical competence upon entering the workforce; or*
- undertake specialist / advanced practice*

in medicine, dentistry, nursing, midwifery or allied health.”



In relation to prosthetics and orthotics, embedded teaching and training is within the scope of the above definition and therefore must be costed within this study. As outlined in Appendix 2, to complete the education course available in Australia, 22% of the final year content runs in collaboration with clinical teaching facilities in a distributed learning model. This learning model includes supervised practice periods of 16 weeks full time per student. Without completing this supervised practice period, the qualification cannot be obtained. AOPA membership requires that this qualification is completed for all Australian membership applications. In addition, all AOPA members must be able to demonstrate the ability to conduct and adhere to all of the AOPA 2014 competency standards

(<http://www.aopa.org.au/publications/standards-and-codes>) which ensure safe practice in the Australian environment. It is highly unlikely these standards would be met without completing this supervised practice period. In turn, AOPA membership often determines whether an individual is eligible for employment and the care provided eligible for private health insurance rebates. It is also pertinent to note that within orthotics and prosthetics, as per many Allied Health professions in Australia, the teaching and training provided prior to qualification attainment is all that many will receive in order to develop their competence as there are no specific requirements that new graduate teaching and training occurs.

An example of embedded teaching and training in conjunction with patient care which commonly occurs within the supervised practice periods is for a student to observe a practitioner assessing and casting an amputee client for a new prosthesis; the student would then conduct their own assessment and take a cast to practice the physical application of the theory they have previously learnt. In order to understand how effective their casting technique was, the student would then manufacture a prosthesis from their cast which is an additional prosthesis to that which the practitioner will facilitate and at future appointments with the client, the student will fit the prosthesis they have manufactured following fitting by the experienced practitioner.

This process ensures the student has access to clients who require treatment but that the client does not have to attend extra appointments in addition to their usual care, however each appointment takes substantially longer in order to allow the teaching and training to occur. The prosthesis that the student manufactures and fits to a client cannot be relied upon to be of optimal fit and function and therefore the experienced practitioner must also conduct the treatment. In addition, the health system or funding body responsible for the prosthesis cannot be charged for the student prosthesis, therefore the consumable costs required to manufacture the prosthesis, the supervision time of the experienced practitioner and the costs



associated with loss of alternate client treatment the practitioner could have been conducting, as well as the machinery, workshop space and further supervision that the student consumes during manufacture, must somehow be accounted for in order to make this learning process sustainable.

This example demonstrates that embedded care within prosthetic and orthotic teaching and training incurs all of the associated costs outlined within the consultation document:

“In these situations, additional costs can potentially be incurred by the hospital whilst supporting T&T because:

- *either the trainees or trainers are not actively participating in clinical service delivery and are substantively observing the practice of patient care being delivered;*
- *patient care activities take longer to conduct whilst delivering T&T so productivity / efficiency is lower; and*
- *use of consumables may increase.”*

Therefore given the extensive nature of embedded care within prosthetic and orthotic teaching and training and the in-scope nature of this within the teaching and training definition recommended for use, it is likely professional teaching and training of students would be unsustainable if this aspect were not costed within this project.

Embedded care encompasses the benefits of integrated learning between education and public health facilities. The exclusion of embedded care would indicate that the education sector could deliver all the required teaching and training independently if required. Professional competency standards and course accreditation requirements as well as the trend toward increased exposure to ‘real life’ situations, indicates that embedded care is a vital component of the teaching and training process. Embedded care is where the important benefits of the current system lie and it is therefore crucial to ensure it is properly costed so that this component remains sustainable into the future.

4. Do you think that embedded T&T can be aligned to the amount of other (direct and indirect) T&T taking place in hospitals?

If by the term ‘aligned’ the researchers intend to gestimate the amount of embedded T&T based on the volume and cost of direct and indirect teaching and training then AOPA do not believe this would be an accurate method.



Embedded learning by this documents definitions is clearly requires a separate type of teaching and training. The costs for this type of learning must be identified independently in order to ensure that the amount of this type of learning built into an education program remains appropriate for the competencies required. Without accurately costing this type of learning, there is a risk that within an activity based funding model, the type of learning built into a program is influenced by the cost effectiveness of the method rather than its appropriateness to achieving required learning outcomes and competencies. It is vital for optimal learning and the safety of the public accessing services into the future that the type of teaching and training utilised is not heavily influenced by funding model development such as this project entails.

5. Is it practical or feasible to capture embedded T&T?

Teaching and training can be captured via the same data collection methods currently being utilised for other aspects of practitioner activity within organisational Patient Administration Systems and is therefore feasible. However, due to the inconsistent nature of definitions and reporting mechanisms to date, for a national study of this size it would seem that clear guidelines of how to attribute teaching and training proportions of client care are required and therefore data would need to be collected prospectively for it to be accurate and consistent.

6. If so, should the study aim to capture costs associated with

- a. trainees and trainers not actively participating in patient care;**
- b. reduced productivity; and/or**
- c. consumable use increase.**

As per the example provided in question 3, all points noted above need to be captured in order to understand the true costs of embedded care and make this type of teaching, training and learning sustainable. Given that students are generally not considered employees, this group of trainees may not be required to account for their time with or without patient care and general numbers could be accessed via a variety of methods (see question 12).

Consumables are an important cost factor in this type of learning, however for all costs related to consumables, irrelevant of the teaching and training activity, the methodology for understanding true consumable costs needs to be carefully considered. For example, within public health facilities it is common that department budgets are set for a financial period and



will have line items considering costs such as consumables, printing and IT allowances, however it is not common that the proportion of these attributable to teaching and training will be separated from all other department costs. Therefore, it may not be possible to collect this data accurately in a retrospective manner. An alternative may be to utilise a method which determines an average consumable cost per student by considering the activities which must take place for learning requirements and the consumables required within these. This would need to be conducted on a profession by profession basis as it is extremely likely that consumable costs for Podiatry or Prosthetic and Orthotic teaching and training would be higher than that for Physiotherapy or Social Work for example. This same consideration applies to both embedded and direct teaching and training activities.

7. How might embedded T&T be captured in a way that is robust, delineates T&T from patient care and also minimises impost on clinicians, trainees and health services?

AOPA would be supportive of the third option outlined in the Consultation paper (copied below) in order to achieve this.

- *Real-time data collection through use of disruptive technologies such as an app that clinicians and trainees can use to record embedded T&T activities. This represents an innovative solution that may provide better response rates and more robust data than a survey, but has yet to be tested and would need to comply with hospital technology and occupational health policies;*

9. Are there any specific research products (refer to step 1 of the research costing methodology) that should be captured as part of this costing study?

It appears from the definitions provided within the consultation paper that research costs will be assessed in relation to what is currently occurring. It is AOPA's interpretation that this will ensure that hospitals remain as contributors to research rather than have the capacity to be the primary drivers of required research. Currently, many of the costs associated with research will be hidden from public health facility records, for example, an external individual might submit a HREC application to a hospital, the ethics committee costs to process it will be captured, however the extensive work required to prepare the document will go unaccounted for unless the project is driven by a hospital employee. The administratively driven methodology described will not allow for an optimal and sustainable model where hospitals can drive the required research to improve client care but is more likely to perpetuate the



current model in place and ensure that health research remains reliant on funding and cooperation from other sectors.

In addition, the intention to understand research capability and outputs of research over a six month period may not be representative of what occurs over a longer time frame given the extensive time period required to produce quality research.

10. Is there any data that should be collected, which does not appear in Appendix B?

- Appendix B indicates that the number of Allied Health students placed will be recorded, AOPA would recommend that in order to meet the goals of the study and ensure sustainable teaching and training into the future, information regarding the duration and activities conducted by these students is vital to gather for all direct, indirect and embedded care activities.
- It is indicated that “Expenditure associated with delivering direct teaching and training activities – e.g. room rental, consumables, equipment and training material printing costs in the general ledger” will be recorded, however as previously identified, these costs may be difficult to differentiate given the budget model that many public health facilities utilise and an alternative model for identifying costs may be required. In addition it will be vital to ensure that these costs are also calculated for embedded activities.
- AOPA is aware that a number of public facilities highly involved in delivering orthotic and prosthetic teaching and training do not have access to HR systems which include rostering which is indicated as one of the primary sources for data collection.
- It is unclear as to whether the time required to organise appropriate clients to attend for student education sessions and transport reimbursement to assist these clients will be included within both direct and embedded activities, if not, these costs should be considered.

12. What systems exist (for example, within health services, jurisdictional health departments or peak bodies) that can provide the data items in Appendix B?

AOPA do not have any database information which would assist with this costing project, however would identify the following resources and individuals as the most appropriate information sources to begin with in relation to prosthetics and orthotics.



- As per the final question in Appendix 2; individuals who are best placed to assist due to their significant involvement in all activities related to teaching and training and access to a public hospital database are:
 - Emily Duke - Royal Melbourne Hospital - Parkville Campus; Clinical school (prosthetics) coordinator: Emily.Duke@mh.org.au
 - Diana Poole – St Vincent’s Hospital Melbourne; Department Manager Prosthetics and Orthotics: Diana.Poole@svha.org.au
 - Clinical school orthotics involvement
 - Patient Administration System (PAS) collects Teaching and Training information across Allied Health
- Health Round Table collects data on various public hospitals across a range of areas and allows for comparison between hospitals, however not enough of these hospitals report prosthetic and orthotic data to allow for sufficient comparison and it should therefore be noted that if Health Round Table data is to be utilised it will not be representative of what is occurring in prosthetics and orthotics.
- Within Victoria there is a system coordinated by the Department of Health titled ‘Vicplace’ which was instigated to enable student placement management across a number of public hospital facilities who engage with a variety of Universities. Unfortunately due to the small number of student placements occurring within orthotics and prosthetics, Vicplace would not allow the profession to be a part of this system. Such decisions are an example of how a small workforce may then be continually disadvantaged when it comes to reviews and future funding. AOPA would encourage reviews such as this to demonstrate the importance of incorporating all allied health services which are vital to multidisciplinary healthcare.
- La Trobe University have a database regarding the absolute student numbers who undertake various types of teaching and training activities within clinical placements and documents regarding the requirements they have of students and facilities whilst on these placements which would provide the information for our profession Nationally, perhaps replacing the information which Vicplace collects for other professions within Victoria. Contact details for the relevant person within La Trobe University are: Kerry Fisher - K.Fisher@latrobe.edu.au – Phone: 9479 5864.



- AOPA are interested to better understand how the participating costing study sites will be chosen and encourage the researchers to ensure that all disciplines are adequately represented within those sites. As outlined, with one University course in Australia, the difference between teaching and training requirements in Victoria as compared to other states and territories of Australia are significant and therefore, not having study sites within a Victorian public health facility which engages with the full La Trobe University teaching and training program would likely lead to under representation of the profession within this study and create risk around the sustainability of professional teaching and training. In addition, only utilising overarching administrative departments as compared to specific department statistics is unlikely to provide accurate and representative data of allied health departments. However, large public health facilities often have a specific data analysis department who may be appropriate to assist with access to retrospective data at a departmental level.



Appendix 1:

Occupation Summary: Australian Orthotist/Prosthetists

Key Purpose: The role of the orthotist/prosthetist is to promote quality of life through a client centred approach to the provision of orthotic and prosthetic treatment.

Description: *Orthotist/Prosthetists assess the physical and functional limitations of people resulting from illnesses and disabilities, including limb amputations, and provide orthoses and prostheses to restore function or compensate for muscular and skeletal disabilities.*

Tasks of the occupation include:

- assessing clients' emotional, psychological, developmental and physical capabilities using clinical observations, evidence based assessment techniques and outcome measures
- designing, prescribing and fitting orthoses and prostheses with the client to meet their personal and treatment goals
- undertaking and/or co-ordinating the safe manufacture of orthoses and prostheses
- continually evaluates the fit, function, quality and safety of orthoses/prostheses and modifies as required to ensure a client's personal and functional outcomes in relation to established treatment goals
- working with other Health Professionals to enhance collaborative practice to improve client access to care via coordinated team reports, care plans and service improvement activities
- working with external bodies to provide specialist advice to specific client groups such as those requiring third-party compensation and medico-legal representation
- recording clients' progress and maintaining professional relationships in accordance with relevant legislative requirements and ethical guidelines
- maintaining and extending professional competence to ensure new techniques, technology and evidence are integrated into practice

Entry level qualification to practice in Australia:

An Australian Qualification Framework Level 7 qualification (Bachelor Degree) is required for entry to this occupation in Australia. This is reflected in public sector awards and the AOPA membership eligibility criteria. The only Bachelor Degree accepted for entry into the profession is a Bachelor in Prosthetics and Orthotics. A generalist health degree or alternative allied health



qualification does not allow entry into the occupation. The current minimum tertiary education available in this profession in Australia is a Master in Clinical Prosthetics and Orthotics through La Trobe University, Melbourne.

Orthotics and prosthetics is a self-regulated profession. The AOPA membership accounts for 70% of the profession nationally. Whilst registration or licensing is not mandated, some funding body guidelines restrict the provision of funded services to those with AOPA membership. Further to this, public sector employment is increasingly restricted to those practitioners who can demonstrate membership eligibility to the AOPA.

Further requirements:

Ongoing AOPA membership is restricted to practitioners who adhere to the mandatory, annual Continuing Professional Development program requirements, scope of practice and code of ethics for the profession. The AOPA requires all members to demonstrate knowledge currency and adherence to the 2014 competency standards.

Definitions:

Orthosis (pl. Orthoses).

An externally applied device used to modify the structural or functional characteristics of the neuro-musculoskeletal systems. Orthoses may be Prefabricated, Customised or Custom Made (International Organisation for Standards, 1989). An orthosis is the true term for a brace or appliance that is designed and fitted external to the body in order to achieve one or more of the following goals: control or alter biomechanical alignment, protect and support a healing injury, assist rehabilitation, reduce pain, increase mobility, increase independence.

Prosthesis (pl. Prostheses).

An externally applied device used to replace wholly, or in part, an absent or deficient limb segment" (International Organisation for Standards, 1989).

Prosthetist (pron: Prosthe-tist).

An allied health professional who is clinically responsible for the assessment, prescription, design, manufacture and fitting of all types of prostheses to patients (International Organisation for Standards, 1989).

Orthotist (pron: Ortho-tist).

An allied health professional who is clinically responsible for the assessment,



prescription, design, manufacture and fitting of all types of orthoses to patients
(International Organisation for Standards, 1989).



Appendix 2:

Open Response Questions

The following response has been previously provided to Paxton Partners via Lin Oke of the Allied Health Professionals Australia (AHPA) on behalf of the Australian Orthotic Prosthetic Association (AOPA) following consultation with staff from the only Prosthetic and Orthotic education course in Australia and clinicians currently involved in student education within public clinical settings.

1. Please describe the pathways for undergraduate (or postgraduate) students to enter your profession.

Currently there is only one University in Australia who offer education which results in a degree that qualifies individuals to be a member of the AOPA; the University is La Trobe University Melbourne campus and the combined degree is the Bachelor of Health Science / Master of Clinical Prosthetics and Orthotics (BHS/MCPO). Students enrolled in 2015 at La Trobe University will enter a new course structure, the Bachelor of Applied Science / Master of Clinical Prosthetics and Orthotics (BAS/ MCPO)

Entry pathways include:

Undergraduate: 4 years full time study, entry from high school leavers and E-Type applications. Based upon the Victorian ATAR score, in 2014 the entry score for the course was 85.5, 2015 selection is currently in progress.

Postgraduate: 2 years full time study, eligible applicants require a relevant prior degree (in the past seven years).

Entry requirements – Victorian Certificate of Education (VCE)

Prerequisite

VCE Units 3 and 4: a study score of at least 30 in English (EAL) or at least 25 in English other than EAL; and a study score of at least 25 in two of Biology, Chemistry, any Mathematics, Physical Education or Physics.

Year 12 and non-year 12 extra requirements



Applicants may wish to provide other documentation in support of their application. Non-Year 12 applicants must complete and submit a [VTAC Personal Statement online](#) for other information to be considered during the selection process e.g. details on work experience or reasons for applying. Selection may also be based on ATAR, GPA or STAT Multiple Choice.

Subject bonus

A study score of 30 in any Mathematics, Physical Education or any Science equals 4 aggregate points per study. A study score of 25 in Health and Human Development equals 4 aggregate points. A study score of 20 in any LOTE equals 4 aggregate points per study. Overall maximum of 12 points.

Entry requirements – General Entry Masters (GEM)

Prerequisite

Bachelor degree, normally completed within the last seven years. Highly recommended prerequisites are tertiary-level subjects in anatomy and physiology, including regional musculoskeletal anatomy. Desirable prerequisites are tertiary-level subjects in biomechanics, clinical assessment, psychology, pathology, materials technology, evidence-based practice, research methods or statistics, and human movement.

Students without a background in prosthetics and orthotics fabrication skills will be required to complete the bridging course in P&O Fabrication skills and occupational health & safety.

2. Is your profession self-regulated, or are clinicians required to obtain / maintain some form of registration in order to practice independently?

AOPA is the body who self-regulate the profession in the absence of legislated requirements for registration. Based on current membership numbers and the 2011 ABS results, it is predicted that AOPA represent approximately 75% of the currently practicing professionals in the orthotic and prosthetic profession.

Eligibility requirements for AOPA membership essentially include the need to have studied a dual stream (prosthetic and orthotic) course which is equivalent to Australian Qualification



Framework Level 7. Further detail can be found here: <http://www.aopa.org.au/membership-information/guidelines-for-applicants>

In order to maintain AOPA membership individuals are required to do the following:

- 30 points of CPD per calendar year
- Adhere to all standards and codes, particularly the code of ethics and professional competency standards: <http://www.aopa.org.au/publications/standards-and-codes>

Recency of practice requirements are scheduled for introduction in 2015.

- 3. If registration requirements must be met in order to practice independently, please describe any specific registration requirements that would normally need to be supported by the (physical and human) resources of a public hospital.***

Irrelevant of registration or self-regulation and/or conducting practice in a private or public setting, it is an individual's responsibility to ensure they practice within their scope of practice and competent skill set. In conjunction with this, each organisation is responsible for ensuring that all employees are competent to undertake any tasks requested of them. In order to ensure this occurs the organisation's resources would need to consider:

- Credentialling
- Continuing professional development

- 4. Please describe the options available for professionals in your discipline to undertake specialist or advanced practice, and any additional qualification or registration requirement that must be met in order to obtain recognition as a specialist or advanced practitioner.***

Currently AOPA do not stipulate specialist or advanced practitioner categories or skill sets. AOPA regulate the profession through members agreeing to and abiding by a particular set of standards related to ethics, competency standards, code of conduct etcetera. Specifically relating to the practice of orthotist/prosthetists, all members are expected to be able to meet the AOPA 2014 competency standards at all times in order to ensure safe practice within the Australian healthcare setting. A copy of the standards can be found at this address:

<http://www.aopa.org.au/publications/standards-and-codes>



The complexity of some technology does mean that the supplier of that technology requires practitioners to complete a specific course and become certified to fit that technology to a client, before being able to do so.

Question	Trainee group		
	Students	New graduates	Postgraduate / Specialist / Advanced trainees
<p>If possible, please provide an approximate breakdown of the proportion of teaching and training activity that occurs in the following settings, for each trainee group</p>	<ul style="list-style-type: none"> The BAS / MCPO runs in collaboration with clinical teaching facilities in a distributed learning model in all fourth year subjects = 120 credit points of the 540 credit point structure (starting 2015) or 22% of the total teaching program 53% occurs as part of patient care 47% occurs separately to patient care (La Trobe University figures) 	<ul style="list-style-type: none"> Unknown, varies across facilities 	<p>N/A - <i>***Please note that for simplicity all information relating to tertiary education which leads to the MCPO qualification has been included within the students column, however due to the Masters level of education 3rd and 4th years of this program are considered Postgraduate studies. Until all four years have been complete individuals are not eligible for AOPA membership</i></p>
<p>Please list any activities that:</p> <p>a) - <u>are provided by public health services</u>; and</p> <p>b) - <u>take place separately to patient care</u></p> <p>that commonly support the teaching and training requirements of each trainee group</p>	<ul style="list-style-type: none"> Guest lecturers from public health services are regularly involved in aspects of clinical teaching across multiple year levels, ~additional 5% of total program in subjects such as: POR3SLF – Spinal and Limb Fractures Supervision/demonstration of cast modifications and manufacturing of orthoses and prostheses occurs without the patient present Presentation/discussion/evaluation of assessment tasks 	<ul style="list-style-type: none"> Individual mentoring as per individual facility guidelines Interdisciplinary new graduate programs exist in some facilities and include orthotic/prosthetic graduates and orthotic/prosthetic staff to provide tutorials – these are often to allied health, nursing and medical groups – the time this 	<ul style="list-style-type: none"> Many departments have professional development which ensures knowledge sharing and a focus on evidence based care which usually involves one staff member lecturing/demonstrating on a specialist area they work within and/or raising awareness of and analysis published literature on a topic



Question	Trainee group		
	Students	New graduates	Postgraduate / Specialist / Advanced trainees
	<ul style="list-style-type: none"> • Lectures relevant to subject content • Preparation of content to be taught • Organisation of suitable volunteer clients to enable required demonstrations/teaching etc. to occur • Support for travel costs for volunteer clients • Assessment of examinations include current clinical staff from public health services • An example of how these activities are incorporated for one subject run by the University and the time required by the public hospital facility to meet the requirements are outlined below (example provided by Royal Melbourne Hospital) - Clinical school program 4 students at a time, 5 sessions of 4 hour duration plus a tutorial with 10 students for 4 hours – 4 times per year = total of 360 individual student hours per year. These sessions are outlined by the university according to their teaching curriculum, require specific preparation by the teaching clinician, setting aside of the allocated time in 	<p>takes from the perspective of the graduates and the information providers differs by facility</p> <ul style="list-style-type: none"> • Preparation of content • Lectures and demonstrations to various medical teams and nursing specialty areas • As orthotist/prosthetists are heavily involved in the rehabilitation area, a number of P&O departments provide tutorials for rehabilitation registrars; again the amount varies, some facilities note an average of 1 hour per fortnight is dedicated • Other occasional inservices, lectures etc. occur within organisations on an ad hoc basis as new procedures/technology 	



Question	Trainee group		
	Students	New graduates	Postgraduate / Specialist / Advanced trainees
	order to conduct the sessions and attendance at planning meetings approximately twice per year.	etc. develops	
<p>Please list any activities that:</p> <p>a) - <u>are provided by public health services</u>; and</p> <p>b) - <u>take place as part of patient care</u></p> <p>that commonly support the teaching and training requirements of each trainee group</p>	<ul style="list-style-type: none"> • 1st year observational one day placement • Supervised practice periods of 16 weeks full time per student in 4th year studies • Clinical school subject run in fourth year includes some direct patient assessment and treatment provided in clinical facilities • Technical Students: Some organisations provide a placement opportunity for technical students – for example Royal Melbourne Hospital provide supervision for 4 weeks per year to students from the School of Health Science in Sweden 	<ul style="list-style-type: none"> • Supervised and assisted practice – this occurs to varying levels within facilities and dependent upon the individual’s job role, how quickly they are deemed competent to work independently etc. – some facilities have their own list of competencies which must be demonstrated prior to independent client management – one facility estimates 40% of the supervising clinicians time is consumed whilst assessing competence in the new graduate • Mentoring • Within multidisciplinary clinics - education of medical and other allied 	N/A



Question	Trainee group		
	Students	New graduates	Postgraduate / Specialist / Advanced trainees
		health staff <ul style="list-style-type: none"> • Training to junior allied health staff (primarily centred around different prosthetic/orthotic designs/uses/patient management) within joint sessions (such as inpatient Physiotherapy). 	
<p>Please list any activities that:</p> <p>a) - <u>are provided by education providers(e.g. universities) in a public health setting; and</u></p> <p>(b)- <u>take place separately to patient care</u></p> <p>that commonly support the qualification or registration requirements of each trainee group</p>	<ul style="list-style-type: none"> • LTU staff in collaboration with partners in the distributed learning model participate in assessment tasks such as oral presentations and critique assessment of fourth year students and supervision and assistance of students where extra staff from the facility are not available 	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> •
<p>Please list any activities:</p> <p>a) - <u>are provided by</u></p>	<ul style="list-style-type: none"> • <i>Nil</i> 	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> •



Question	Trainee group		
	Students	New graduates	Postgraduate / Specialist / Advanced trainees
<p><u>education providers(e.g. universities) in a public health setting; and</u></p> <p><u>(b)- take place as part of patient care</u></p> <p>that commonly support the qualification or registration requirements of each trainee group</p>			
<p>Please list the most common types / levels of clinical professionals that provide supervision of each trainee group</p>	<ul style="list-style-type: none"> • Within Victoria the student supervisor role is typically incorporated within a Grade 2 job description, however all staffing levels provide some supervision during client interactions dependent upon the opportunities arising during the time period the individual is present. • Individuals with a Bachelor of Prosthetics and Orthotics (BPO) and relevant clinical experience. 	<ul style="list-style-type: none"> • Grade 2 & 3 (Victorian levels) clinical staff within discipline training to new graduates • All levels participate in providing inservice training across disciplines 	<ul style="list-style-type: none"> • Some facilities provide internal supervision training to assist staff with taking on these responsibilities within their job role
<p>Please list any existing data sources that are commonly available within health services (if any) that describe the nature, duration, type of provider or number of recipients of</p>	<ul style="list-style-type: none"> • Most facilities collect some level of information however it is dependent upon the nature of the administration system as to how detailed this is and how consistent the format may be with other allied health professions: The Royal Melbourne P&O 	<ul style="list-style-type: none"> • Mandatory training which new employees must complete eg: OH&S – infection control, CPR etc. are recorded via a centralised system within most public 	<ul style="list-style-type: none"> •



Question	Trainee group		
	Students	New graduates	Postgraduate / Specialist / Advanced trainees
teaching and training activities that are delivered each trainee group	<p>Department have internal records on the programs they run for students. St Vincent's Hospital Melbourne utilise their Patient Administration System (PAS) to record Teaching and training time and some detail regarding the activities conducted during this time will be available.</p> <ul style="list-style-type: none"> La Trobe University have a written record of the facilities each student goes to and for how long during each calendar, as well as clinical placement guidelines that are used nationally to support the clinical placement experience and this website may be of interest: www.armlatrobe.com 	<p>hospitals</p> <ul style="list-style-type: none"> Royal Melbourne Hospital record the Professional Development which staff undertake at a department level 	
Please list any health service staff that should be consulted to obtain an understanding of teaching and training requirements that re relevant to your discipline.	<ul style="list-style-type: none"> <i>Emily Duke – Royal Melbourne Hospital – Clinical school (prosthetics) coordinator: Emily.Duke@mh.org.au</i> <i>Diana Poole – St Vincent's Hospital Melbourne – Department Manager Prosthetics and Orthotics: Diana.Poole@svha.org.au</i> 		