Final Report on the creation of:


RAVEN CONSULTING GROUP

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# Table of Contents

1 Terms and acronyms used in this report iv
2 Executive Summary vi
3 Introduction 1
   3.1 Health professional training in Victoria 1
   3.2 Simulation-based education and training 1
      3.2.1 Simulation in a national context 1
      3.2.2 Supporting the growth of simulation in Victoria 1
   3.3 Developing a strategic plan 2
4 Methodology 3
   4.1 Project management 3
   4.2 Drafting the strategy 3
      4.2.1 Forming the EAG 3
      4.2.2 EAG workshop 1 3
      4.2.3 EAG workshop 2 3
   4.3 Stakeholder consultations 4
      4.3.1 CPN Executive Committee meetings 4
      4.3.2 Stakeholder surveys 4
      4.3.3 Facilitated interactive review 5
      4.3.4 VCPC meeting 5
   4.4 Finalising the strategy (EAG workshop 3) 5
5 Outcomes 6
   5.1 Drafting the strategy 6
      5.1.1 Forming the EAG 6
   5.2 Stakeholder consultation 15
      5.2.1 CPN Executive Committee meetings 16
      5.2.2 Facilitated interactive review 16
      5.2.3 Stakeholder surveys 17
      5.2.4 VCPC meeting 18
   5.3 Finalising the strategy 18
      5.3.1 EAG workshop 3 19
      5.3.2 Completing the update 19
6 Discussion and Suggested Actions 20
   6.1 Project timing 20
   6.2 Strategy development 20
      6.2.1 Consultation activities 21
   6.3 Implementing the plan 21
   6.4 On-going sustainability 23
7 Acknowledgements 24
8 Appendices 25
9 References 35
1 Terms and acronyms used in this report

As a general rule, the language used within this report is intended to be generic. Therefore, unless a very specific meaning is intended, terms should be viewed in their broadest meaning. As there is no agreed set of terms used across the spectrum of health professions in relation to simulation-based or clinical education and training, Table 1 and Table 2 provide a list of the acronyms and terms (respectively) used in this report.

Table 1: Acronyms used in this report

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPCLE</td>
<td>Best Practice Clinical Learning Environment</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing professional development</td>
</tr>
<tr>
<td>CPN</td>
<td>Clinical Placement Network</td>
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<tr>
<td>CSP</td>
<td>Commonwealth Supported Place</td>
</tr>
<tr>
<td>EAG</td>
<td>Expert advisory group</td>
</tr>
<tr>
<td>FIR</td>
<td>Facilitated interactive review</td>
</tr>
<tr>
<td>HWA</td>
<td>Health Workforce Australia</td>
</tr>
<tr>
<td>RTO</td>
<td>Registered training organisation</td>
</tr>
<tr>
<td>SBET</td>
<td>Simulation-based education and training</td>
</tr>
<tr>
<td>SLE</td>
<td>Simulated learning environment</td>
</tr>
<tr>
<td>TAFE</td>
<td>Technical and Further Education</td>
</tr>
<tr>
<td>VCPC</td>
<td>Victorian Clinical Placements Council</td>
</tr>
<tr>
<td>VET</td>
<td>Vocational education and training</td>
</tr>
<tr>
<td>Term</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Clinical placement</td>
<td>The supervised practice component of health practitioner education. In some disciplines it may be referred to as practical placement, fieldwork placement or clinical rotation (and there are likely other variations).</td>
</tr>
<tr>
<td>Education and training</td>
<td>Often, education is used to refer to structured courses, whereas training refers to less-structured activities. Within this report, use of either term should be taken to mean all possible definitions of both terms.</td>
</tr>
<tr>
<td>Education provider</td>
<td>Those organisations involved in the provision of education, including institutes of TAFE, universities, providers of VET and RTOs more broadly.</td>
</tr>
<tr>
<td>entry-level health practitioner education</td>
<td>Education that provides the first point of entry to health care practice or to allow initial registration, and includes university and VET sector courses.</td>
</tr>
<tr>
<td>Health and social care</td>
<td>The prevention, treatment, and management of illness and the preservation of mental, physical and social well-being through the services offered by appropriately qualified practitioners.</td>
</tr>
<tr>
<td>Health care practitioner</td>
<td>A person with specific training in the prevention, treatment, and management of illness and the preservation of mental, physical and social well-being.</td>
</tr>
<tr>
<td>Health service</td>
<td>Refers to any organisation – large or small, public or private, including aged care, private allied health clinics and general practices – providing health or social care.</td>
</tr>
<tr>
<td>Learner</td>
<td>A person undertaking formal or informal education. It is intended to include professional development as well as activities offered through universities, TAFEs, VET providers or other RTOs.</td>
</tr>
<tr>
<td>Patient or client</td>
<td>A person for whom health or social care is provided.</td>
</tr>
<tr>
<td>Simulation</td>
<td>Any educational method or experience that evokes or replicates aspects of the real world in an interactive manner.</td>
</tr>
<tr>
<td>Simulation community of practice</td>
<td>The network of individuals and organisations that identify as providers or users of simulation-based education and training.</td>
</tr>
<tr>
<td>Simulation educator</td>
<td>Any person using simulation as a mode of teaching.</td>
</tr>
<tr>
<td>Simulation technician</td>
<td>Any person responsible for the delivery of technical aspects of simulation, such as console operation or audiovisual control, as well as the maintenance of simulation facilities, equipment, resources etc, but not involved in the teaching of content within SBET.</td>
</tr>
<tr>
<td>Simulation-based education and training system</td>
<td>The network of individuals and organisations that identify as providers or users of simulation-based education and training.</td>
</tr>
<tr>
<td>Simulationist</td>
<td>Professionals involved in modelling and simulation activities and/or with providing modelling and simulation products and/or services.</td>
</tr>
<tr>
<td>Stakeholder</td>
<td>Any person or organisation with a self-identified interest in SBET.</td>
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</table>
2 Executive Summary

It is anticipated that in the coming years, Victoria (indeed Australia) will experience a rapid growth in the required number of clinical placement student hours to support the education and training of the future health workforce. This growth has been driven by workforce shortages and a subsequent increase in the number of Commonwealth supported entry-level training places (CSPs) in health professional courses. Student growth is expected to be sustained by the removal of enrolment caps for university courses (from 2012) and a national goal of self-sufficiency in workforce supply by 2025. Although these activities will result in growth in practitioner numbers (and therefore improved workforce supply), in the short term there will be significant pressure on health and social care services to provide high-quality clinical placement experiences.

Amongst a number of strategies to relieve the pressure on clinical placements, is the greater use of simulation-based education and training (SBET) to reduce, replace or complement learning in a clinical setting. SBET has been identified by stakeholders as a useful tool to increase clinical training capacity and efficiency, without negatively impacting on patient, learner, educator or staff safety. Independent of its capacity to augment clinical placement capacity, simulation has proven to be a powerful methodology for the teaching of specific procedural skills as well as clinical management, teamwork, decision making and communication skills (amongst many others).

Nationally, Health Workforce Australia (HWA) is implementing a $94 million program of activities and funding to support increasing the capacity of the health system to provide clinical training via the use of simulated learning modalities. This program includes an allocation of funding directly to stakeholders via a request-for-proposal process, aimed at supporting the capital, establishment and recurrent costs of new and existing SBET facilities. Victoria's SBET activities have taken place over a slightly longer term, with the Department of Health (the department) funding infrastructure purchases in over 30 clinical skills SLEs in 2005, while simultaneously supporting the development and delivery of train-the-trainer programs.

In 2010, as part of a broader clinical placement development and enhancement strategy, the department commissioned a review of Victorian clinical skills SLEs. Amongst a number of findings, the review suggested the creation of a statewide plan for the development of SLEs within Victoria. In 2011, through the Peninsula CPN, the department funded a more detailed review of clinical skills SLEs (in that CPN alone), which further confirmed the need for a statewide plan and highlighted the lack of knowledge of clinical skills SLEs across that CPN.

These circumstances – growth in required number of clinical placement student hours, the implementation of a national work program and recommendations for a statewide plan for clinical skills SLEs – led to the initiation of the current project – creation of the Victorian Strategy for the Development of Simulation-Based Education and Training 2012 – 2015 (Health and social care).

This report provides an account of the activities that took place as part of creating the strategy. The project was conducted by a team of consultants led by Dr Richard Huysmans (Raven Consulting Group) from August to October 2011, over four stages:

1. Drafting the strategy
2. Consultations on the draft strategy
3. Finalising the strategy
4. Final reporting
**Drafting the strategy**
The strategy was drafted with significant input from an expert advisory group (EAG) through two half-day workshops. The draft strategy was refined and approved for use as the consultation draft.

**Consultations on the draft strategy**
Four consultation activities were conducted throughout September 2011. The first two weeks focused on gaining feedback from all 11 Clinical Placement Network (CPN) Executive Committees, via attendance at their September meetings. This feedback was collated and the strategy updated to inform consultation with the Victorian Clinical Placements Council (VCPC, the body to which CPNs report) and also a facilitated interactive review (FIR, open to all stakeholders). Throughout September an on-line survey was available for all stakeholders to complete. In mid-September the survey was updated to reflect the feedback received to that point and bring it in-line with the strategy presented to the VCPC and used within the FIR.

**Finalising the strategy**
All of the feedback was collated and the strategy updated for final review and approval by the EAG, as part of a third workshop (early October). The final strategy, reflecting all feedback received throughout the project was presented to the VCPC, via the department in mid-October and approved for circulation shortly after.

**Final reporting**
Following completion of the Victorian Strategy for the Development of Simulation-Based Education and Training 2012 – 2015 (Health and social care) the final report was prepared (this document) including the following suggested actions:

### Suggested Action 1
Consider the use of open CPN Executive Committee meetings as a consultation activity for future projects.

### Suggested Action 2
Communicate the plan and its intent to relevant state and federal government departments and organisations.

### Suggested Action 3
Future initiatives should be required to demonstrate their alignment with the strategic plan in order to be eligible for funding.

### Suggested Action 4
Support the development of SBET initiatives which are broadly applicable and scalable.

### Suggested Action 5
SBET funding bodies should consider the inclusion of a criterion focused on patient centeredness in their assessment processes.

### Suggested Action 6
Implementation of the Victorian Strategy for the Development of SBET 2012 – 2015 (Health and social care) should be viewed as a pathfinder project for increasing the relevance of the VCPC and CPNs to the post-qualification clinical education and training system.

### Suggested Action 7
When supporting the development of SBET initiatives decision-makers are encouraged to keep the outcomes of recent reviews top of mind.

### Suggested Action 8
Future SBET initiatives should be reviewed for their capacity to positively contribute to the on-going sustainability of SBET.
3 Introduction

3.1 Health professional training in Victoria
In recent years, Victoria has successfully secured a large number of additional Commonwealth-supported entry-level places (CSPs) in health professional courses[2]. In addition to this growth in CSPs, and on the back of the Bradley Review of higher education[3], the past two years have witnessed a shift in the education sector from a regulated system that caps the number of CSPs, to a more open system where universities will be funded for student places on the basis of demand, with caps removed for enrolments in 2012[4]. Coupled with a national goal of self-sufficiency in terms of workforce supply by 2025[5], this is likely to significantly increase the numbers of people undertaking health-related training in Victoria. Whilst this growth in students will have a positive impact on the available workforce in the medium to long term, it places significant short to medium term pressure on health services to meet the associated clinical placement demand. This in turn places increased pressure on postgraduate and existing workforce training programs as health service training systems broadly become increasingly stretched.

Health care stakeholders, including education providers, health services and government, are working to address the challenge of improving system-wide clinical learning capacity and efficiency through identifying and implementing innovative training solutions.

3.2 Simulation-based education and training
One solution to the difficulty of finding clinical placements has been to reduce, replace or complement them through the greater use of simulation-based education and training (SBET). SBET has been identified by stakeholders as a useful mechanism to increase clinical training capacity and efficiency, without negatively impacting on patient, learner, educator or staff safety. Independent of its capacity to augment clinical placement capacity, simulation has proven to be a powerful methodology for the teaching of specific procedural skills as well as clinical management, teamwork, decision making and communication skills (amongst others).

3.2.1 Simulation in a national context
At a national level, Health Workforce Australia (HWA) is currently undertaking a significant body of work to encourage the (further) use of SBET in Australia[6] including support for staff training, infrastructure developments and recurrent operations[7]. Several activities have been conducted under the auspices of these programs including a profession-based review of education using simulation, which identified common elements of educational programs that could be successfully delivered (across the country) using simulation–based activities[8].

3.2.2 Supporting the growth of simulation in Victoria
Since 2005, the Victorian Department of Health (the department) has supported the development or enhancement of over 30 SLEs across the state. These investments have been further supported through department-funded train-the-trainer programs and investment from individual health services and education providers.

Building on these investments, the department commissioned several projects aimed at developing clinical placement capacity (while maintaining quality) starting with Clinical Placements in Victoria: Establishing a Statewide Approach[2] and culminating in A New Model of Clinical Placement Governance in Victoria[9] – the basis of the newly formed Victorian Clinical Placements Council (VCPC) and Clinical Placement Networks (CPNs)[10]. All projects noted the significant role simulation could play in clinical education and the need for coordination across the state[11-12].
More recently, in 2010, the department commissioned a study to review the existing levels of clinical skills simulated learning environment (SLE) infrastructure in Victoria\textsuperscript{(13)}. Specifically, this review examined the type, capability, deployment and utilisation of existing SLE equipment, including barriers to increased SLE utilisation. Amongst other findings, the review noted there is likely adequate SLE infrastructure within Victoria, but it is not fully utilised due to issues of staffing and staff training. Indeed the review suggested a number of actions be taken including\textsuperscript{(13)}:

- Work with SBET providers on their staffing requirements, covering staff profile, staff training and better role definition.
- Work with SBET providers to resolve their space issues, particularly those where expansion into more or new space is not an option.
- Explore the creation of a statewide plan for the development of SBET.

In 2011, the Peninsula CPN endorsed the development of a review to identify how the access and use of clinical skills SLEs, within the Peninsula CPN, could be improved\textsuperscript{(14)}. A major finding of the review was the limited knowledge of SLE infrastructure across the CPN, with many stakeholders reporting lack of knowledge of SLEs was a key barrier to accessing them. The review also reiterated the staffing issues identified in the statewide review and several actions were suggested, including\textsuperscript{(14)}:

- Provide contact and infrastructure details of all SBET providers within the CPN, via the CPN’s website.
- Investigate the feasibility of establishing a library-style system for managing SLE infrastructure and equipment.
- Form an SBET sub-committee of the Peninsula CPN to guide SBET development within the CPN.
- Identify specific staff recruitment and training needs for effective delivery of learning through SBET.

### 3.3 Developing a strategic plan

With two recent reviews identifying the need to improve coordination of and access to SBET at both the macro- (state) and micro- (CPN) levels, the creation of a statewide plan was the logical next step to informing and planning the statewide development of SBET. Given the long-term leadership role intended for the VCPC, this group was the obvious entity to lead the development of the plan.

While the focus of the VCPC is primarily on professional entry-level health practitioner education and training, the VCPC recognised that SBET occurs across the continuum of education and training, including entry-level, postgraduate specialisation and professional development and that this plan should be applicable to all levels of SBET. It was identified that the plan should:

- Identify a set of principles to inform strategic investment across Victoria;
- Identify opportunities to improve utilisation of simulation to increase clinical placement capacity and efficiency;
- Consider infrastructure requirements in the immediate, medium and long term;
- Consider training requirements for staff; and
- Align with the Victorian clinical placements strategy.
4 Methodology

4.1 Project management

Led by Dr Richard Huysmans (Raven Consulting Group), a team of three consultants undertook the majority of the work, with a further three consultants brought on for the facilitated interactive review (see Section 4.3.3, page 5). Dr Huysmans was the primary point of contact for the consulting team with the department’s Sector Workforce Planning Branch.

Within the strict time limits imposed on the project, a highly consultative approach was adopted for the collection of data and subsequent drafting and review of the strategy. Broadly speaking, the initial discussion of ideas and development of the draft plan for consultation was informed by an expert advisory group (EAG), established under the auspice of the VCPC. The entire plan was distributed to stakeholders who, depending on their role in the clinical placement governance system, were invited to comment by:

- Attendance at a CPN Executive Committee meeting (CPN Executive Committee members only),
- Completion of an on-line survey (no restrictions),
- Participation in a facilitated interactive review (no restrictions), and/or
- Attendance at the VCPC meeting (VCPC members only).

These comments were collated and presented in the form of a strategic plan to the EAG for final comment and sign-off.

4.2 Drafting the strategy

4.2.1 Forming the EAG

To ensure appropriate input and expertise informed the development of the strategic plan, the VCPC endorsed the formation of an EAG. Potential members of the EAG were shortlisted based on discussions between the VCPC and the Department of Health, with some consultant input. Following contact by a departmental representative, fourteen people (including representatives from the Department of Health and HWA, see Appendix 1) agreed to participate at three half-day workshops conducted at the department’s offices in Melbourne. Two were held at the beginning of the project and one at the conclusion of the consultation process. Draft Terms of Reference (ToR, see Appendix 2) were created and distributed prior to the first meeting of the group.

4.2.2 EAG workshop 1

The first workshop was conducted on 9 August 2011. As the group had not formally met before, the workshop included a brief introduction of all members and a ratification of the ToRs. This was followed by a series of facilitated discussions specifically related to the project, namely:

- Summary of activities to date (i.e. background to the project);
- Identification of key issues (both internal and external to SBET in Victoria);
- Identification of stakeholders;
- Defining the mission; and
- Clarifying the vision.

The full agenda for the meeting is provided in Appendix 3. Other than noting the outcomes of discussions, formal minutes of the meeting were not taken.

4.2.3 EAG workshop 2

The second workshop (12 August 2011) commenced with a summary of outcomes from workshop 1, including consideration of proposed draft mission and vision statements. The major activity of workshop 2 was a SWOT (strengths, weaknesses, opportunities and threats) analysis for SBET in Victoria. This information was used
as the basis for identifying strategies to capitalise on strengths and opportunities, or to avoid threats and weaknesses. There was also some discussion of requirements to achieve the proposed strategies.

The full agenda for the meeting is provided in Appendix 4. Other than noting the outcomes of discussions, formal minutes of the meeting were not taken.

Following the workshops, their outcomes were reviewed and the consultants developed the draft strategy, which was used during the consultations described below.

4.3 Stakeholder consultations

4.3.1 CPN Executive Committee meetings

The consultants attended each of the 11 CPN Executive Committee meetings held through September 2011. In most cases, the consultants were allocated 30-40 minutes for this discussion, which focussed on key elements of the strategic plan (definition, mission, vision and strategic priorities and associated objectives). Via their Project Managers, each CPN Executive Committee member received a copy of the draft strategy as preparation for the visit. Feedback and comments from committee members were noted on the day and recorded in an MS Word file. The contents of the MS Word files were then combined into an MS Excel file to facilitate comparison across consultations, and ultimately the consultants’ response to all comments.

4.3.2 Stakeholder surveys

Stakeholders (identifed as such through their involvement in previous projects or listing on CPN mailing lists) were notified via email (5 September 2011) about the project and how they could participate. This email included:

- A link to the on-line survey;
- The draft strategic plan for consultation; and
- A link to the RSVP form for the facilitated interactive review (FIR, see Section 4.3.3).

It was originally planned to have one survey open throughout September. However, following the FIR (see Section 4.3.3) it was seen as redundant to continue collecting responses against the original draft strategy. As a result, on 20 September 2011 a second survey was created (survey 2) using the updated definition, mission, vision, strategic priorities and objectives. Simultaneously, survey 1 was closed for responses. Those attempting to complete survey 1 were presented with an automated response indicating the survey was closed and were provided with a link and a request to complete survey 2.

Both stakeholder surveys were built in Survey Monkey and collected demographic information (in the form of the name and type of the respondent’s employing organisation), the location of the organisation with respect to CPNs and health disciplines of interest to the respondent (the list was aligned to the disciplines involved in the HWA the simulation curriculum review project). Both surveys collected the respondent’s views on various elements of the strategic plan including:

- Definition of simulation
- Mission
- Vision
- Principles
- Strategic priorities and associated objectives

As part of the question text, any necessary information (e.g. definition of simulation, mission, vision etc.) was provided to the respondent.

The majority of questions were asked in a five-point Likert response scale format. Both surveys included survey logic, which was generally applied to negative responses on the Likert scale and sought clarification via an open text field. Both surveys are provided as separate files to this report (SLE strategic plan consultation survey 1.pdf and SLE strategic plan consultation survey 2.pdf).
4.3.3 Facilitated interactive review
The facilitated interactive review (FIR) was conducted on 19 September 2011 at Bayview on the Park. Stakeholders were invited to participate via an email from the VCPC email address, with a link to an on-line RSVP form. Receipt of RSVP was confirmed via email. The email also contained two attachments – the draft strategic plan for consultation (see separate file SLE Strategic Plan Draft for Consultation.pdf) and a summary of the updated strategic plan elements (see Appendix 5).

Additional consultants were brought in to support delivery of the FIR (three in total) and prior to the FIR, a two-hour training session was held to educate all facilitators (six in total) on the survey, how it was intended to work, their role as facilitators and the broader objectives of the FIR. The availability of mobile internet technology and associated survey-data capture and collection tools were essential to the success of the event. Thus, ensuring all facilitators were sufficiently competent in the use of the tools was essential. Similarly, it was important to ensure all computers could connect to the internet and access the on-line survey.

The FIR was structured in two sessions. The first session focused on completing an on-line survey with the aid of a facilitator; the second session presented the data back to participants for review and further comment. Sufficient facilitators were used to ensure there were no more than eight participants per facilitator. Two of the senior consultants moved between the tables providing content expertise and clarification on discussion points, and also conducted real-time data analysis as the surveys were completed by each table. The two surveys were based on the on-line stakeholder survey, taking into account the feedback received to that point (from the CPN Executive Committees and survey respondents).

The first session of the FIR was itself divided into two halves – the first 30 minutes was used for completion of a survey focused on definition, mission and vision (see separate file SLE SP FIR Definition, Mission, Vision survey.pdf), and the second 30 minutes was used for completion of a survey focused on strategic priorities (see separate file SLE SP FIR Strategic Priorities survey.pdf).

Both surveys were created in Survey Monkey\[15\] and designed such that completion of the first survey automatically began the second survey. The majority of questions were asked in a three-point Likert response scale format, with some space devoted to open text responses. Through the use of radio buttons and dropdown lists, most questions allowed the facilitator to nominate the number of respondents per response category per question (e.g. five agrees and two neutrals) rather than one response for the entire table.

Data entered into Survey Monkey\[15\] surveys is automatically submitted as part of progressing to the next question. Survey Monkey\[15\] also automatically collates the data and is able to provide a simple report. As part of the FIR, this automatic submission and collation functionality was used, however a visual report (e.g. bar chart) was also prepared using MS Excel\[17\]. These charts were then placed in an MS Power Point presentation along with the comments received on each section. The first and second sessions of the FIR were separated by a short break to permit complete analysis of the data collected in the first session.

4.3.4 VCPC meeting
The VCPC was presented with a verbal progress report at their 22 September 2011 meeting. This was followed by a discussion of the strategy document more broadly, (as opposed to specific elements of it), as many VCPC members are also CPN Executive Committee members.

4.4 Finalising the strategy (EAG workshop 3)
Workshop 3 was conducted at the end of the strategic plan consultation process (2 October 2011) and was intended as a meeting to describe activities to date, ratify the plan and discuss implementation and funding issues.

The full agenda for the meeting is provided in Appendix 6. Other than noting the outcomes of discussions, formal minutes of the meeting were not taken.

At the conclusion of workshop 3, the strategy was updated to reflect all comments received and submitted to the VCPC, via the department, for endorsement.

# Due to our preferences for reporting – number of people rather than number of tables – the base reporting tools were not sufficient
5 Outcomes

5.1 Drafting the strategy
The draft version of the Victorian strategy for the Development of Simulation-Based Education and Training (2012-2015) (initially termed the Victorian Simulated Learning Environment Strategic Plan) for consultation was developed based on feedback received through two workshops with the EAG. The first workshop focused on setting the principles and the second focused on identifying the strategies.

5.1.1 Forming the EAG
All proposed EAG members were approached for their willingness to participate and replacements were sought as necessary. Some members had specific simulation expertise, however, the project team was mindful that the group required a broad range of education experience to objectively and realistically assess the merits of simulation-based education and training (SBET). Attempts were also made to have an appropriate mix and representation of genders, CPNs, disciplines and educational focus (i.e. university, TAFE and CPD). The 14-member EAG (including representatives from the Department of Health and HWA) ratified the ToRs at the start of workshop 1.

5.1.2 EAG workshop 1
The majority of EAG members attended the first workshop, although not all were able to attend for the entire duration or in person. As detailed in the agenda (see Appendix 3), the workshop sought to identify the stakeholders to be covered/included in the plan and the issues the plan should address (at the state, national and international levels), as well as define simulation, its purpose (mission statement) and vision for the future (vision statement).

Provided below is a summary of the discussions pertaining to each topic on the meeting agenda. Although the summary as presented implies a separate discussion for each item, discussions actually occurred across topics throughout the workshop.

Defining simulation
The starting point for discussions and developing the strategic plan more broadly was to define simulation. The EAG was asked to consider how they would define simulation. The immediate history of simulation, particularly simulation in Victoria, is one focused on equipment (perhaps at the expense of other modalities). As a result, the EAG was eager to ensure the definition of simulation was clearly broader than equipment. A definition often cited within the literature and also used on occasion by HWA is one provided by Gaba in 2004:\[16\]:

*Simulation is a technique – not a technology – to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner.*

For future workshop activities this was paraphrased as:

*Simulation is any educational method or experience that replicates characteristics and dimensions of reality in health and social care delivery.*

Identifying the issues
Essential to the development of an effective strategic plan is an understanding of the issues facing the entity (or in this case the activity) of focus. Through the use of a mind-mapping tool (Mind Manager\[17\]), the consultants facilitated a discussion of (and simultaneously documented) the issues facing SBET, noting recent work at the state- and national-levels investigating clinical skills SLEs\[13-14\] and the use of SLEs in health professional education\[10\] respectively.

# Although the term simulation-based education and training (SBET) was introduced late in the strategic plan development process, for consistency and ease of referral it will be used throughout this document.
The issues identified were broad ranging covering, space, training of educators, accessibility and availability of resources (people, equipment, scenarios etc.), history of simulation within Australia and knowledge of the sector (Figure 1).

**Figure 1: SBET issues mind-map**

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**Defining the stakeholders**

To help identify stakeholders, the EAG first listed potential categories of stakeholder. Five categories were agreed upon and over 20 organisational groups or entities were subsequently recorded as having an interest in SBET as it occurs in Victoria (Table 3). Although entities and organisations are only listed against one category in Table 3, it was acknowledged many fall into more than one.

**Table 3: SBET stakeholders**

<table>
<thead>
<tr>
<th>Category</th>
<th>Entity/Organisational group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current users of SBET</td>
<td>Universities, VET sector (including TAFE), Other RTOs, Health services, Professions, Professional bodies, Regulatory authorities, Australian Defence Force</td>
</tr>
<tr>
<td>Potential/future users of SBET</td>
<td>VCPC, CPN Executive Committees</td>
</tr>
<tr>
<td>Those with an interest in clinical placement governance</td>
<td>Health Workforce Australia, Department of Health, Department of Human Services, Department of Education Employment and Workplace Relations, Department of Health and Ageing</td>
</tr>
<tr>
<td>Those with an interest in health workforce</td>
<td>IT developers (e.g. for second life), Equipment manufacturers</td>
</tr>
</tbody>
</table>
Defining the mission
The EAG were guided through a process aimed at describing the purpose (and therefore the mission) for simulation as it applies to the education and training of health care practitioners within Victoria. The EAG were asked to consider answers to the question “what are we (simulation) here to do?” Further guidance was provided in the form of sample mission statements and clarifying questions:

- What is the purpose of simulation; who does it serve; how is it unique from other activities?
- What are the basic needs (educational, political, social etc.) that simulation exists to fill or what are the basic problems simulation exists to address?
- What is the role of simulation in addressing these needs/problems?

In an open discussion, the EAG articulated many reasons to use simulation:

- Addressing the capacity of the health and social care system to train the next generation of professionals.
- Optimising the range of experiences that learners are exposed to.
- Expanding the opportunities for appropriate multi-disciplinary training.
- Minimising the risk to patients/clients associated with training health professionals.
- Minimising the risk to learners associated with training.
- Minimising the risk to the health care system.
- Minimising the cost to the health care system.
- Expanding the opportunities for appropriate multi-disciplinary training.
- Minimising the risk to patients/clients associated with training health professionals.
- Minimising the risk to learners associated with training.
- Minimising the risk to the health care system.
- Minimising the risk to the health care system.
- Expanding the opportunities for appropriate multi-disciplinary training.
- Minimising the risk to patients/clients associated with training health professionals.
- Minimising the risk to learners associated with training.
- Minimising the risk to the health care system.
- Minimising the risk to the health care system.

Subsequently, the consultants used this information to draft the mission statement that was used as part of stakeholder consultations:

In the context of initiatives to increase the state’s capacity for high quality health professional education, simulation will contribute to optimising the efficiency and effectiveness of learning in the clinical or social care environment.

It will enhance the range of experiences that learners are exposed to and expand the opportunities for appropriate multi-disciplinary training, while minimising risks to patients/clients, learners and to the health care system overall. Simulation will contribute to and enable competency-based training and assessment, and will both foster and reflect innovation in clinical education and training.

Clarifying the vision
Within strategic planning, a vision describes what an organisation (or in this case the activity) should look like as it implements the relevant strategies and subsequently achieves its full potential. To help create a vision for SBET in Victoria, the EAG were asked to consider the question “where and what do we want to be?” bearing in mind the components of SBET including (amongst other things) people, services, structures, resources, culture and external perceptions. Sample visions were also provided.

During open discussions, the EAG suggested the following as desired outcomes for SBET and thus potential elements for inclusion in the vision statement:

- Improved quality and safety of professional practice in health disciplines.
- Better control over the range of experiences learners have during their training.
- Increased range of options for training.
- Expanded access to simulation across the learner population.
- Well-integrated, coordinated system.
- Improved equity of access to appropriate, fit-for-purpose simulation.
- More efficient, better-optimised simulation facilities.
- Increased numbers of, and better trained, educators.
- Increased capacity for high quality health professional training in Victoria.
- More efficient use of facilities.

Similarly to the mission, the consultants used these elements to draft a vision statement that was used as part of stakeholder consultations:

Over the next four years (2012 – 2015), simulation will contribute to the increased capacity for high quality health professional training in Victoria, through a well-integrated and coordinated network of facilities and resources characterised by:

- More efficient simulation facilities, resources and environments, optimised for expanded access in terms of the number and range of learners and delivering appropriate, fit-for-purpose simulation;
- Increased numbers of well-trained educators; and
- Accessible, affordable and innovative resources.

5.1.3 EAG workshop 2
The majority of EAG members (or pre-arranged alternates) were in attendance at workshop 2. As per the first workshop, some members were unable to attend the entire workshop and/or in person.
The start of workshop 2 was briefly devoted to confirming the draft mission and vision statements for use in consultation activities. As the mission and vision were drafted by the consultants following the first workshop, workshop 2 was the first opportunity for the group to consider and comment upon the draft statements. Although the EAG felt both statements were longer than ideal, the draft mission and vision were approved for use in statewide consultation activities.

Building on the outcomes of workshop 1, the aim of workshop 2 was to develop strategies and note associated requirements (in terms of staffing, staff training, equipment etc.) to build on strengths, reduce weaknesses, capture opportunities and avoid threats (see Appendix 4 for agenda).

**Figure 2: SWOT analysis mind map**

Provided below is a summary of the discussions pertaining to each item of the meeting agenda. Once again, although the summary as presented implies a separate discussion took place for each agenda item, discussions actually occurred across topics throughout the workshop.

**SWOT analysis and strategy development**

Through the use of a mind-mapping tool (Mind Manager) the consultants facilitated (and simultaneously documented) the SWOT analysis. The discussion started with a focus on the weaknesses of SBET within Victoria. The weaknesses identified ranged from lack of staff and staff training, to poor distribution of facilities and resources, to limited integration of SBET into curricula (i.e. it tends to be an add-on or after
thought), to difficulty identifying and accessing SBET. It quickly became evident that improved coordination/networking/information-sharing amongst the SBET community of practice would address many of the identified weakness (although the specifics of how this would be achieved were not discussed).

Although the discussion did move between the relative strengths, weaknesses, opportunities and threats of SBET in Victoria, the workshop was time-constrained. As a result, most time was spent discussing weaknesses and threats. In some respects this represents the position of SBET – still trying to establish itself in Victoria – and justifies the creation of a strategic plan. However, this does not diminish the fact there are also significant opportunities and strengths of SBET.

Time constraints also prevented a thorough discussion of the strategies. Although the EAG members and consultants proposed and noted strategies during the SWOT analysis, there was not a detailed consideration of what each proposed strategy might mean for SBET in Victoria and/or how it might be implemented (see Figure 2, for the full SWOT analysis and strategy development mind-map).

**Enablers**
As noted above, the workshop was significantly time limited. As a result, there was little opportunity to note (let alone discuss) what the enablers of each strategy might be, other than to recognise that some enablers may also be current strengths or opportunities, or related to current weaknesses or threats.
5.1.4 Setting the strategic priorities
The workshops were conducted within significant time constraints (only two half-day sessions were possible). As such, the consultants were required to create the strategic priorities based on the outcomes of the two workshops, as opposed to the creation of strategic priorities being a part of the workshops. Similarly, the principles upon which further development of simulation should take place were developed based on discussions amongst EAG members, rather than as part of discussions.

The draft principles and strategic priorities were based on high-level categorisation of the issues identified during the SWOT analysis. They were aligned with the draft definition, mission and vision, as well as the principles outlined in the Victorian clinical placement strategy. They attempted to provide a framework within which individual strategies and activities could be planned and undertaken.

The following draft principles were proposed in the draft strategy:
• Simulation has intrinsic value as a teaching and learning methodology.
• Ensuring all health professional learners have access to the learning opportunities and modalities that will best prepare them for safe, high quality practice is the most important consideration in relation to the availability of simulation resources and facilities.
• Victorian simulation resources and facilities are a public good and should be valued, applied efficiently and distributed fairly.
• The Victorian simulation system should embody good governance, ethical management and transparency in decision-making.
• The best outcomes will be achieved if stakeholders collaborate to identify and implement solutions that are responsive to local needs.

In identifying the priorities, the consultants noted the Victorian simulation system is one component of the state’s clinical education system, and therefore the development of simulation must align with the broader landscape of clinical education and training. Across the state, clinical placements required for entry-level health-professional education are now being coordinated by the VCPC via the CPNs. The VCPC has developed a strategic plan for clinical placements in Victoria (for the period 2012 – 2015) and has identified the following strategic priorities:
• Enhance capacity
• Assure and improve quality
• Support innovation
• Strengthen governance

In line with these priorities — and taking into account the issues that are particularly relevant to the effective and efficient use of simulation in Victoria — three key priorities (and subsequently strategic priorities) for simulation were identified for the period 2012 – 2015. The context of each is described in the following sections.
5.1.4.1 Key issue 1 – Management and organisation

The Victorian Clinical Skills SLE Infrastructure Review[13] highlighted the abundance of simulation resources in Victoria. However, consultations conducted as part of that review, as well as the current strategic planning process, revealed that despite the level of resourcing, access is an issue, preventing meaningful integration of SBET into curricula more broadly. This would suggest that simply having the facilities, resources and infrastructure does not guarantee the desired outcome. Notwithstanding that individual facilities may be well run, the failure to translate adequate facilities into sufficient access overall suggests deficiencies in the coordinated management and organisation of simulation resources (as also identified in the Peninsula CPN review[14]).

A number of issues relating to management and organisation were articulated, including:

- mal-distribution of facilities and resources, including the location of skilled personnel;
- insufficient coordination to achieve critical mass for some disciplines to access SBET in some areas;
- cost structures and business models of simulation facilities are often focused on cost recovery to its fullest (and sometimes a profit-making) extent; and
- absence of a suitable support network for simulation professionals.

To address these issues, a strategic priority focused on management and organisation was proposed. The intended outcome, objectives and strategies are summarised in Table 4.

**Table 4: Draft objectives and strategies for strategic priority 1 – Management and organisation**

<table>
<thead>
<tr>
<th>Outcome: A stakeholder-led simulation system that is sustainable, coordinated and efficient</th>
<th>Draft Objectives</th>
<th>Draft Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Victorian simulation system functions as a coordinated whole, supporting the use and development of appropriate simulation modalities, at the right time and in the right place</td>
<td>Through the VCPC and CPNs, establish statewide and network mechanisms for coordinating various aspects of resourcing, maintaining, operating and managing Victorian simulation facilities and resources</td>
<td>Future investment and allocation of resources is based on need and addresses statewide strategic priority criteria</td>
</tr>
<tr>
<td>The business models of simulation facilities are financially sustainable</td>
<td>Investigate models of SLE staffing structures that support efficient use of SLE facilities</td>
<td>SLE efficiency and effectiveness is supported at a network level through collaborative and coordinated planning and development mechanisms for funding and resourcing opportunities</td>
</tr>
<tr>
<td>The process for accessing simulation resources, simulation infrastructure and SLEs is common and consistent across the state</td>
<td>Determine capability, capacity and utilisation of SLE’s at a network level</td>
<td>SLE infrastructure and resources are documented and updated within CPN data profiles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Establish common processes for access to simulation resources, simulation infrastructure and SLEs at a network level</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Support expanded access to SLE facilities beyond traditional perceptions of applicability</td>
</tr>
</tbody>
</table>
5.1.4.2  Key issue 2 – Capacity and quality

The capacity for high quality SBET depends upon suitable simulation resources and appropriately skilled personnel. As discussed earlier, the level of simulation infrastructure within Victoria was not identified as a barrier to increasing simulation capacity. Instead, stakeholders identified inadequate numbers of appropriately trained and prepared simulation educators and technicians, as well as a lack of space to maximise the effective and efficient use of equipment or to innovate, as the main capacity constraints. These issues were reiterated during the development of the strategic plan, with a further two issues being identified:

- lack of quality standards for simulation infrastructure, environments, teaching and learning; and
- lack of career structure and role clarity for simulation educators.

To address these issues, a strategic priority focused on capacity and quality was proposed. The intended outcome, objectives and strategies are summarised in Table 5.

Table 5: Draft objectives and strategies for strategic priority 2 – Capacity and quality

| Outcome: Appropriate and sufficient simulated learning environments to meet the needs of the clinical education system in Victoria, offering uniformly high quality experiences for learners. |
|---|---|
| **Draft Objectives** | **Draft Strategies** |
| • There are sufficient numbers of appropriately trained educators and technicians, distributed appropriately relative to the facilities, resources and requirements | • Create a statewide simulation workforce profile (current and required) |
| | • Support the development of, and access to, SLE training programs (including making use of HWA-funded programs) |
| | • Provide incentives for educator and technicians to take up roles in areas of need |
| • Quality standards for learning using simulation are defined and applied across the system to ensure teaching and learning activities represent best practice | • Support the development and implementation of quality standards being developed by the Australian Society for Simulation in Healthcare |
| | • Implement the BPCLE as it applies to SLEs, including use of associated indicators as appropriate |
| • The Victorian simulation workforce is valued, appropriately skilled and sustainable | • Develop a continuing professional development framework for simulation educators and technicians. |
| | • Define a career pathway for simulation educators and technicians |
5.1.4.3 Key issue 3 – Innovation and capability
Within the context of SBET, capability refers to both the ability of the simulation community of practice to deliver a particular scenario and the awareness of the education provider (including professional bodies) of the applicability of simulation to the curriculum. Therefore, while having adequate infrastructure is clearly important, the capability for delivery of innovative SBET primarily depends upon the awareness – by both simulation and academic personnel – of the potential of simulation to meet the desired learning objectives.

The Victorian Clinical Skills SLE Infrastructure Review\(^{(13)}\) did not report equipment as a major barrier to immediately improving the capability of the system. Indeed, the review identified staff numbers and their training/skill mix were greater barriers to capability development (also identified in the Peninsula CPN SLE review\(^{(14)}\)). In developing this strategic plan, several other issues relating to innovation and capability were also identified:

- lack of integration of SBET into some curricula, reflecting traditional silos and boundaries;
- perception of SBET being synonymous with infrastructure/equipment;
- lack of research/evidence base supporting the use of SBET;
- lack of visibility and access (physical and cost) to champions/leaders; and
- limited knowledge of simulation resources amongst the broader clinical education community.

To address these issues, a strategic priority focused on innovation and quality was proposed. The intended outcome, objectives and strategies are summarised in Table 6.

### Table 6: Draft objectives and strategies for strategic priority 3 – Innovation and capability

<table>
<thead>
<tr>
<th>Draft Objectives</th>
<th>Draft Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>The use of simulation is evidence-based</td>
<td>Support the conduct of research at a Victorian level</td>
</tr>
<tr>
<td></td>
<td>Establish links to leading international simulation centres to foster exchange of expertise and ideas</td>
</tr>
<tr>
<td>Simulation is evident as a teaching and learning methodology in all curricula as appropriate and there are suitable simulation activities for every discipline.</td>
<td>Engage with appropriate accreditation/registration bodies to acknowledge the use of simulation in professional entry courses</td>
</tr>
<tr>
<td></td>
<td>Integrate learning using simulation in the curricula of courses including making use of HWA funded curriculum project outcomes</td>
</tr>
<tr>
<td></td>
<td>Support disciplines to implement the interprofessional learning findings from the HWA curriculum mapping project</td>
</tr>
<tr>
<td></td>
<td>Support simulation curriculum development tools and activities</td>
</tr>
<tr>
<td>Stakeholders are well-informed about the uses, practicalities, potential and limitations of simulation as a teaching and learning methodology</td>
<td>Develop and implement a communication strategy</td>
</tr>
<tr>
<td>A platform of excellence for simulation, where resources and expertise are accessible to all stakeholders</td>
<td>Establish resource and expertise sharing mechanisms</td>
</tr>
<tr>
<td></td>
<td>Establish mentoring pathways</td>
</tr>
</tbody>
</table>
5.1.5 Guiding implementation and monitoring
Early planning for the EAG workshops included a preliminary discussion of issues associated with monitoring and implementing the strategic plan. However, the tight timeframe for delivering the strategic plan, coupled with the availability of EAG members, required the duration and number of workshops to be reduced. This necessitated a focus on the strategic planning activities that are required to occur before a discussion on implementation and monitoring can be conducted. To support stakeholder discussion regarding implementation and monitoring of the strategic plan this section was drafted outside of the EAG. This section listed the major stakeholders of SBET and described what their roles and responsibilities could be. It also included a section focused on measurement of progress proposing deliverables, accountable entities and timelines for each of the draft strategies.

5.2 Stakeholder consultation
The *Victorian Simulated Learning Environment Strategic Plan 2012 – 2015 (Draft plan for consultation)* was distributed to stakeholders for their comment in early September 2011 (the draft plan used during consultations is provided as a separate file to this report – *SLE Strategic Plan Draft for Consultation.pdf*).

The consultation process was conducted throughout September 2011. Four specific consultation activities were undertaken:

- Attendance at September CPN Executive Committee meetings;
- A survey on key elements of the draft strategic plan open to all stakeholders;
- Attendance at the September VCPC meeting; and
- A facilitated interactive review, open to all stakeholders.

Essentially, all processes were designed to be conducted simultaneously. However, due to the timing and duration of some activities, it was possible to have an iterative process where feedback from some activities was taken into consideration prior to the next. This was particularly true of the stakeholder survey, which was updated following the FIR, which itself was influenced by discussions with the CPN Executive Committees and earlier survey data (see Table 7 for schedule of activities).

<table>
<thead>
<tr>
<th>Consultation activity</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPN Executive Committee meetings</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitated interactive review</td>
<td></td>
<td></td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Stakeholder survey 1</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Stakeholder survey 2</td>
<td></td>
<td>✔️</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>VCPC meeting</td>
<td></td>
<td></td>
<td></td>
<td>✔️</td>
</tr>
</tbody>
</table>

The following sections provide a summary of the consultation activities, but do not provide a detailed list of comments received. Instead, a summary table is provided as an appendix, including the final outcome (see Appendix 7).

5.2.1 CPN Executive Committee meetings
Two of the three consultants attended all 11 of the September CPN Executive Committee meetings. The exception to this was the first meeting, where all three consultants attended to ensure consistency of approach.

The CPN Executive Committee meetings were spread throughout the first two weeks of September (from 2 to 14 September). Although an hour was requested for each meeting, due to most meetings having quite large agendas, the consultations were often allocated 40 minutes or less. Taking account of the allocated time, discussion was restricted to the definition of simulation, mission, vision, strategic priorities and associated objectives.
Although some committees requested alternate parts of the draft strategy be discussed, the consultants kept to the pre-defined topics to ensure consistency in consultations across CPN Executive Committees.

Feedback from earlier meetings was discussed at subsequent meetings to facilitate the consultation process, as well as ensure feedback was representative of as broad a group of stakeholders as possible. In general, the feedback received was constructive and relatively consistent across CPNs.

Following each meeting, the feedback was summarised as an MS Word file and these were collated in MS Excel workbook by topic (i.e. all comments on the definition were collated in one worksheet within the MS Excel workbook). As noted earlier, feedback was relatively consistent. In instances where there was not consistency, issues were resolved in the favour of the majority view (i.e. more CPNs expressing the view). In cases where there was a deadlock, the consultants used their discretion.

As a result of the discussions with CPN Executive Committees, changes were made to all elements of the plan that were consulted on. The collated feedback and consultant response is provided as a separate file to this report (SLE CPN Consultation summary – Draft.xlsx).

5.2.2 Facilitated interactive review

The key element of a facilitated interactive review (FIR) is the presentation of review results back to the group for comment amongst all participants as part of the session. As well as providing immediate feedback to participants about their involvement (a key factor in encouraging longer-term participation), this method of review also serves to juxtapose conflicting ideas/comments. Thus, it may possible to resolve such issues during the review, rather than being forced to make an executive decision in the absence of stakeholders. At the very least, an FIR will increase participants’ awareness of issues that might be in conflict with what they see as easy, immediate or obvious solutions.

Overall, 24 people participated in the FIR. Most were from metropolitan Melbourne, however several travelled from regional Victoria including Gippsland and Maryborough. As participants arrived they were able to self-select a table, up to a limit of seven per table. Each table had one facilitator to guide them through completing one electronic copy of the survey.

Across all questions, most of the responses on the Likert scale were agree or neutral, with a small number disagree. The most notable exception to this was in relation to the vision, where a large number of participants disagreed with the vision statement.

The open text responses provided valuable insight into reasons for disagreement, as well as providing useful suggestions to improve each element or the strategy as a whole. For example, participants suggested “health” should read “health and social care” to ensure all relevant disciplines perceive they are included in the strategy and that “education” may be a better term to use than “learning”. Furthermore, participants noted the depth and breadth of SBET is broader than the current CPNs and VCPC, yet they are being proposed as the lead entities – indeed the VCPC is the sponsor of this project.

As a result of the FIR, a number of changes were made to various elements of the strategy that were subsequently mirrored in the on-line survey (see following).

5.2.3 Stakeholder surveys

It was originally planned to have one survey open throughout September. However, following the FIR it was deemed unnecessary to continue collecting responses against the original draft strategy. As a result,
on 20 September 2011 a second survey was created using the updated definition, mission, vision, strategic priorities and objectives. Simultaneously, the first survey was closed for responses. The following sections briefly describe the results of survey 1 and 2 respectively.

Survey 1
Survey 1 was open from 1 September to 20 September inclusive. During that time 53 respondents started the survey. The majority (47) answered the question regarding the type of organisation they belong to and 36 (76%) indicated it was a health service, 12 (25%) said education provider, 5 (10%) said simulated learning environment and 1 (2%) said other.

All CPNs were represented (45 responses to the question), with the most respondents coming from Central CPN (12, 26%), and the least Hume CPN (3, 6%). Most CPNs had between 5 and 8 respondents.

All disciplines were represented (note this list was limited to those disciplines forming the first phase of the HWA curriculum mapping project[8]), with the majority of respondents indicating an interest in nursing (42, 89%). The next closest was medicine (27, 57%), followed by physiotherapy (20, 42%). The lowest was dentistry (7, 14%), however most disciplines had between 10 and 20 responses.

Although it is not possible to say the survey is representative of all disciplines, CPNs or organisation types, these demographic data suggest all were represented.

Table 8 summarises the responses to key questions for each section of the survey. As can be seen, the majority of respondents were in agreement with the definition, mission, vision, principles, and strategic priorities in the draft strategy.

Table 8: Summary of survey 1 response data

<table>
<thead>
<tr>
<th>Item</th>
<th>Number in agreement</th>
<th>Percentage in agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition of simulation</td>
<td>50</td>
<td>96</td>
</tr>
<tr>
<td>Mission</td>
<td>42</td>
<td>87</td>
</tr>
<tr>
<td>Vision</td>
<td>41</td>
<td>86</td>
</tr>
<tr>
<td>Principles (combined result)</td>
<td>44</td>
<td>97</td>
</tr>
<tr>
<td>Strategic priority 1</td>
<td>43</td>
<td>93</td>
</tr>
<tr>
<td>Strategic priority 2</td>
<td>41</td>
<td>91</td>
</tr>
<tr>
<td>Strategic priority 3</td>
<td>42</td>
<td>93</td>
</tr>
</tbody>
</table>

In addition to the Likert-scale responses, over 50 comments were received across the survey. Many resonated with other feedback received on the strategy or the current state of the simulation community of practice within Victoria:

The survey responses (particularly the open-text comments) were taken into consideration as part of the planning activities for the FIR (see Section 5.2.2, Facilitated interactive review, page 16) as well as preparing for discussions with the VCPC (see Section 5.2.4, VCPC meeting, page 18) and the final workshop with the EAG (see Section 5.3.1, EAG workshop 3, page 19).

Survey 2
Survey 2 was open from 20 September to 30 September (inclusive). The web-link to the survey was sent to all FIR registrants, encouraging them to complete the survey and pass the link onto their colleagues.

In total, 15 respondents started the survey and 13 (86%) completed it. The spread of respondents was different to survey 1, with 6 (42%) indicating they work within a health service, 7 (53%) nominating an education provider and 2 (15%) indicating a simulated learning environment.
Most CPNs had at least one respondent (the exception being Grampians), although relative to other CPNs Northern and Loddon Mallee were both over-represented (5 each, 38%).

Most disciplines had two or more respondents indicate an interest in the particular discipline, with nursing the highest (7, 63%) and psychology the lowest (0).

Table 9 summarises the responses to key questions for each section of the survey. As can be seen, the majority of respondents were in agreement with the updated definition, mission, vision, principles, and strategic priorities.

Table 9: Summary of survey 2 response data

<table>
<thead>
<tr>
<th>Item</th>
<th>Number in agreement</th>
<th>Percentage in agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition of simulation</td>
<td>13</td>
<td>86</td>
</tr>
<tr>
<td>Mission</td>
<td>13</td>
<td>86</td>
</tr>
<tr>
<td>Vision</td>
<td>14</td>
<td>93</td>
</tr>
<tr>
<td>Principles (combined result)</td>
<td>15</td>
<td>100</td>
</tr>
<tr>
<td>Strategic priority 1</td>
<td>13</td>
<td>92</td>
</tr>
<tr>
<td>Strategic priority 2</td>
<td>10</td>
<td>71</td>
</tr>
<tr>
<td>Strategic priority 3</td>
<td>11</td>
<td>78</td>
</tr>
</tbody>
</table>

Just over 15 comments were received across the survey, with several respondents noting the changes made to parts of the strategy and suggested they were improvements. The survey responses (particularly the open-text comments) were taken into consideration as part of the planning activities for the final workshop with the EAG (see Section 5.3.1, EAG workshop 3, page 19) and creating the final strategic plan (see Section 5.3.2, Completing the update, page 19).

5.2.4 VCPC meeting

All three consultants attended the VCPC meeting (22 September 2011) to ensure their collective experiences of the consultation process could be drawn upon if required.

The versions of the definition of simulation, mission, vision, strategic priorities and associated objectives presented to the VCPC took into account the feedback collected to that point and were well received. This allowed the discussion to quickly proceed to other points of concern for the consultants and the VCPC.

Feedback on the order of strategic priorities was inconsistent and thus a decision to change could not be made with confidence that it represented a majority view. Therefore, the consultants sought the views of the VCPC, who indicated the original order was appropriate, but that further text should be added to the strategic plan explaining the priorities are equally weighted. The VCPC had a number of comments, most of which could be addressed by reducing the detail in the implementation and monitoring section.

5.3 Finalising the strategy

At the completion of the consultation period (30 September 2011), the consultants reviewed the current versions of the definition, mission, vision and strategic priorities, in the context of feedback received and updated them as appropriate. As the consultation process itself provided supporting evidence for many of the strategic priorities, large parts of the introduction to each strategic priority were also updated.

The final strategy was presented to the EAG as part of a third workshop aimed and ratifying the strategy as well as reviewing the upcoming funding announcement from HWA.

5.3.1 EAG workshop 3

The majority of EAG members were in attendance, although not all were able to attend for the entire duration or in person. As detailed in the agenda (see Appendix 6), the workshop sought to provide an overview of the consultation activities and their outcomes, and subsequently ratify the updated strategic plan. The final section of
the meeting was scheduled to be devoted to the department to discuss imminent funding opportunities (and will not be reported on here).

Given the volume of feedback and the diversity of sources – in terms of disciplines, learner level, SBET experiences, etc. – it was not surprising the consultation process generated a number of new (and somewhat untested) ideas, conflicting suggestions for improvements and requests for more inclusive language. In many cases, this resulted in the consultants needing to make executive decisions on the inclusion or omission of some of the feedback. Although various EAG members were involved in one or more of the consultation processes outside the EAG (and thus aware of most of these conflicts and the executive decisions made by the consultants), ratification of all elements of the strategic plan was not possible during workshop 3 (implementation and monitoring in particular).

Further adding to the complications, there were conflicting (new) ideas presented at the final EAG workshop that proved difficult to resolve amongst the group.

5.3.2 Completing the update

Having ratified the plan title, definition, mission, vision and strategic priorities with the EAG, these elements were updated in the strategic plan. The consultants also updated the entire document to reflect the global changes discussed – e.g. patient focus, replace “learning” with “education and training” etc – and ensure there was sufficient context supporting each of the strategic priorities.

As mentioned above, the section on implementation and monitoring was significantly re-drafted, removing most of the information specifying activities and changing the title to roles and responsibilities. The roles and responsibilities themselves were also updated, recognising the complex organisational relationship of SBET stakeholders (i.e. education providers and health services are able to be SBET users or providers or both).

After a short review process, the final strategy was presented on 12 October 2011 and approved for circulation as the Victorian Strategy for the Development of Simulation-Based Education and Training 2012 – 2105 (Health and social care) on 20 October 2011. The final strategy is provided as a separate document to this report - SBET Strategic Plan 2012-15_final.pdf.
6 Discussion and Suggested Actions

The nature of this project (creation of a strategic plan) does not easily lend itself to a discussion of and subsequent suggestion for future activities relating to the project deliverable, as the deliverable itself includes what the future activities should be. In this case, an immediate funding source is evident, thus the discussion of early implementation activities may also be of little value as they will be determined by the willingness of stakeholders to propose and undertake projects (although there is some scope to suggest statewide projects). Thus, this section of the report will concentrate on discussing the project as it was undertaken and how it might be improved for future (similar) projects.

6.1 Project timing

Within the Victorian Clinical Skills SLE Review, the authors note that clinical skills labs have been in operation in Victorian since 1985, with a rapid and recent growth in size and number over the past few years\[13\]. This growth is cited as one of the factors behind the poor coordination identified in that report and in the consultation activities undertaken as part of creating the strategic plan. The clinical skills SLE report goes on to suggest improvements to coordination through the creation of a statewide strategic plan for clinical skills centres. Notwithstanding the opportunity presented by the availability of funding from HWA, the department should be commended for supporting the VCPC to build on the clinical skills review. Further, it should also be commended for broadening the scope of the recommendation, and supporting the creation of a strategic plan covering SBET in its broadest terms.

Indeed, as a result of the creation and subsequent implementation of this strategic plan, it will now be possible to take steps towards several other suggested actions posed within the clinical skills SLE review including:

- Engagement of all known simulation facilities;
- Improved role definitions for positions within SBET;
- Creation of SBET staff development activities; and
- Resolution of some space and storage issues.

In supporting the development of the strategic plan for SBET in Victoria, the department has also addressed comments received during the clinical skills review that “previous processes had been started but not finished”\[13\].

As noted above, the time between reporting on the clinical skills review and publishing the strategic plan was short – approximately 12 months. However, the timeframe for the development of the strategic plan was much shorter – approximately three months. It is acknowledged a number of factors have contributed to this tight timeframe, including an opportunity to optimise the utilisation of national funding through the development of a statewide framework.

Conducting such a significant project in such a short timeframe may have left some stakeholders feeling unheard and perhaps disconnected from the process and therefore the plan. This may mean some stakeholders are unaware of the plan or unwilling to consider how it might apply to them and their work. At this point it is unclear how this could be rectified, although the funding available for developing SBET may encourage (perhaps even force) people to consider how the strategic plan applies to them.

6.2 Strategy development

The entire strategy was proposed to be developed in consultation with the EAG, established under the auspice of the VCPC. Indeed, they played a major role in early development activities as well as providing significant input prior to final endorsement by the VCPC. The formation of the EAG was guided by the VCPC and the group’s activities were defined by ToRs (see Appendix 2).
The ToRs were essential to the formation of the EAG, defining its role in terms of creating the strategic plan, as well as outlining the temporary nature of the group. At times, the group’s focus narrowed to specific elements or activities within SBET, likely due to one of the end uses of the strategic plan – to guide the state-managed HWA SBET request for proposals process. Although not the plan’s raison d’être, its role in guiding the state-managed HWA SBET request for proposals process proved useful in both bringing the group together and ensuring specific elements of SBET within Victoria were discussed. However, on occasion, these discussions were longer than might have reasonably been expected and thus may have been at the expense of other elements of SBET within Victoria.

Thus, although it is clear the immanent availability of funding was advantageous to the project, it may have also driven specific (perhaps unintended) outcomes. In the future, as was the case with this project, these issues should be identified early and appropriately managed.

6.2.1 Consultation activities
The tight timeframe for the delivery of the strategic plan was noted at the start of the project, with efforts made to conduct the broadest possible consultation within that timeframe. As part of these efforts, the initially proposed three FIRs were reduced to one, and attendance at all 11 CPN meetings was added in recognition that these committees are elected to represent the wider stakeholder group.

This approach served to ensure every CPN received an opportunity to contribute (although not all interested stakeholders from within each CPN could attend), as well as raising the profile of SBET amongst all CPNs and stakeholders that might not have otherwise participated in the planning process – a particularly positive outcome.

Although there were certainly time (and perhaps financial) imperatives behind reducing the number of FIRs, feedback suggested additional open consultation activities were required. The success of the FIR, in both engaging stakeholders and critically appraising the strategic plan, further supports the value of including additional similarly open activities in future consultations. Given the success of the visits to CPNs and the need to have additional open activities, in instances such as this (limited time and perhaps limited money), it may be appropriate to hold open CPN Executive Committee meetings and/or append consultation activities to CPN Executive Committee meetings.

Suggested Action 1
Consider the use of open CPN Executive Committee meetings as a consultation activity for future projects.

Regardless of the consultation approach used, sufficient notification time is essential to encouraging participation. Although highly interested or committed stakeholders will attend an event (virtually) regardless of the lead time, short notification periods only serve to provide reasons for non-attendance and disengagement. Comments received during the consultation process with CPN Executive Committees suggested rural or regional stakeholders require as much as eight weeks notice of consultation activities, due to the way rosters are structured and planned in advance. Within this project, provision of such advanced notice was not possible and may have affected participation.

6.3 Implementing the plan
Currently, funding of SBET comes from a variety of sources and this is set to continue into the foreseeable future. Given the nature of health and social care delivery and the education of its practitioners, it is likely a large amount of that money originates from government funding of TAFEs, universities or health services in the form of grants for education and training or perhaps even infrastructure purchase and development. Therefore, to the extent that this expenditure will need government (particularly state government) approval, initiatives should demonstrate their alignment with the strategic plan. Given the diversified nature of government funding sources available to health and social care education organisations, the VCPC, through
the Department of Health will need to communicate this strategy and its implications to other relevant state and federal government departments and organisations including but not limited to:

- Department of Business and Innovation;
- Department of Education and Early Childhood Development;
- Health Workforce Australia;
- Department of Health and Ageing; and
- Department of Education, Employment and Workplace Relations.

In many respects, the value of the strategic plan amongst stakeholders may well be set by how projects are held to account against the strategic plan, despite the fact funding will come from multiple and diverse sources.

**Suggested Action 2**

Communicate the plan and its intent to relevant state and federal government departments and organisations.

**Suggested Action 3**

Future initiatives should be required to demonstrate their alignment with the strategic plan in order to be eligible for funding.

The diversity of funding sources has allowed the development of pockets of excellence within SBET in Victoria. As identified through this strategic planning process and previous reports, this excellence is somewhat isolated and not always accessible or readily available. Although it may not be possible to rectify this situation immediately, future SBET activities should be implemented with the broader Victorian simulation system in mind. At a minimum, this would mean new activities are not detrimental to existing activities and do not reinforce silos of operation. Ideally, proposed SBET activities should be able to demonstrate sufficient applicability and scalability to allow use across multiple disciplines, educational levels, CPNs or the state (as appropriate).

**Suggested Action 4**

Support the development of SBET initiatives which are broadly applicable and scalable.

In several of the consultation activities, the “lack of a patient focus” was identified as a failing of the strategic plan (see Appendix 7). However, stakeholders could not sufficiently define what they meant by “lacking a patient focus” to warrant inclusion within any of the strategic priorities or objectives. For example, stakeholders could not articulate what a greater patient focus meant in the context of how teaching or learning would be developed or delivered, other than to suggest that simulation needs to reflect the patient journey/experience (as with any other health or social care education method).

In contrast to the broader stakeholder group, the EAG were able to articulate this focus more strongly and suggested the need for patients to be included on committees/panels involved in the development of SBET activities. As this is (essentially) the inclusion of patients at a particular point in the SBET development process, it was felt that specific mention did not need to be made in any strategic priority. Rather, it was felt that SBET activities should include patients in the design process, particularly if they wish to be considered as innovative or high-quality.

**Suggested Action 5**

SBET funding bodies should consider the inclusion of a criterion focused on patient centeredness in their assessment processes.

As the owners of the strategic plan, the VCPC (and by extension the CPNs), will likely be the entity managing the balance between professional-entry and post-qualification education and training. Thus, instead of simply supplementing current expertise with experts at the postgraduate level, achieving the balance should be viewed as a pathfinder activity, with the ultimate aim of the VCPC and CPNs establishing protocols capable of covering the
continuum of clinical education and training in a sustainable fashion (as proposed in the report A New Model of Clinical Placement Governance in Victoria\(^9\)).

**Suggested Action 6**

**Implementation of the Victorian Strategy for the Development of SBET 2012 – 2015 (Health and social care) should be viewed as a pathfinder project for increasing the relevance of the VCPC and CPNs to the post-qualification clinical education and training system.**

Given the high degree of overlap between the issues identified in the Victorian and Peninsula CPN clinical skills SLE reviews\(^{[13-14]}\) and the current strategic planning process, it is likely those issues are persistent and applicable to all CPNs. Indeed, the list of suggested actions from both reviews makes for a compelling list of statewide projects (notwithstanding their focus on clinical skills SLEs over SBET more broadly):

- The location, contact, equipment and booking details of all SLEs... should be accessible via the... website.
- Determine the feasibility of establishing a library-style system for managing SLE infrastructure and equipment.
- Form an SLE-focused sub-committee... to guide SLE development...
- Identify staff recruitment and training needs for effective delivery of learning through SLEs.

Thus, decision-makers are encouraged to read (or re-read as the case may be) the recent reviews on clinical skills SLEs for potential statewide projects and/or to ensure future activities, within the context of the strategic plan, align with actions suggested within the reviews.

**Suggested Action 7**

**When supporting the development of SBET initiatives, decision–makers are encouraged to keep the outcomes of recent reviews top of mind**

**6.4 On-going sustainability**

As brought to our attention on many occasions throughout the consultation process, sustainability is not just about funding. Indeed, the absence of specific funds for SBET would likely not mean the demise of simulation or simulation centres. However, what it might mean is that SBET continues to be out-of-reach for many education providers or disciplines (particularly those focused on entry-level health practitioner education).

Similarly, the poor allocation of funding may not result in the demise of simulation, but it may result in Victoria confronting the same issues when it reviews the SBET strategic plan in 2015. Therefore, it is important that funds are allocated to activities that address longer-term sustainability (particularly sustainable access).

Given the limited knowledge of SBET resources across the state, creation of (and open access to) a statewide database of SBET resources or experts would go some way to ensuring continued sustainability of access. This would require some resources be allocated to the creation of the database – a spreadsheet in its simplest form – and the ongoing maintenance of the database allocated to a specific group. Given the role the VCPC is playing in the current process, it might take the lead. However, there are existing groupings that represent simulation stakeholders (such as the Australian Society for Simulation in Health Care and the Victorian Simulation Alliance), and these might be more appropriate entities to manage such a database, particularly as it relates to covering the continuum of education.

Beyond database creation and management this group might also take responsibility for overseeing the SBET strategic plan more broadly. Although the VCPC led the creation of the strategy, it may be appropriate to
have a SBET-focused entity lead its implementation. As noted in the strategic plan and discussed above as part of a recommendation of an earlier review, the creation of a SBET-focused sub-committee of the VCPC (newly-formed or adapted from existing structures or organisations) would make a positive contribution to on-going sustainability. The creation of a sub-committee of the VCPC will serve to keep SBET sufficiently on the clinical education and training agenda. Indeed, such a proposal was made during discussions with the EAG, although the details were not discussed at length.

If a SBET-focused VCPC sub-committee were formed (or a similar overseeing body established) Their role would need to go beyond grant management or dispute resolution and extend to understanding the requirements of the SBET community of practice in order to articulate and advocate requirements to relevant funding bodies. The sub-committee could also facilitate interactions and identify new connections and collaborations. Importantly, the group would be of the community and for the community, focused on the breadth of SBET and inclusive of all interested disciplines.

In some respects it could be argued that the on-going sustainability of simulation access could be (essentially) guaranteed by specifically including SBET activities in the curricula of courses, particularly entry-level health practitioner courses. This means making simulation activities part of the accredited course, not an optional element. Such an approach may have the added outcome of increasing the recognition of simulation as a method of teaching and learning in its own right (a principle of the SBET strategy). Integration at this level requires health care practitioners (who themselves comprise the accrediting committees), understand the value of SBET and how it can contribute to the education and training of practitioners of their discipline.

**Suggested Action 8**

Future SBET initiatives should be reviewed for their capacity to positively contribute to the on-going sustainability of SBET.

**7 Acknowledgements**

The consultants (Dr Huysmans, Dr Cohen and Ms Keast) would like to thank the Department of Health for the opportunity to undertake this project. The participants are also thanked for their involvement, particularly those who gave up time to participate in the EAG or CPN Executive Committee meetings, complete the on-line survey and/or attend the facilitated interactive review.
Appendix 1: EAG members

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geoff Solarsh (Chair)</td>
<td>Monash University</td>
</tr>
<tr>
<td>Meg Morris</td>
<td>The University of Melbourne</td>
</tr>
<tr>
<td>Jenny Keating</td>
<td>Monash University</td>
</tr>
<tr>
<td>Amanda Cameron</td>
<td>La Trobe Regional Hospital</td>
</tr>
<tr>
<td>Katie Walker</td>
<td>Health Workforce Australia</td>
</tr>
<tr>
<td>Leone English</td>
<td>Holmesglen Institute</td>
</tr>
<tr>
<td>Leanne Basham</td>
<td>Deakin University</td>
</tr>
<tr>
<td>Denielle Beardmore</td>
<td>Ballarat Health Services</td>
</tr>
<tr>
<td>Karen Livesay</td>
<td>Victoria University</td>
</tr>
<tr>
<td>Debra Nestel</td>
<td>Monash University</td>
</tr>
<tr>
<td>Debra Kiegaldie</td>
<td>Southern Health</td>
</tr>
<tr>
<td>Robert O’Brien</td>
<td>St Vincent’s Health</td>
</tr>
<tr>
<td>Peter Morley</td>
<td>Royal Melbourne Hospital</td>
</tr>
<tr>
<td>Steve Kozel</td>
<td>Department of Health</td>
</tr>
</tbody>
</table>
Appendix 2: EAG Terms of Reference

Purpose
The EAG – Simulated Learning Environments (SLEs) - has been established to provide expert advice and leadership to guide the development of a Victorian SLE strategic plan and the implementation of a statewide funding round for SLEs to be undertaken in partnership with Health Workforce Australia.

Role and function
The EAG will:
1. Consider current and previous SLE related work conducted at both a state and national level to determine principles to guide SLE activities in Victoria.
2. Consider solutions and strategies that will enable increased utilisation of SLEs to train and develop the future health workforce.
3. Participate in planning activities and provide strategic advice to inform the development of a draft Victorian SLE Strategic Plan.
4. Support stakeholder input to the development of the Victorian SLE strategic plan.
5. Work directly with the Department of Health to inform the implementation of a statewide funding round to support SLEs in Victoria.

Membership
The members of the EAG shall be:
- Four representatives of the VCPC (two metropolitan and two rural)
- A representative of the Department of Health
- A representative of Health Workforce Australia
- A representative of the Victorian Simulation Alliance
- Up to three independent expert members.

The Chairperson will be the nominated representative of the VCPC.

Meeting protocol
All members shall declare any potential conflict of interest at the commencement of each meeting. The Chairperson will decide as to whether that member should absent themselves from discussion of the identified issue.

Proxies are not permitted without prior approval of the Chairperson.

Duration of meeting
Meeting duration will vary depending on meeting purpose.

Frequency of meeting
Meetings are to be held as required. This will include:
- Two half-day workshops to inform the development of the draft Victorian SLE Strategic Plan
- One half-day workshop to confirm the strategic plan and agree associated recommendations

Quorum
A quorum shall be half the members plus one.

Duration of EAG
The EAG shall be constituted for the duration of the development of the Victorian SLE strategic plan.

Commencement date
August 2011

Conclusion date
30 October 2011
### Appendix 3: EAG workshop 1 agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00 pm</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:15 pm</td>
<td>Welcome and overview</td>
</tr>
<tr>
<td></td>
<td>• Geoff Solarsh, Advisory Group Chair</td>
</tr>
<tr>
<td></td>
<td>• Steve Kozel, Department of Health</td>
</tr>
<tr>
<td></td>
<td>• Katie Walker, Health Workforce Australia</td>
</tr>
<tr>
<td>1:30 pm</td>
<td>Overview of current Victorian SLE arrangements</td>
</tr>
<tr>
<td></td>
<td>• Summary of findings from state-wide review</td>
</tr>
<tr>
<td>1:45 pm</td>
<td>Identification of key issues</td>
</tr>
<tr>
<td></td>
<td>• What are the major issues the Victorian SLE Strategic Plan must address?</td>
</tr>
<tr>
<td></td>
<td>• The internal (i.e. Victorian) context</td>
</tr>
<tr>
<td></td>
<td>• The external (i.e. national and international) context</td>
</tr>
<tr>
<td></td>
<td>• Who are the major stakeholders and what are their needs/expectations with respect to the major issues</td>
</tr>
<tr>
<td>3:00 pm</td>
<td>Afternoon tea</td>
</tr>
<tr>
<td>3:15 pm</td>
<td>Identifying the endpoint: what are we trying to achieve?</td>
</tr>
<tr>
<td></td>
<td>• Defining the mission</td>
</tr>
<tr>
<td></td>
<td>• Clarifying the vision</td>
</tr>
<tr>
<td></td>
<td>• Identifying the key objectives</td>
</tr>
<tr>
<td>4:45 pm</td>
<td>Summary of workshop outcomes</td>
</tr>
<tr>
<td>5:00 pm</td>
<td>Close</td>
</tr>
</tbody>
</table>

### Appendix 4: EAG workshop 2 agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00 pm</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:15 pm</td>
<td>Brief recap of the outcomes of Workshop 1</td>
</tr>
<tr>
<td>1:25 pm</td>
<td>Defining the starting point for the strategy, in terms of current:</td>
</tr>
<tr>
<td></td>
<td>• Strengths</td>
</tr>
<tr>
<td></td>
<td>• Weaknesses</td>
</tr>
<tr>
<td></td>
<td>• Opportunities</td>
</tr>
<tr>
<td></td>
<td>• Threats</td>
</tr>
<tr>
<td>2:00 pm</td>
<td>Identification of strategies to:</td>
</tr>
<tr>
<td></td>
<td>• Build on strengths</td>
</tr>
<tr>
<td></td>
<td>• Reduce or eliminate weaknesses</td>
</tr>
<tr>
<td></td>
<td>• Capture opportunities</td>
</tr>
<tr>
<td></td>
<td>• Avoid threats</td>
</tr>
<tr>
<td>3:00 pm</td>
<td>Afternoon tea</td>
</tr>
<tr>
<td>3:15 pm</td>
<td>Articulating the requirements</td>
</tr>
<tr>
<td></td>
<td>• What will be needed to realise the strategies, in terms of:</td>
</tr>
<tr>
<td></td>
<td>• Infrastructure</td>
</tr>
<tr>
<td></td>
<td>• Staffing</td>
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<tr>
<td></td>
<td>• Staff training</td>
</tr>
<tr>
<td></td>
<td>• Other requirements (particularly in relation to stakeholder engagement)</td>
</tr>
<tr>
<td>4:45 pm</td>
<td>Summary of all workshop outcomes and next steps</td>
</tr>
<tr>
<td>5:00 pm</td>
<td>Close</td>
</tr>
</tbody>
</table>
Definition of Simulation
Simulation is any educational method or experience that evokes or replicates substantial aspects of the real world in a fully interactive manner.

Mission
Simulation will contribute to optimising the efficiency and effectiveness of high quality learning in health and social care environments and will reflect innovation in education and training.

It will enhance the range of experiences that learners are exposed to and expand the opportunities for appropriate interprofessional education and training, while minimising risks to patients/clients, learners and to the health care system overall.

Vision
Simulation will be delivered through a well-integrated and coordinated network of facilities and resources characterised by:
- Efficient simulation facilities, resources and environments;
- Well-trained educators; and
- Accessible, affordable and innovative resources; optimised for expanded access in term of the number and range of learners and delivering appropriate, fit-for-purpose simulation.

Strategic Priority 1
Desired outcome: Victoria has a stakeholder-led simulation system that is sustainable, coordinated and efficient

Objectives:
- The Victorian simulation community of practice functions as a coordinated network, supporting the use and development of appropriate modalities, at the right time and in the right place
- The business models for development and delivery of simulation-based learning are financially sustainable

Strategic Priority 2
Desired outcome: There are appropriate and sufficient simulation resources to meet the needs of the education system in Victoria, offering uniformly high quality education for learners

Objectives:
- There are sufficient numbers of trained simulation educators and technicians, distributed appropriately relative to the facilities, resources and requirements
- Quality standards for learning using simulation are defined and applied across the system to ensure teaching and learning activities represent best practice
- The Victorian simulation workforce is valued, appropriately skilled and sustainable

Strategic Priority 3
Desired outcome: There is broad awareness and understanding of simulation as a teaching and learning tool, where the development of simulation is driven by educational goals

Objectives:
- The use of simulation is evidence-based
- Simulation is evident as a teaching and learning methodology in curricula as appropriate and there are suitable simulation-based learning resources for all disciplines that require them
- Stakeholders agree well-informed about the uses, practicalities, potential and limitations of simulation as a teaching and learning methodology
- Innovative, best-practice resources and expertise are available to all stakeholders

Appendix 5: Updated strategic plan elements used in FIR

Appendix 6: EAG workshop 3 agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:30 pm</td>
<td>Welcome</td>
</tr>
<tr>
<td>2:35 pm</td>
<td>Overview of consultation activities and feedback</td>
</tr>
<tr>
<td></td>
<td>• Feedback received on definition, mission, vision, strategic priorities, desired outcomes, objectives</td>
</tr>
<tr>
<td></td>
<td>• Feedback received on other elements of the strategy</td>
</tr>
<tr>
<td>3:15 pm</td>
<td>Ratification of the strategy</td>
</tr>
<tr>
<td></td>
<td>Consideration of the final draft strategy</td>
</tr>
<tr>
<td>4:00 pm</td>
<td>Request-for-Proposals and Next Steps</td>
</tr>
<tr>
<td>4:25 pm</td>
<td>Close</td>
</tr>
</tbody>
</table>
# Victorian Simulated Learning Environment Strategic Plan

Simulation is any educational method or experience that replicates characteristics and dimensions of reality in health and social care delivery. Simulation is a technique – not a technology – to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner.

## Principles
- Simulation has intrinsic value as a teaching and learning methodology.
- Ensuring all health professional learners have access to the learning opportunities and modalities that will best prepare them for safe, high quality practice is the most important consideration in relation to the availability of simulation resources and facilities.
- Victorian simulation resources and facilities are a public good and should be valued, applied efficiently and distributed fairly.
- The Victorian simulation system should embody good governance, ethical management and transparency in decision-making.
- The best outcomes will be achieved if stakeholders collaborate to identify and implement solutions that are responsive to local needs.

## Mission
In the context of initiatives to increase the state’s capacity for high quality health professional education, simulation will contribute to optimising the efficiency and effectiveness of learning in the clinical or social care environment.

It will enhance the range of experiences that learners are exposed to and expand the opportunities for appropriate multi-disciplinary training, while minimising risks to patients/clients, learners and to the health care system overall. Simulation will contribute to and enable competency-based training and assessment, and will both foster and reflect innovation in clinical education and training.

## Vision
Over the next four years (2012 – 2015), simulation will contribute to the increased capacity for high quality health professional training in Victoria, through a well-integrated and coordinated network of facilities and resources characterised by:
- More efficient simulation facilities, resources and environments, optimised for expanded access in terms of the number and range of learners and delivering appropriate, fit-for-purpose simulation;
- Increased numbers of well-trained educators; and
- Accessible, affordable and innovative resources.
<table>
<thead>
<tr>
<th>Comments received</th>
<th>Final version/response</th>
</tr>
</thead>
</table>
| • Use “simulation based-learning” instead of “simulated learning environment”  
• Add “infrastructure” to the title given the equipment focus of the strategy | The Victorian Strategic Plan for the Development of Simulation-Based Education and Training |
| • Avoid the word “replace” by using “augment”  
• It is not necessary to use “substantial” or “fully”  
• Context (i.e. health and social care) needs to be included | Simulation in health and social care refers to any educational method or experience that evokes or replicates aspects of the real world in an interactive manner. |
| • Define “simulation system”  
• Lacks patient focus | • Simulation has intrinsic value as a teaching and learning method.  
• The most important consideration in relation to the availability of simulation resources and facilities is ensuring all health professional learners have access to the learning opportunities and modalities that will best prepare them for safe, high quality, patient-centred practice.  
• Victorian simulation resources and facilities are a public good and should be valued, properly maintained, applied efficiently and distributed fairly.  
• The Victorian simulation community of practice should embody good governance, ethical management and transparency in decision-making.  
• The best outcomes will be achieved if stakeholders collaborate to identify and implement solutions that are responsive to local needs. |
| • Too long and too wordy  
• Should not include such a direct link to clinical placement capacity  
• May not adequately cover the depth and breadth of SBET  
• Concern about the use of “competency-based”  
• Simulation should never replace actual clinical experience | Simulation will make an innovative contribution to optimising the efficiency and effectiveness of high quality teaching and learning in health and social care environments.  
It will enhance the range of experiences for learners and expand the opportunities for appropriate inter-professional education and training, while minimising risks to patients/clients, learners and to the health and social care system overall. |
| • Not visionary enough  
• Too equipment focused  
• No patient focus  
• Effect on clinical placements not evident.  
• Who will coordinate this activity/achievement of the vision? Stakeholders? If so, it needs to be made clear  
• Does the system need to be innovative?  
• Too long | Simulation-based education and training will be delivered through an integrated and coordinated community of practice that provides quality, fit-for-purpose simulation. The community of practice will be characterised by:  
• Efficiently used simulation facilities and resources, that are innovative, affordable and optimised for expanded access;  
• Well-prepared educators; and  
• An active research and development program. |
<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Draft version</th>
</tr>
</thead>
</table>
| **Strategic Priority 1** | Outcome: A stakeholder-led simulation system that is sustainable, coordinated and efficient.  
Objectives:  
• The Victorian simulation system functions as a co-ordinated whole, supporting the use and development of appropriate simulation modalities, at the right time and in the right place  
• The business models of simulation facilities are financially sustainable.  
• The process for accessing simulation resources, simulation infrastructure and SLEs is common and consistent across the state |
| **Strategic Priority 2** | Outcome: Appropriate and sufficient simulated learning environments to meet the needs of the clinical education system in Victoria, offering uniformly high quality experiences for learners.  
Objectives:  
• There are sufficient numbers of appropriately trained educators and technicians, distributed appropriately relative to the facilities, resources and requirements  
• Quality standards for learning using simulation are defined and applied across the system to ensure teaching and learning activities represent best practice.  
• The Victorian simulation workforce is valued, appropriately skilled and sustainable |
| **Strategic Priority 3** | Outcome: Awareness and understanding of simulation as a teaching and learning tool, with a view to encouraging curriculum-driven development of simulation  
Objectives:  
• The use of simulation is evidence-based  
• Simulation is evident as a teaching and learning methodology in all curricula as appropriate and there are suitable simulation activities for every discipline.  
• Stakeholders are well-informed about the uses, practicalities, potential and limitations of simulation as a teaching and learning methodology  
• A platform of excellence for simulation, where resources and expertise are accessible to all stakeholders |
<table>
<thead>
<tr>
<th>Comments received</th>
<th>Final version/response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenging to achieve;</td>
<td>Outcome: Victoria has a stakeholder-led simulation community of practices that is sustainable, coordinated and efficient.</td>
</tr>
<tr>
<td>Define “simulation system”</td>
<td>Objectives:</td>
</tr>
<tr>
<td>Change “process” to “principles”</td>
<td>• The Victorian simulation community of practice functions as a coordinated network, supporting the use and development of appropriate modalities, at the right time and in the right place</td>
</tr>
<tr>
<td>Concern there could be conflation of financially sustainable with financially self-sustainable</td>
<td>• The business models for development and delivery of simulation-based education and training are financially sustainable for providers and users of SBET</td>
</tr>
<tr>
<td>who will be the coordinating entity</td>
<td>• The principles for accessing simulation-based education and training resources are common and consistent across the state</td>
</tr>
<tr>
<td>Define “stakeholder-led”</td>
<td></td>
</tr>
<tr>
<td>I have concerns about the terms “common” and “consistent”</td>
<td></td>
</tr>
<tr>
<td>Notions of best practice are usually highly contextualised and can limit creativity</td>
<td>Outcome: There are appropriate and sufficient simulation resources – including personnel – to meet the needs of the simulation-based education and training system in Victoria, offering uniformly high quality education for learners.</td>
</tr>
<tr>
<td>May not adequately cover the depth and breadth of simulation-based education and training</td>
<td>Objectives:</td>
</tr>
<tr>
<td>Define “sufficient”, “appropriate”, “technician” and “education system”</td>
<td>• There are sufficient numbers of highly-skilled simulation educators and technicians, distributed appropriately relative to the facilities, resources and requirements</td>
</tr>
<tr>
<td>Replace “trained simulation educators” with “highly-skilled simulation educators”</td>
<td>• Quality standards for learning using simulation are defined and applied across the system to ensure teaching and learning activities represent best practice</td>
</tr>
<tr>
<td>Define “platform of excellence”</td>
<td>• The Victorian simulation workforce is valued, appropriately skilled and sustainable</td>
</tr>
<tr>
<td>May not adequately cover the depth and breadth of simulation-based education and training.</td>
<td></td>
</tr>
<tr>
<td>Evidence-based and innovation are mutually exclusive</td>
<td></td>
</tr>
<tr>
<td>Lacks patient focus</td>
<td></td>
</tr>
</tbody>
</table>

Outcome: There is broad awareness and understanding of simulation as a teaching and learning method, where the development of simulation is driven by educational goals

Objectives:

• The use of simulation is evidence-based
• Simulation is evident in educational programs as appropriate and there are suitable resources for all disciplines that require them
• Stakeholders are well-informed about the uses, practicalities, potential and limitations of simulation as a teaching and learning method
• Innovative, best-practice resources and expertise are available to all stakeholders
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1. May not take into account the depth and breadth of simulation-based education.</td>
<td>1. Replaced SLE, with SBET. Reviewed document to reduce references to equipment.</td>
</tr>
<tr>
<td>2. “health” should read “health and social care”</td>
<td>2. Accepted</td>
</tr>
<tr>
<td>3. “education” may be a better term to use than “learning”</td>
<td>3. Replaced “learning” with “education and training”</td>
</tr>
<tr>
<td>4. Depth and breadth of SBET is broader than VCPC or CPNs</td>
<td>4. Included definition of stakeholders; included discussion of SBET within the context of VCPC and CPNs</td>
</tr>
<tr>
<td>5. the TAFE sector should also be included in simulation”</td>
<td>5. Defined stakeholders as well as health care practitioners within a “Glossary of terms”</td>
</tr>
<tr>
<td>6. “the project must link into activities being conducted by the Australian and international simulation societies”</td>
<td>6. Included in proposed strategies</td>
</tr>
<tr>
<td>7. “we need to train the health workforce in simulation”</td>
<td>7. Included in proposed strategies</td>
</tr>
<tr>
<td>8. The existing “territorial, knowledge, skills and IP silos… …need to be addressed”</td>
<td>8. –</td>
</tr>
<tr>
<td>9. “Educating stakeholders… …will be one of the biggest challenges for this project”</td>
<td>9. –</td>
</tr>
<tr>
<td>10. It may not be practical or realistic to implement the plan in areas of the health education and training system where the department and VCPC have little influence</td>
<td>10. –</td>
</tr>
<tr>
<td>11. The strategy does not feel like a VCPC document, it feels more like a department document</td>
<td>11. Modified the roles and responsibilities section</td>
</tr>
<tr>
<td>12. Some sections of the strategy are aimed at a too low level/contain too much detail</td>
<td>12. Modified the roles and responsibilities section</td>
</tr>
<tr>
<td>13. “learning” to “education and training”</td>
<td>13. Accepted</td>
</tr>
</tbody>
</table>


