**Review of the Macquarie University Speech Pathology Clinic**

**Executive Summary of the Report from the Review Panel**

Prepared by A/Prof Linda Cupples, Head of Linguistics

During the 24th and 25th June, 2008 the Macquarie University Speech Clinic (MQSC) was reviewed by an invited panel (Associate Professor Lindy McAllister, Dr Miranda Rose, and Ms Martina Steimer), convened by the Head of the Linguistics Department, Associate Professor Linda Cupples. The terms of reference included reviewing the mission, goals and objectives of the clinic, examining options for the organisational and administrative structure of the clinic, and reviewing the financial status and financial viability of the clinic.

The review panel acknowledged that many of their recommendations were suggested by individuals in their submissions to the review process. The recommendations of the review are structured around 7 major categories.

1. 1. the need to continue the MQSC
2. 2. the need for major and regular revision of the business plan

 3. revision of the assumption that the MQSC must be self-funded/cost neutral

 4. the organisation and management structure of the MQSC

 5. utilising the MQSC to its full capacity

 6. enhancing models of clinical education utilised in the MQSC

 7. additional general points emerging from the review, beyond the terms of reference.

 In this executive summary, the recommendations of the review panel are included verbatim, but the associated text has been condensed and summarized.

**1. Continuing the MQSC**

***Recommendation 1. Continue to operate and develop the MQSC on the Lane Cove site.***

The review panel believes that the continuation of a University speech pathology clinic is essential for the sustainability and growth of the MSLP programme at Macquarie University. NSW Universities all compete for access to quality clinical education placements in the community; hence, ensuring access to quality on-campus placements reduces competitive pressure. Further, novice students are often more difficult to place in community facilities as clinicians juggle their caseload priorities with increased student education needs. Thus, having an on-campus clinic ensures that novice students can be placed successfully. On-campus clinics also allow for tighter program controls on these vital early student clinic learning experiences, ensuring a high quality and consistent experience for students. The panel argued that the existing facilities of the MQSC are state of the art and should allow for an excellent and substantial University clinic to develop. There are, however, some challenges in terms of geographic location. addressed in sections 5 and 7.

**2. Major and Regular Revision of the Business Plan of the MQSC**

***Recommendation 2. Review the business plan in a collaborative, systematic, regular fashion so that it becomes owned by stakeholders.***

***Recommendation 3. Clarify the purpose of MQSC as a private, public, joint public/private clinic, or predominantly teaching clinic.***

***Recommendation 4. Clarify financial expectations for MQSC operation re self-funding, partial or full cost-recovery.***

The panel reported that the MQSC has a comprehensive business plan in place but there is a perception that the plan is a rigid and unchangeable document, solely focused on delivering an immediate operating surplus. There also appears to be some confusion regarding the clinic’s market positioning: is it predominately a private clinic or a teaching clinic? In addition, key stakeholders do not appear to have a shared ownership of the mission statement, goals and objectives of the clinic. The panel noted the necessity for systematic and collaborative reviews of the mission statement, key business assumptions, marketing plan and outcomes on a regular basis, with opportunities to input from all stakeholders. The plan should be a flexible and living document, able to be amended in light of changing circumstances within MQSC, the Division and University. There is also an immediate need to develop a shared mission statement (seealso Recommendation 16), investigate how the optimum staffing mix can be implemented given HR constraints and develop supplementary income via external contracts.

**3. Continued MQSC should be financially viable**

The panel agreed that there should be an overall expectation that the clinic generates sufficient income to meet the majority of operating costs. However it was noted that other Australian University clinics do not operate under a 100% self-funding model.

***Recommendation 5. Review the current and potential client base around MQSC and in areas of need further afield to ascertain service demands and appropriate pricing of sessions.***

A concern was raised that some aspects of the pricing structure were a hindrance to retaining clients. The panel recommended that MQSC should consider reviewing the characteristics of the client catchment area, to ensure that prior assumptions about price sensitivity and service demands are still valid. It may be possible to engage the University marketing and development area to develop and conduct a market survey for a low or competitive cost.

***Recommendation 6. Explore options to create new, diverse income streams.***

***Recommendation 7. Consider engaging a specialist allied health clinics business manager on a short term consultancy to advise on effective marketing and contracting for external SP contracts, and advise on a viable balance of internal subsidy versus income generation strategies. Ms Carolyn Burrows, Manager of UQ allied health clinics, would be an appropriate consultant.***

The panel noted that the clinic is funded predominately by the allocation of clinic tuition fees and external client service fees. This creates a significant financial risk to the clinic during low throughput periods. There is an immediate need to diversify the clinic income to provide a buffer during non-teaching times and low throughput periods. Additional income streams could be generated by:

* Development of external service contracts (e.g. school literacy programs) that provide an income source during non-teaching periods and opportunities for community outreach. They may also be an alternative avenue for diversifying the caseload.
* Engaging the University fundraising area to seek donations or part-sponsorship for targeted external programs (eg. Summer intensives, school readiness, school enrichment programs)
* Exploring the viability of an internal service fee for use of clinic facilities and staff time in externally funded research projects.

***Recommendation 8. Create flexibility in employment contracts for clinical educators to reflect service needs and patterns.***

Staffing costs are a significant component of clinic expenditure and there are both short and long-term needs to optimize the staffing profile and employment patterns to meet the financial goals of the clinic. A more flexible approach to employment contracts would allow the clinic to contain staffing costs during lower throughput periods.

***Recommendation 9. Macquarie University to review its expectations and policies for financial support of on-campus clinics and look to a staged process for MQSC achieving greater financial stability.***

The panel noted that it is not feasible to expect a University Clinic to be 100% self-funded. No other Australian University speech pathology clinic operates on this basis. The Acting Dean and General Manager both acknowledged that a small operating deficit (e.g. $50,000) could be sustainable. The panel strongly encouraged the Division and Department of Linguistics to explore further what level of ongoing financial support is feasible. Potential options could include:

* Phased development funding tied to agreed outputs and/or deliverables. This could assist with covering realignment activities but also to encourage a move towards greater self-funding.
* Investigate how the “super clinics” model at University of Queensland operates.
* Review options within the University and new Faculty funding models.

**4. Organisation and Management Structure**

***Recommendation 10. Delete Level 9 Clinic Manager Position.***

***Recommendation 11. Ensure clinical educators have access to appropriate expertise and support concerning the development, implementation and revision of more flexible models of clinical education. In the short term this could be accessed through a suitable academic staff member and eventually through a new proposed Director of Clinical Education position.***

***Recommendation 12. Ensure current clinical educators have access to suitable line management. In the short term, Dr Beth Armstrong has offered to take on this role until a suitable Director of Clinical Education is sourced.***

At present the MQSC is running at a substantial annual deficit with no immediate view of reversal. The panel argued that this is untenable, and that the current management tasks of the clinic do not warrant the employment of a Level 9 Clinic Manager. The clinic currently employs 1.0EFT clinic receptionist and two part-time clinical educators totalling 1.0EFT. Further, the clinical education and supervision model utilised in the clinic appears to be that two students are placed with one clinical educator for the day and each student is expected to see 3-4 clients per day. Currently, there is little use of more flexible options such as:-

* Peer learning (within year level and across year level) e.g., two students working together on the one client case, learning from each other, debriefing together
* Group supervision
* Clinical educator taking on aspects of the service provision during early stages of student placement; sliding scales of clinical educator/student levels of responsibility consistent with client complexity and student learning needs.

***Recommendation 13. Establish a Director of Clinical Education Level B academic position.***

The panel supported a proposal to create a new Director of Clinical Education position that over time would lead to the amalgamation of the current Clinical Education Coordinator and Clinic Manager positions. They argued that the role of Director of Clinical Education is vital in a professional preparation programme such as the MSLP degree. The Director of Clinical Education role would include:-

* Planning, implementing, and evaluating the clinical education programme of the degree, in collaboration with academic, clinic, and administrative staff
* Providing academic leadership on clinical education curricula matters
* Supporting students in their clinical education units
* Supporting University and external agency staff in their clinical education activities
* Promoting and carrying out research in clinical education and other topics
* Overseeing the administration of student placement schedules
* Planning and providing high quality clinical education professional development activities to University and external agency staff incorporating current best practice evidence.

Such academic roles argue strongly for the Director of Clinical Education position to be an academic rather than a general staff position. However, in the event that recruitment is difficult, the role could be a general staff position, although this would not be preferable.

***Recommendation 14. Develop and implement a significant clinic promotion plan aimed at establishing a higher community profile leading to significantly increased client referral across a wider range of client groups.***

***Recommendation 15. Involve Macquarie University Marketing Division in the development and delivery of this promotion plan.***

Although the facilities at the MQSC Lane Cove Road site are first class, the clinic appears to have a low profile in the local and referring community. In order to attract sufficient referrals and to develop a full range of services at the MQSC, it is essential to invest time and money into significant promotional activity. This may include a rebranding and re-imaging exercise as part of the promotional plan. It would be wise to consult University marketing resources for support in this endeavour.

***Recommendation 16. Revise the mission and strategic plan of the clinic involving all relevant stakeholders***

The clinic mission statement was developed by academic staff prior to the employment of the clinic staff. In order for the staff to work in a cohesive and goal directed manner it is essential that staff are committed to and are clear about their mission. It is therefore imperative that time is spent revising the mission statement in a collaborative fashion. This would allow an opportunity to involve significant stakeholders in its development, such as community members and referral agents. Further, once the revised mission statement is developed, a revised strategic plan should be created taking into account the current small scale nature of the clinic activities, the desired size and scope of the clinic in 5 years time, as well as the incremental goals and steps that will be necessary in order to reach that full scope.

***Recommendation 17. Document the communication lines and methods for all relevant stakeholders. Adjust job descriptions to reflect these.***

The panel noted an overwhelming feature of the current management and organisation structure of the MQSC clinic involved a lack of clear communication. Follwing the development of a revised mission and business plan, the panel considered it essential to refine the communication lines and clearly document these in all relevant job descriptions, policies, and procedures. Further, it is essential for all stakeholders to engage in regular face to face as well as email/written communication. The panel applauded the recent instigation of regular joint academic and clinic staff meetings which had already led to improvement in staff perceptions, morale, and communication. The panel noted that it is vital that clinic staff feel part of the academic department and their contributions to department decision making should be valued and encouraged. Thus, meetings might alternate between clinic and academic sites so both groups of staff feel a sense of belonging and comfort in each environment. Clinicians can be involved in many aspects of teaching activities and contribute to curriculum development in a variety of ways. Pre-clinical tutorials could for example be developed with and largely delivered by clinical educators. Equally, academic staff can contribute to clinic policies and procedures, development of evidence-based practices, and general clinic education issues.

**5. Utilising the MQSC to its full capacity**

There are clear strategic actions which could be taken to make better use of the clinic, which would lead to an increased financial base, increased quality of clinical education and increased staff and student satisfaction with being in the clinic.

***Recommendation 18. The new Director of Clinical Education ensures that balanced profile of full time/part-time, continuing/sessional appointments are made to provide MQSC with maximum staffing flexibility across the year.***

***Recommendation 19. The new Director of Clinical Education ensures that clients are allocated from a central register of MQSC clients in flexible ways to ensure workload balance for educators and quality care for clients.***

The panel noted that job descriptions need to include clear statements of expectations for direct client service, with and without students in attendance at the clinic. Once job descriptions are clear for the clinical educators, the employment patterns of clinical educators as a body and the employment pattern of individual clinical educators need to be reviewed. The panel recommended that there be a combination of

1. a. whole of year appointments versus sessional contracts, and

 b. full time and part time contracts.

There needs to be at least one, preferably full time CE employed across the whole of the year who can ensure continuity of caseload management and initiatives of the clinic. If the clinic is not able to be fully utilised across the inter-semester breaks (July and Dec-Feb) then some clinical educators can be employed on sessional contracts; that is, they work for 15 weeks in each semester. It is important that clients are seen as clients of the clinic, not belonging to any particular clinical educator.

***Recommendation 20. MQSC be open for extended hours into early evenings and Saturdays.***

The panel argued that the clinic must be open for extended hours into early evenings and Saturdays to capture new client groups such as school aged children with language learning and literacy problems, adults with voice or fluency disorders. Part-time appointments of clinical educators could be strategically made to ensure extended hours of operation.

***Recommendation 21. As new clinical educator appointments are negotiated, someone monitor that all have part of one day in MQSC in common.***

The panel argued that the employment pattern must provide for all clinical educators to be have at least one day in the clinic in common to provide some overlap for professional development, quality assurance projects and staff meetings. Part of the communication problems within the clinical education/MQSC team and between academic and MQSC staff is related to not all staff being able to assemble at one time for meetings.

***Recommendation 22. The clinical education programme be examined to ensure students are available for year round placement in MQSC.***

***Recommendation 23. Clinical educators be supported to adopt flexible approaches to clinical education such that year round placements are sustainable and do not lead to burn-out.***

***Recommendation 24. Workload allocations for clinical educators be flexible to allow periods of heavier versus lighter student loads cross the year to avoid burnout.***

Accounting for 4 weeks annual leave for clinical educators, ‘down weeks’ at beginning and ends of major clinical placement periods for the purposes of preparing for the placement cycle or client service block ahead, completing student assessments and client paperwork at the end of placements/client service cycles, or participation in professional development or research activities, the clinic could provide student &/or client services for at least 44 weeks per year.

***Recommendation 25. Dr Beth Armstrong, along with the new Director of Clinical Education and/or Business Plan consultant, should actively pursue increased referrals and external contracts for MQSC.***

Financial viability, optimal use of the clinic, diverse and quality clinical education and staff and student satisfaction depends on building a more diverse client base for MQSC. Extended opening hours and the use of summer intensives will recruit more school aged and adolescent children with language and literacy problems, and clients of all hours with fluency and voice problems. In addition, lucrative school-based services should be able to be secured by MQSC given developed special needs funding and a high demand for SP services in schools. The plan to offer services in aged care facilities could be further developed.

***Recommendation 26. Clinical educators should continue to provide client services in periods when students not available and be clear about why this is desirable.***

The panel noted that clinical educators need to see their roles as more diverse than just engagement with clients for the purposes of provision of clinical education. They have a role to play in a) building the financial base of the clinic through service provision when students not present; and b) ensuring client care by providing ongoing client care when students not present. To facilitate this process, clients should be strategically selected for students from the MQSC client pool (as recommended above) to provide a mix of clients who will take a break from service or complete treatment when students finish a placement cycle together with those who will need continued treatment. It will then be possible to create a manageable caseload for clinical educators between student placements.

***Recommendation 27. MQSC staff and MSLP staff review the clinical education units’ content and sequence with a view to identifying what foundational skills for students can best be acquired when, where and in what manner.***

The panel recommended that the MSLP academic and CE staff explore the benefits versus disadvantages of having all students complete their foundation clinical learning experiences in the on-campus clinic. The benefits of diversity in clinical experiences versus assuring a minimum set of clinical skills with which to proceed to external clinics needs discussion. External clinics do often provide feedback that they find novice students too difficult to take because of the increased time required for teaching basic clinical skills.

***Recommendation 28. MQSC be used for diverse educational activities to enhance use and profile of the clinic and breakdown the ‘us and them’ divide.***

Students and staff alike suggested various ways and rationales for which better use could be made of the MQSC for diverse educational activities. The panel supports these and other ideas which will be generated from improved communication between stakeholders. These ideas include:

* Pre-clinical tutorials/basic clinical skills could be taught at the clinic and involve clinical educators in staffing of these tutorials. This would help break down the ‘us and them’ divide.
* Master classes could be conducted by clinical educators with relevant clients and with appropriate client consent could be ‘beamed’ into the group room/s of the clinic to increase numbers of students accessing learning opportunities, as well as to external speech pathologists (who may pay for such professional development).
* Departmental seminars could be run in the clinic on best practice ideas or research.

***Recommendation 29. Accessibility to MQSC be improved after discussion between stakeholder groups about issues involved in extended access.***

The panel noted that students need enhanced access to tests and resources housed in the clinic, possibly with access outside clinic hours.

***Recommendation 30. A plan for use of the MQSC for research activities be developed.***

***Recommendation 31. Costings for use of the MQSC by those holding external competitive grants which require access to MQSC need to be included in the new Business Plan.***

University programmes need to engage in research for a range of reasons. Macquarie University has active research programmes in a range of areas which require a facility and caseload like that of the MQSC. The panel noted the focus in various submissions on the desirability and feasibility of the clinic as a venue for the conduct of research relevant to the broad agenda of the Department as well as the Speech Pathology program. Some of these proposals specifically indicate financial benefits for the clinic. Other research activities will enhance the standing of the clinic and assist academic/clinical integration. In addition, clinical educators should be encouraged and supported with access to funds and time release to engage in relevant research.

**6. Enhancing models of clinical education used in MQSC**

***Recommendation 32. When a collaboratively developed, shared vision and mission for the MQSC is being developed (as recommended above), a shared set of expectations for students’ learning experiences should be developed and a shared philosophy regarding learning, clinical education and supervision should be promoted.***

***Recommendation 33. Flexible client and student allocation models need to be explored (e.g., beyond 2 students to one clinical educator for 6-8 clients at all times) including:***

1. o ***Pairs of students with one client***

 o ***CE taking sessions while one student or several observe***

 o ***Peer learning (within and across years)***

 o ***Year one and year two pairs***

 o ***Group supervision***

The panel noted that approaches to clinical education used in the clinic at present seem overly rigid, and not grounded in a well articulated educational philosophy. A philosophy of clinical education, with new models and approaches should be developed in collaborative dialogue between MSLP and MQSC staff.

***Recommendation 34. A coherent program of professional development for MQSC staff regarding clinical education approaches and strategies needs to be jointly developed by relevant stakeholders, and implemented by the new Director of Clinical Education. This should include adapting style of teaching/supervision to different learning needs and styles, and managing challenging students.***

Implementation of new models will require professional development of clinical educators needed to support new models. This should be a high priority of the new Director of Clinical Education.

***Recommendation 35. As part of the marketing of MQSC and securing new services to build financial viability, consideration is given to developing new services that also address clinical education needs.***

Quality clinical education and client services, and staff and student satisfaction requires MQSC to deliver contracted services off-site. As previously mentioned, contracts with schools or aged care facilities could be developed which take clinical educators and students into such settings. Models of clinical education and supervision will accordingly need to be adapted to fit the context, the model of service delivery and the numbers of students involved.

**7. Additional points**

During the review it was recognized that there are a number of University level polices and practices that directly affect MQSC, but which MQSC has little direct control or influence over:

***Recommendation 36. MQSC and other University clinics should be encouraged to continue lobbying Office of Facilities Management to offer free parking to clients and improved shuttle bus services.***

Clients are charged an additional $5 parking fee on top of clinic fees. Other University clinics offer parking “scratchies” paid for or subsidized by the clinic or Department. The current free bus service is very restrictive and adds to isolation of staff and students from the academic department. This is a common concern with other University clinics and 299 Lane Cove Rd tenants.

***Recommendation 37****.* ***The University clinics and Departments should provide feedback to the Division (Faculties) and University regarding the inadequacies of current funding and business model philosophies for clinic operations.***

The University is currently implementing a new management and administrative structure. There will also be review of Faculty funding models and business planning philosophies.

***Recommendation 38. A special category of clinical general staff could be established to cater for the different employment needs and requirements of clinical staff.***

A number of concerns were voiced regarding the inflexibility of Macquarie University employment options for clinical staff and the current capping of new general staff positions; in particular that clinical staff appointed under general staff contracts are not granted similar access to professional development as staff under academic classifications. It is also difficult to appoint clinical staff to academic positions without PhD completion. If all MQ clinics feel strongly about these issues they should consider providing a joint a submission in new EB negotiations.

Executive Summary prepared by A/Prof Linda Cupples based on the report by the review panel, which comprised:

A/Prof Lindy McAllister

Dr Miranda Rose

Ms Martina Steimer

17th July, 2008