MEETING	Australian Council of Deans of Health Sciences	
MEETING CHAIR	Professor Ian Wronski and Robyn Adams	
DATE	Thursday 21 March 2019	
TIME	9-4.00	
Location	Deakin Downtown Reception desk check in required.	727 Collins Street, Melbourne.
Members	**Attending**	**Apologies**
Central Queensland University	Michelle Belligan, Tony Schneiders	
Charles Sturt University	Megan Smith	
Curtin University	Georgina Fyfe	Archie Clements, Keith Hill
Deakin University	Colin Bell, Catherine Bennett	
Edith Cowan University	Natalie Ciccone	Moira Sim,
Flinders University	Michelle Miller	
Griffith University		Analise O'Donovan
James Cook University	Ian Wronski	Pamela Stronach
Latrobe University	Catherine Itsiopoulos, Pamela Snow , Adam Bird	
Monash University	Terry Haines	
QLD University of Technology	Ross Young, Helen Weir,	
University of Canberra	Michelle Lincoln	
University of Newcastle		Shane Dempsey
University of Queensland	Bruce Abernethy,	Sarah Roberts-Thomson
University of South Australia		Esther May
University of Sydney	Kathryn Refshauge	Stella Vasiliadis
Western Sydney University	Felicity Blackstock	Gregory Kolt
In attendance		
ACDHS EO	Robyn Adams	
ACDHS AO		Kat Kenyon
Invited Guests	Professor Paul Worley National Rural Health Commissioner	
	Members (9) of the National Allied Health Advisors and Chief officers (NAHAC)	

MEETING	***Australian Council of Deans of Health Sciences***	
	21 March 2019	
	Meeting Minutes	
Item		***Actions***
1	**Welcome, introductions and apologies** Following general introductions, ACDHS EO Robyn Adams welcomed new university member Edith Cowan University – represented today by Natalie Ciccone. Welcome also to new representatives – Professor Colin Bell (Deakin) and Associate Professor Georgina Fyffe (Curtin). Apologies as noted in the attendance table above. The chair acknowledged the work of outgoing members – Professor Catherine Itsiopoulus and Professor Catherine Bennett, thanking both for their contributions to the Council. The minutes of the 17 October 2018 ACDHS meeting were approved **Action items status report** • Close action item 180302 • Need to consider action item 180303 re the ACDHS-IAHA collaboration agreement • Outstanding action items 180305 and 180306 were noted and considered important to progress. o Planning priorities have not been addressed. This is a carryover item and still needs work. Membership to ACDHS has grown without marketing. There was discussion about who we wanted as members – it has always been the "health science heavy" universities, not those who only graduate one or two AH courses. o Also a question has since emerged about how should we relate to the specific discipline group (e.g. Deans Council for Physiotherapy) • Noted also that the focus of the Executive teleconference held on 6 December included broader discussion on strategic direction, but primary focus of discussion was to inform the recruitment action and location for the new ACDHS EO. **Correspondence** • KPMG Benchmarking study • Accreditation Systems Review due 28/3 • ANZSRC Review Due 7 June • RHMT Evaluation- request for 2 ACDHS nominees for consideration o Professor May and Professor Wronski nominated • AHPRA: MBA consultation • APC standards consultation • Article request- overseas student information- draft developed by Kat Kenyon • VAHRC sponsorship request (not actioned)	Chair to sign approved minutes EO to convene an ACDHS executive meeting with agenda items to include ACDHS mission, priorities membership
2	**Clinical Education writing group feedback and discussion** Progress on the 4 papers on aspects of clinical education Papers raising issues related to clinical education: There was some general discussion about the role of the papers for advocacy and prompting discussion, Noted that there was very little in the literature. Not sure of where to publish. Papers will be worked on	

	more prior to circulating to members but we need to clarify who we are challenging in these papers – who is our audience? ➢ **Paper 1 (Catherine I)** an introduction to the suite of papers but will also stand-alone. Themes of stakeholder engagement, professional practice education and training, and tensions and concerns around the duality of disciplinary educators will be addressed, to set the scene for other papers to expand. The student in clinical education should be considered as a benefit not a burden. There is little in the literature addressing these themes. ➢ **Paper 2 (Terry H)** will be looking at incentives through an economic lens at the supply and delivery of clinical education. He argues that there is a "market failure" because we need more professionals to deal with future health care needs but training them relies on the current workforce supervising clinical placements. The differences in strategy and arrangements between states and universities are a further complication. We need both quantity and quality but the latter is not always covered in the agreement, as there are tensions from providers between these two aspects. So the paper will look at new models of incentivizing placements via agreements, and emerging market models for how these might be structured. What other ways are there to enhance practice education (simulation, peer learning, other complementary strategies). How can assessment be more efficient and effective, and what is the future for private practice models? ➢ **Paper 3 (Kathy R**) looking more deeply at the value that students bring with them in clinical education. There needs to be a systematic way of capturing discussion points and moving forward with ideas such as: allowing students to do more than observe in some professions – would need legislative change. Private practice and NGO sectors need to be included, especially for rural workforce capacity building. ➢ **Paper 4 (Esther M)** competency vs capability is shaping into a summary of the main issues and current constructs and understandings of these two concepts. Not a new conversation but clarity required to take the discussion about clinical education forward. ➢ Questions to address – need some work yet: o What are the capabilities our students need to have for future workforce? o What should quality clinical education look like? o How do we quantify value of students in the health workforce? ➢ **Discussion and next steps** EO to provide feedback to writing groups to progress the working drafts. Option to convene a half day writing session to facilitate consistent use of terminology and minimise duplication. Not confirmed *Publication strategy*: Ross Young to discuss options with AHR *Social media:* develop one pagers and social media commentary from papers once finalised ➢ **NAHC CE symposium August 5 2019** *Jointly developed by the Australian Council of Deans of Health Sciences and the National Allied Health Clinical Educator Network (a subcommittee of NAHAC- the national Allied Health Advisors and Chief Officers)* The Symposium (chaired by Professor Esther May) will commence with a series of short presentations on topical issues in clinical education drawn from both providers of clinical education placements and from universities. Presenters are Kathy Refshauge, Lindy McAllister, Susan Alexander and Liza-Jane Mc Bride. Participants will have the opportunity to share experiences and practices around current management of student placements as they work in small groups to reflect on presentations, respond to structured questions, discuss possible solutions and develop recommendations to meet future needs/demand.	EO to provide feedback to writing groups to progress the working drafts. Ross Young to discuss options with AHR develop one pagers and social media commentary from papers once finalised

	Draft questions to be addressed at this stage are ○ What capabilities will our future AH workforce need? ○ What should a quality student placement look like? ○ How do we optimise the value/ contribution of students on clinical placements? ○ What does a successful transition to practice look like? A panel, formed by the invited speakers, will synthesize discussions and distil recommendations, providing opportunity for discussion and planning the next steps for collaborative conversations on allied health clinical education to meet future health needs. ➢ There will be a teleconference with the working group and invited speakers on April 10. ➢ EO encouraged ACDHS members and colleagues to consider registering for this event once workshop and conference registrations are open. ➢ Note that both Kathy Refshauge and Terry Haines are invited key note presenters at the National Allied Health Conference 5-8 August in Brisbane http://www.nahc.com.au/program	
3	**Key issues and sector developments.** Confirmed 2019 annual membership subscription to remain at $15,000 ex GST Submissions and reviews, ➢ Accreditation Systems Review due 28/3 ○ Discussion recommended ACDHS response support the preferred governance model and comment strongly on matters of efficiency and minimising duplication/waste and to express support for interprofessional education and systems enabling timely and responsive innovations within curricula. ➢ ANZSRC Review Due 7/6/2019 ○ Recap of previous work by the ERA working group which proposed a recommendation to form a new 4 digit code within Division 11 to named 'Allied health and rehabilitation' or something similar. ○ Key issues remain the relative invisibility of allied health research given the size of Division 11 compared to other divisions within ANZSRC ○ Within Division 11 , FoR Groups 1103 and 1117 are significantly larger than other FoR groups (containing 25 and 19 6 digit fields respectively) ○ The meeting today confirmed prioritising 1103 for ACDHS responses ○ Bruce will ask UQ colleague to update the work previously provided ○ Activity to be progressed initially by ACDHS working party including Pam Snow as a new member in addition to Kathy Refshauge, Bruce Abernathy, and Gregory Kolt. ➢ RHMT Evaluation ○ ACDHS initially contacted to provide input to the Terms of Reference for this review. Professor May provided the ACDHS response ○ ACDHS was then contacted to nominate to members for consideration for the Reviews Expert Reference Group ▪ Professors May and Wronski were nominated as the current and immediate past chairs of ACDHS and each their universities have a UDRH and/or RCS. ➢ AHPRA: MBA consultation;	EO to develop response and submit EO to convene a teleconference meeting of ERA/ANZSRC working group Professor Abernathy to request update of previous work

	➢ APC standards consultation ➢ Rural Health Commissioner- allied health focus 2019 " … *to improve access to allied health services and to improve quality of services… and to improving distribution of rural allied health workforce* …" ➢ AAHLF update and feedback ➢ Aboriginal and Torres Strait Islander higher education and health (Matters to raise) o No specific matters raised apart from consideration required regarding the ACDHS-IAHA collaboration agreement ➢ Allied Health Assistant content in curricula- no specific update ➢ NDIS- EO discussions with NDIS BLWC allied health specialist co-ordinator, Katie Bourke. Information now available at https://blcw.dss.gov.au/ ➢ ACDHS staff: current EO extended again until August 30 as there have been delays in recruitment process for new EO	
4	**National Rural Health Commissioner** Allied health focus 2019 including: improving access to allied health services and quality of services and improving distribution of the rural allied health workforce GF notes What can ADCHS offer to this role? Paul senses that the time is right for thinking in a confident way. Hears calls for change for many years have been largely unanswered at commonwealth level. Thinks it might be the lack of "life and death" impact of the profession but implications of drastic maldistribution of health professionals is effecting quality of life of rural folk, and unnecessary hospitalization etc. PW interested in what he can do as an independent advocate. Thinks part of the dilemma is that here is no strong AH voice, but rather as individual disciplines. Lack of training ability for rural folk to be able to study AH without moving to the city. Career opportunities are a challenge – lots of churn in junior roles. Hard to find sustainable attractive jobs in rural Australia – funding is there but in bits across a number of sectors. Approaches to change this – the rural generalist program to support junior workforce. Change the short-term exposure to rural practice only Aboriginal Medical Services sector – only spends small amount on allied health Pharmacy guild and optometry Australia has been more successful in lobbying- PW posed the question as to why these 2 groups were more successful PW – looking for advocacy of "do-able things" that the government (DoH) can manage to provide. Needs to report to the minister by October (to inform 2020 budget development) and a discussion document in June for wider consultation Discussion points: Commonwealth contributes to chronic disease via PHNs. These seem to have opportunities for expansion. Should there be an obligation to provide clin ed? We don't need more evidence of the need	

	Issue of participation rates for allied courses – participation for eligibility is an issue – educational opportunities are not equal so we are not ready for end-to-end rural workforce. Move towards GEM programs might be better pathway? Complicated by other issues such as First in Family – HEPPP funding HEPPP but how is it targeted? PW is looking for evidence of what makes a difference for bringing grads into the rural areas for rewarding and sustained careers. Full time jobs need to be designed for their setting, working with different service models. The jobs that exist are hard work. New grads might be wary of such challenging roles. Findings that the churn for AH in rural has more effect in rural rather than urban contexts (impact greater if 1 of 2 leave compared with 1 of 10 or more). Need block grants to tackle these issues, but, for example ➢ NDIS with its client-focused payment arrangements, precludes block funding options (…*unless perhaps market failure can be demonstrated- tbc*) ➢ However AMS has block finding and they use it for medical/nursing etc. Aboriginal health workers perform a lot of the AH scope of practice. But seems to be a westernised model of education and training so perhaps reframing AH as wellbeing might be useful. Transitioning from assistant AH roles (TAFE trained) could be a way forward – might be related to the step-up of human bioscience requirements. Would be helpful to fund more sub-bachelor places as pathways Student led clinical – blocks to establishing them in rural areas are the supervisors, the costs and funding models (who pays). Regional unis compete with health workforce for staff. Tele-supervision is possible ECU spoke about the Mt Magnet inter-professional experience e.g. in residential care placements. Started with a model funded by HWA and is now sustainable, with UDRH funding. Travel costs, accommodation are an issue too for longer placements. Cost of living and opportunity costs mean not all students CAN go to rural placements. Financial models have been developed for longer placements in medicine but not for allied health. On positive note rural health is much more on the agenda now but it also has a perception of a deficit model and you get a better clinical education in urban placements. Must work on communication the likelihood of a better more inter-professional experience of a broader scope of practice in the rural placement. Also there is a national focus on allied health.	
5	**National Rural Health Commissioner Post-lunch session** *Continuing discussion Members of the National Allied Health Advisors and Chief Officers joined the meeting NAHAC.* Welcome NAHAC members and their contribution to the discussions Key messages so far • We don't have an AH workforce strategy, rural or otherwise • PBS access for endorsed prescribers is not available- this places an increased cost burden on the patient	

	• ..and unis are providing training but we need the roles being able to use the skills • Tele health and access to MBS items for AH other than Psychology • Need a chief allied health commissioner and a national strategy • Promote blended funding models – funding from multiple places for the client group. Need to sort managing this esp for private practitioners. The original RHS funded Mt Isa model still works. Good onboarding, good supervision, good line management, good CPD, funding for return trips to city etc. are keys to success. There are differences in rural areas – some places are more attractive to place students or attract staff than others and needs to be taken into account. Some jobs/placements are more attractive than others. We cannot match students with ideal areas as universities have limited relationships for clinical placement. We could be more innovative with delivery modes. Rural training hub idea – government structure has been locked in as a medically dominated model. Harder to add in AH now. PW was asked what he wanted to get from this session – <u>wants feedback on the feedback.</u> o Thinks most of what we are hearing today has been in the grey literature before so we are not getting traction on these issues. o Looking for advocacy group with firm and cohesive arguments around key issues to resolve in a complex disciplinary system. o Accreditation is seen as a blockage but no national call for accreditation bodies to be proactively supportive of rural health (unlike Medicine when the AMA promoted this). Rural generalist idea required flexibility so they could fit well into local needs (demographics etc). In the discussion about health vs education vs government - In what states are Rural impact statements required for every piece of legislation? SA does, where it works very well. QLD in part. Other countries have these or similar. They are useful to provide evidence for the minister to argue for consideration. PW will send a summary of today's discussion for further feedback, especially where there is evidence to support a viewpoint, especially access to services and workforce distribution. What ideas do we have for moving things forward? ill join our meeting NAHAC	
6	**Joint ACDHS- NAHAC discussions** ➢ Discussion MBS review –Allied Health report GF notes **Discussion MBS review –Allied Health report**. o First report in more than 30 years on over 5000 items. Recommendations out for comment until the **17 May**. o Recognizes that system as is will not solve some problems, so the MBS review can only address so much.	

	○ Mental health – tiered interventions noted. Is there a translation to other chronic care clients? How do you determine complexity? Need for further evidence. ➢ **Topics posed by NAHAC for discussion with ACDHS** Research capacity in each jurisdiction ○ Research capacity in each jurisdiction is an AAHLF priority. ○ Katherine (Chair of NAHAC) for example, works closely with SA universities and gets rapid research responses to inform policy. ○ How do we support our local CAHO? ○ Should let CAHOs know the timeframes for student projects etc. Can be very helpful in both directions. ○ Many opportunities for studying eg changes in scope of practice. *ACTION: NAHAC will circulate names and contact details of regional CAHOs to allow communication of research strategy.* Teaching students about safety and quality ○ Teaching students about safety and quality. ○ For example, WAHTN is building an allied Health platform with focus on training opportunities. ○ ACT working on this – are the standards introduced at the right level – early enough? ○ In QLD is a pre-placement requirement. ○ Needs to be embedded in practice. ○ Is it part of the accreditation standards for curricula? ○ Should NAHAC ask? AHPRA-regulated courses may. Discussion questions ○ Do universities recognise allied health as a collective Depends on which university. Structural arrangements can influence the naming. Community does not always know what allied health includes (differs in different jurisdictions). May also have deficit connotations. Language can influence how things are perceived. ➢ Do Health Translation networks in each jurisdiction have a focus on allied health? ○ WAHTN recently secured NHMRC recognition by having a multidisciplinary focus through allied health. Tend to start with a medical dominance but AH can change the direction. ○ Need to develop a strategy for allied health that transcends all contexts and sectors. ○ What are the key areas of priority? Working with AAHLF towards a workshop at the national conference in August 8th. ○ Hoping to have more influence in decision-making. ○ Have to be clear about who you are trying to influence and how it fits.	NAHAC will circulate names and contact details of regional CAHOs to allow communication of research strategy**.**
7	**2019 meeting dates** ▪ Meeting #2 ○ July 1 Canberra suggested and confirmed ○ Note the ANZAHPE conference is in Canberra July 1-4 ▪ Meeting #3 ○ Date not confirmed ○ October Adelaide suggested	
	Meeting closed at 4pm	