



Government of **Western Australia**
Department of **Health**

Transforming Teaching, Training and Research

Clinical Senate Meeting

Final Report

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Introduction

The role of the Clinical Senate of Western Australia (WA) is to provide a forum where collective knowledge is used to discuss and debate current strategic health issues. Recommendations are made in the best interest of the health of all Western Australians and are subsequently provided to the Director General (DG), the State Health Executive Forum (SHEF) and through the DG to the Minister for Health.

The second meeting of the Clinical Senate of Western Australia for 2016 was held on 3 June at the University Club of WA.

The topic for debate was “Transforming Teaching, Training and Research”.

The enactment of The Health Services Bill 2016 has led to changes in governance for WA Health whose role is as system manager. The Health Services have become separate statutory authorities governed by a Board or Chief Executive, with greater responsibility for delivery of health and support services. Under the Health Services Bill 2016 (now the Health Service Act) the Department of Health, led by the Director General (DG), will become the System Manager responsible for the overall management and strategic direction of WA Health. The DG can issue binding policy frameworks for Health Service Providers (HSPs) to ensure a consistent approach to matters across the WA Health system. HSPs will be responsible for the establishment of local policy for their services, consistent with the relevant policy frameworks. There are 18 policy frameworks in total and the two relating to i) Clinical Teaching and Training and ii) Research informed Senate discussions on the day.

The Health Service Act supports WA Health’s vision to deliver a safe, high quality, sustainable health system for all Western Australians including:

- to promote and protect the health status of Western Australians
- to identify and respond to opportunities to reduce inequities in the health status
- to provide access to safe, high quality, evidence-based health services
- to promote a patient-centred continuum of care in the provision of health services
- to coordinate the provision of an integrated system of health services and health policies
- to promote effectiveness, efficiency and innovation in the provision of health services and teaching, training, research and other services within the available resources
- to engage and support the health workforce in the planning and provision of health services and teaching, training, research and other services.

The benefits for patients, workforce and the community include the delivery of better health, better care and better value through:

- Improved accountability to the community
- More responsive, flexible and innovative health services to the community
- Greater transparency and assurance of safety and quality of health services
- A more sustainable health system strengthened financial management and business intelligence so that resources are allocated fairly and used efficiently to deliver the best in health outcomes.

As per section 4.7 of the Independent Hospital Pricing Authority (IHPA): The Pricing for Australian Public Hospital Services 2016-17 states there is currently no acceptable classification system for Teaching Training and Research (TTR), nor are there mature, nationally consistent data collections for activity or cost data.

The new guidelines identify that: TTR activities represent an important role of the public hospital system alongside the provision of care to patients. However, there is currently no acceptable classification system for TTR, nor are there mature, nationally consistent data collections for

activity or cost data which would allow the IHPA to price TTR using activity based funding (ABF).

The National Health Reform Agreement requires that IHPA provide advice to the Council of Australian Governments (COAG) Health Council on the feasibility of transitioning funding for TTR to an ABF system by 30 June 2018. IHPA has proceeded to the next step of developing a TTR classification by undertaking a comprehensive TTR costing study at a representative sample of public hospitals. The study will run until early 2016, after which work will commence on the development of a teaching and training classification system.¹

The Clinical Senate had previously debated each of these areas however, given the current climate, the Clinical Senate executive, along with the Chief Health Officers, deemed it timely to debate TTR to ensure it remained on the reform agenda.

The specific focus for debate was optimising investment and transparency for TTR. Teaching the next generation, Training the current clinical workforce and ensuring the value add of Research. With this focus, Clinicians considered how to articulate the value and better optimise the investment in our health system to achieve reform.

The co-sponsors for the debate were Professor Gary Geelhoed, Chief Medical Officer and Assistant Director General, Clinical Services and Research, Adjunct Associate Professor Karen Bradley, Chief Nurse and Midwifery Officer and Ms Dianne Bianchini, Chief Health Professions Officer.

A broad range of experts were invited to the debate. Included were leading multidisciplinary academics from all five WA universities, vocational, research and training institutes as well a cross section of clinicians and key health department personnel.

Professor Julie Quinlivan, Chair of the Clinical Senate opened her talk by emphasising the importance of the topic and asked senators to consider how we transform TTR in light of the new health service legislation to maximise advances in health care.

Professor Gary Geelhoed, Assistant Director General, Clinical Services and Research and Chief Medical Officer set the scene for debate and Professor John Challis, Executive Director of the Western Australian Health Translation Network (WAHTN) spoke of ensuring the value add of research.

An additional six short presentations by two presenters for each area focused on: Teaching the next generation; Training the current health workforce; and the value of Research. Presenters included: Professor Keith Hill, Head of the School of Physiotherapy and Exercise Science, Curtin University; Professor David Atkinson, Head of the Rural Clinical School of WA, The University of Western Australia; Ms Penny Keogh, Nurse Director Education, Fiona Stanley Hospital; Professor Jeff Hamdorf, Director, Clinical Training and Evaluation Centre and Professor of Surgical Education, School of Surgery, The University of Western Australia; Ms Sue Davis, Nurse Director, Corporate Nursing Research and Education, Sir Charles Gairdner Hospital; and Dr Nikolajs Zeps, Director of Research, St John of God HealthCare.

Each presenter was asked to provide a five minute three slide response on their area in relation to the: The Good, The Bad and The Opportunities.

¹ Independent Hospital Pricing Authority (IHPA) (2015), 'The Pricing Framework for Australian Public Hospital Services 2016-17'. Commonwealth of Australia, 2015. Page 19. [Viewed 1 July 2016] Available at URL: https://www.iHPA.gov.au/sites/g/files/net636/f/publications/pricing_framework_2016-17_0.pdf

1. Process

The Clinical Senate in Western Australia was established in 2003 and each debate follows a standard process that has been refined over time. This process ensures that senators and others involved have a clear understanding of what is required and receive sufficient information to discuss the topic and then develop recommendations for the Director General of Health (DG) and the State Health Executive Forum (SHEF). A copy of the program is included (Appendix 1).

Prior to the debate, attendees received a series of webinars and pre-reading documents containing background information in preparation for the debate. Speakers and additional expert witnesses are invited to inform discussion on the day. (Appendix 2)

The full day Senate debate traditionally commences with a Welcome to Country, which for this debate was offered by Nyungar Elder, Ms Marie Taylor.

Clinical Senate Chair, Professor Julie Quinlivan followed welcoming attendees and providing an update on senate activities. She introduced the topic for debate calling on senators to work together and use their collective multi-disciplinary skill sets to help identify how to optimise investment in our health system to achieve reform, and articulate the value of TTR into the future.

Director General, Dr David Russell-Weisz officially opened the debate confirming the importance of the debate “there couldn’t be a more important time to look at TTR. We are in a mature environment of Activity Based Funding (ABF) and we have a robust method of funding and measuring how we perform financially and in relation to quality and safety. TTR is critical to what we do in the health system. He also reported on the recommendations from the debate on Superbugs.

Setting the scene for the debate was Professor Gary Geelhoed who provided a comprehensive overview of the many factors that contribute to the spread of multi-resistant organisms and the drivers for antimicrobial resistance. He provided a broad overview of the topic and then concentrated on a range of local initiatives and areas for improvement.

To ensure the value add of research Professor John Challis presented the WA Health Translation Network (WAHTN). He outlined the extensive work being carried out in the WAHTN and demonstrated its’ importance to the future of research in our state.

The next stage of the Clinical Senate process was a series of short presentations around the topic areas of teaching, training and research. It consisted of six rapid fire minute presentations where presenters shared The Good, The Bad and The Opportunities in their subject area. The presentations addressed Teaching – multidisciplinary healthcare teaching and the rural clinical school, Training – mandatory competencies and simulation training in the acute and primary care setting and Research- multidisciplinary public research and engaging the private sector in research. The aim was to inform clinical senators to consider innovations in outpatient care, without losing sight of the features of care that are effective.

The presenters for this session included: Professor Keith Hill, Professor David Atkinson, Ms Penny Keogh, Professor Jeff Hamdorf, Ms Sue Davis and Dr Nikolajs Zeps.

This provided a foundation for the free flowing debate that followed where both senators and invited experts considered the current state of play and opportunities to innovate in this area. The presentations were followed by a plenary debate entitled “Optimising investment and transparency in Teaching, Training and Research”.

The afternoon sessions were devoted to two concurrent workshops in which participants focused either on:

- a) teaching and training or
- b) research.

Recommendations from the workshops were presented in the final session of the day and ranked in order of importance by the full Senate. The Clinical Senate Executive issued a request for a response by the Director General of Health to each recommendation at the next debate. Responses could be:

- a) endorsed,
- b) endorsed in principle, or
- c) not endorsed.

2. Presentations

Mr Bevan Bessen, facilitator for the day, opened proceedings by welcoming participants, acknowledging the traditional owners both past and present, and introducing Nyungar Elder Ms Marie Taylor who offered the Welcome to Country.

Ms Taylor spoke of the significance of reconciliation week sharing a story of Yellagonga meeting the English settlers demonstrating that reconciliation happens when two people of different races meet for the first time and find common ground. She reminded that we are one people.

Professor Julie Quinlivan followed thanking Ms Taylor for her welcome and blessing. In opening the debate she provided an update on activity since the last meeting including the appointment of Ms Tanya Basile, Nursing Co-Director, Medical Specialties at Sir Charles Gairdner Hospital as Deputy Chair.

She reported the debate represents the final debate for some senators whose term will end on 30 June. She thanked retiring senators for their contribution to debates that covered diverse topics as women's health, obesity, value in healthcare, clinical engagement, the patient experience and superbugs. We invite you all to become members of the clinical senate alumni, a new initiative of the clinical senate that will be established once our new terms of reference has been adopted. In reporting on the progress of the review of the TOR and Charter, she stated they have been aligned to the reforms that have taken place across WA health with the passage of the new Health legislation last month. The TOR has been aligned with world best practice in state wide clinical engagement. We have incorporated your feedback survey and from an international literature search. The revised TOR will be sent to the Director General in time for the 1 July changes.

Finally, Prof Quinlivan reported that in reviewing how to best align the Clinical Senate to the new devolved structure of Health in WA, one process to achieve alignment would be through our new Terms of Reference (TOR). We also intend that our next debate will focus on governance, so we can collectively work with the area health boards to facilitate clinical engagement. To this end, she reported that all Health Service board chairs will be invited to attend our next debate.

Professor Julie Quinlivan turned her attention to the topic for debate by emphasising the importance of the topic and asking senators to consider how we transform TTR in light of the new health service legislation to maximise advances in health care.

In speaking of teaching and training she shared this quote:

We look for medicine to be an orderly field of knowledge and procedure. But it is not. It is an imperfect science, an enterprise of constantly changing knowledge, uncertain information, fallible individuals, and at the same time lives on the line. There is science in what we do, yes, but also habit, intuition, and sometimes plain old guessing. The gap between what we know and what we aim for persists. And this gap complicates everything we do.

Atul Gawande, *Complications: A Surgeon's Notes on an Imperfect Science*.

The quote emphasized the complexity of modern medicine. We need to train the next generation of healthcare staff, making sure their knowledge and skills reflect the advances in technology, and also addresses increasingly complex ethical, social, psychological and cultural aspects of healthcare.

Prof Quinlivan stated there are increasing challenges in keeping our current workforce trained, ensuring they make the best use of clinical evidence and how we train our workforce to follow

guidelines that have substantial evidence base behind them. We must also consider if our training techniques, used over many decades are best to keep staff up to date with advances in care. She presented another quote for consideration:

If you put me in charge of the medical research budget, I would cancel all primary research, I would cancel all new trials, for just one year, and I would spend the money exclusively on making sure that we make the best possible use of the clinical evidence that we already have.”

In speaking to research (the ‘R’), she stated research is the cornerstone to improvements in care. We have an obligation to future generations to continue to identify better, cheaper more effective and safer ways to diagnose, treat, cure or palliate our patients. We need to find ways to better the health care of society as a whole. Research is essential to moving forward to advances. How do we ensure research continues, and is relevant and achieves the outcomes we need when we face times of budgetary and workload pressures?

She called on senators to work together and use their collective multi-disciplinary skill sets to help identify how to optimise investment in our health system to achieve reform, and articulate the value of TTR into the future.

Prof Quinlivan introduced the Executive Sponsors for debate who, she stated, were intentionally chosen in order to bring a multidisciplinary perspective. She introduced the sponsors Professor Gary Geelhoed, Chief Medical Officer, Adjunct Associate Professor Karen Bradley, Chief Nurse and Midwifery Officer and Ms Dianne Bianchini, Chief Health Professions Officer.

Together, we would like you to use your diverse skill base to consider how we better optimize the investment in our health system to achieve reform and importantly how do we articulate the value of the investment? You must also consider if we are still siloed in our teaching, training and research.

She stated to further stimulate discussion there would be presentations by Professor Gary Geelhoed who would set the scene for debate and Professor John Challis to provide an overview of the WA Health Translation Network (WAHTN). This would be followed by a panel of presenters in a session on “The Good, the Bad and The Opportunities” who have been tasked with providing short talks on: Teaching the next generation; Training the current generation; and the value of Research. They will present something good, something to be improved and something innovative. Experts include: Prof Keith Hill (multidisciplinary healthcare teaching), Prof David Atkinson (Rural Clinical School), Ms Penny Keogh (mandatory competencies) Prof Jeff Hamdorf (simulation training) Ms Sue Davis (multidisciplinary research – public perspective) and Dr Nikolas Zeps (engaging the private sector). She then welcomed all expert participants for kindly giving of their time to participate in the debate section of the day.

She informed participants that the plenary session would allow for free flowing debate and a broad range of experts who would help inform during the session around the key focus of optimizing investment and transparency in teaching, training and research.

Prof Quinlivan welcomed senators and member representatives and formally reminded participants of how the Clinical Senate of WA operates:

- To work collaboratively, setting aside individual and organisational agenda.
- To state your opinions freely, drawing on your clinical experience and expertise.
- To empower you to influence others in all your professional spheres with the new perspectives gained through the debate.
- To play a leadership role in health reform, developing strong, valid, priority recommendations in the best interests of the health of all Western Australians.

Prof Quinlivan reminded participants that all recommendations would go to the Director General of Health and his executive with an explicit response requested.

She thanked the executive sponsors from the previous debate, Professor Gary Geelhoed and Professor Tarun Weeramanthri who had worked closely with the Director General to consider each recommendation and how they might be taken forward. She then welcomed the Director General, Dr David Russell-Weisz to officially open the day and report back on the recommendations.

Dr Russell-Weisz opened by acknowledging Senate Chair Professor Quinlivan and the speakers and experts assisting with the debate.

The Director General stated that in March senators were charged with considering the impact of an emerging health issue and potentially global health crises in relation to the overuse of antibiotics and the emergence of superbugs. The recommendations from this debate reinforce the need for WA health to have the right strategies in place.

He reported there were 9 recommendations and admitted they generated a lot of debate amongst his executive team. He stated that with The Health Bill now enacted, he did consider the impact of the recommendations in terms of responsibility, which should sit with the Department and which should be the responsibility of Health Service Providers (HSPs). He reminded that the HSPs will have much more autonomy and accountability as of 1 July 2016 and will be legally responsible for health services provided to their community. This will change the dynamics and senators need to consider this when forming your recommendations as I have in responding to them. Dr Russell-Weisz provided a comprehensive response to each recommendation outlining key actions for each. His report follows and includes the fully endorsed recommendations followed by those endorsed in principle and finally, one recommendation which was not endorsed.

Rec 1: Endorsed

That WA Health implement an Electronic Prescribing System (EPS) that may be used across all health facilities and can capture prescribing data so it can be benchmarked and used to monitor compliance with therapeutic guidelines.

Response: The Director General reported the recommendation was endorsed and stated there is no doubt the EPS will be implemented. There are issues in where the priorities are within our ICT journey and the strategy includes an EPS. Replacement of the older ICT system will take priority, but the EPS is clearly endorsed.

Rec 4: Endorsed

WA Health should provide recurrent funding for the Infection Control Automated Surveillance Technology (AST) system, support its implementation, and be responsible for its maintenance.

Response: The Director General reported this will go ahead as the money has been allocated but not yet been used, we have now agreed a method to spread the recurrent funding.

Rec 5: Endorsed

WA Health to develop, area health services to adopt, and hospital executive to promote a statewide framework for standardised training and education to ensure antimicrobial stewardship is everyone's business.

Essential to this is the need to:

- involve key end-users in program (re)design to ensure education is fit for purpose
- target poor-performing disciplines and clinical areas

- include prevention education i.e. IV cannulation, aseptic technique and hand hygiene.

Response: The Director General reported this is very important in the new environment and the health service providers will need to implement this framework.

Rec 6: Endorsed

WA Health mandates each hospital undertake periodic antibiotic usage audits (e.g. National Antibiotic Prescribing Survey (NAPS) and results should be fed to area health services, boards and quality and safety committees for review. Comparative data for similar hospitals should be made publicly available after a three year implementation process.

Response: The Director General reported this recommendation did generate some debate. There is the feeling that this is done sporadically but that it has to be done. He stated we cannot mandate every hospital and this will be easier once the EPS come in however, it must be done in a way that doesn't subsume other priorities

Rec 7: Endorsed

WA Health must write to non-hospital health system managers (e.g. Aboriginal medical services, WA Primary Health Alliance (WAPHA), residential aged care facilities, General Practitioners) and ask them to ensure they have guidelines for antibiotic stewardship that includes consideration of surveillance activities and ability to feedback to their clinicians.

Response: He reported this must be done and we must partner outside of health to get the message across. We must ensure our partners share the same focus of WA Health around this issue

Rec 8: Endorsed

WA Health ensures all 'clinicians' involved in invasive procedures demonstrate competence in aseptic technique. This could be facilitated by the Director General of Health writing to all WA University Vice Chancellors requesting them to ensure students in healthcare-related disciplines are assessed for competency in the practical demonstration of aseptic techniques. Within healthcare facilities, this could be facilitated through staff training.

Response: This is very important and is something we can influence. He emphasised the importance of making sure staff are trained before they work in our hospitals and system.

The following recommendations were Endorsed in principle

Rec 2: Endorsed in principle

The Clinical Senate recommends development of a statewide policy of facility cleaning standards for WA Health.

These will include:

- standardised cleaning procedures that are evidence-based and standard use (detergent, bleach, water). WACHS have already done this body of work and it should be examined for applicability to be adapted statewide
- encouragement for the vocational sector to develop short training courses for cleaning, which could be included as a desirable criterion in employment for cleaners
- raising the profile of cleaning in facilities by having supervisors, minimum language requirements for cleaners and minimising use of casual/agency staff

- a requirement for feedback on cleaning outcomes and environmental monitoring to cleaning staff
- stipulation that audits for compliance with above processes are undertaken, which would be presented to health boards.

Response: The Director General reported there was some debate around this however, it was agreed the department would develop a policy and then it would be up to the health service providers to determine how they would implement the standard.

Rec 3: Endorsed in principle

That and an Antimicrobial Stewardship Program is embedded within a safety and quality framework, that feeds agreed indicators to area Health Service Boards in addition to a central state committee

Response: The Director General reported this is endorsed in principle and will be up to the Health Service Boards to implement.

The following recommendation was not endorsed.

Rec 9: Not endorsed

That a communication and health promotion strategy to promote infection prevention and control and appropriate antibiotic usage be developed and implemented by consumer agencies and key WA Health experts. The strategy should use all contemporary messaging channels, and align with the National Safety and Quality Health Service Standards (NSQHSS). It should include elements to address vulnerable groups such as people living in residential aged care facilities, Aboriginals, prisoners and individuals at risk for transitioning in and out of hospital.

Response: The Director General reported despite the importance of this recommendation he could not endorse it at this time. He cautioned he did not want to over promise and then be unable to deliver particularly given all that has to be done at this time.

In addressing the topic of the day, Teaching, Training and Research, Dr Russell-Weisz stated there couldn't be a more important time to look at TTR. We are in a mature environment of Activity Based Funding (ABF) and we have a robust method of funding and measuring how we perform financially and in relation to quality and safety. TTR is critical to what we do in the health system.

He emphasised the need for a clinical workforce engaged in translating research into practice and stated that it has not been forgotten, there is a TTR budget and we are not uncommitted. Dr Russell-Weisz spoke of the importance of collaboration, outlined the investment by WA Health and emphasised the importance of the research being nearer to care. This is as important as any part of the healthcare budget. He encouraged participants to think outside the box and consider better more innovative ways to do this and quarantine the funds.

In closing, he reminded senators that it was essential for them to consider the impact of the upcoming governance changes specifically, the roles with regard to TTR of both the department and health service providers. The role of the department as system manager responsible for strategic direction and leadership and in securing as much investment as possible from government, within health and outside and, the role of health service providers who as of July 2016 will be legally accountable and responsible for the TTR done in their areas. He asked them to reflect on this when considering recommendations.

Mr Bessen thanked the Director General for his comprehensive response to the recommendations from the previous debate and for providing his thoughts on the importance of

TTR. He then introduced the first speaker for the day, Professor Gary Geelhoed to set the scene for debate.

Professor Gary Geelhoed, Assistant Director General, Clinical Services and Research and Chief Medical Officer set the scene for debate. He provided an overview of the topic in the context of the current health reforms at a local, state and national level. He described the importance of the timing of the debate on TTR labelling it the perfect storm. These are related to problems with funding, the impact on the state due to the price of iron ore, the impact of ABF funding and several years adjusting to the national efficient price. These coupled with new hospitals, a new area health service and the transition to health service boards are causing tremendous churn through the health system making it difficult to focus on research. He identified the fundamental question for discussion as how to balance the short term needs with the elements required for an excellent health service in the long term.

Prof Geelhoed emphasised the need for innovation particularly given the size and spread of our state and in order to gain equity for all West Australians. Pressures on the system are related to WA being the fastest growing state (2005-2015) in Australia (28.9%) which increases demand on our health services. There has also been unsustainable growth in the health budget rising 134% (3.43bn to 8.05bn). Further growth across our health system indicates: births in WA funded services increased by 36.5%; ED attendances by 49.1%; and mental health community service contacts rose to 79.3%. Prof Geelhoed stated there is clearly pressure on our system and the challenge is to consider how we articulate value of government investment in TTR in this high-cost and resourced constrained environment.

He overviewed the new governance model and spoke of the semi-autonomous boards and 18 policy frameworks, two of which include Research and Clinical Teaching and Training. Prof Geelhoed reported there is opportunity as the binding policy frameworks clearly spell out the requirements that all HSPs must comply with in order to ensure effective and consistent activity across the WA health system.

The Research Policy Framework specifies the research requirements that all HSPs must comply with in order to ensure effective and consistent research activity across the WA health system. He stated that the policy framework recognises research as a core function and highlighted one of the purposes as to ensure clarity about the expectations for HSPs to support research and encourage its integration into service provision. There are eight key principles that underpin this policy framework Prof Geelhoed highlighted two of the principles:

- Embedding: wherever feasible, research activities should be integrated as a core function within routine healthcare delivery, to increase opportunities to conduct research; and
- Workforce: champions of academia and research will attract and retain high calibre health professionals who, while producing their own research, will ensure the early introduction to Western Australia of knowledge and advances within their areas of expertise.

Prof Geelhoed stated you do not change by doing the same thing! You need research in order to change. The role of research in the WA public health system is around patient benefits. These must include: improved health outcomes; access to new treatments through clinical trials; and the ability to discard ineffective treatments. Where you stimulate a culture of innovation in the public health system, and generate new knowledge and improve systems. Through new processes, procedures and products and health workforce, you attract and retain high quality staff who are empowered and motivated.

He reported there are also economic benefits with return on investment in some instances to be \$1:70 - \$5:02 for every dollar spent as well as the potential for increased efficiencies and contribution to a more sustainable health system. The evidence is very clear that if you have a good research culture in a hospital you get better outcomes. “The best hospitals in the world are the best because they do research, and it is not a hobby you engage in at the end of the day, it is core business.”

Prof Geelhoed stated there is optimism because under the new reforms there is recognition of TTR in the Health Services Act. There are mechanisms to ensure TTR focus in HSPs and track performance. The Department will provide ongoing funding for research; and FutureHealth WA has provided an extra \$30 million (through 2017).

He outlined the purpose of the Clinical Teaching and Training Policy Framework which is to ensure: clinical teaching and training activity is at a level that ensures future workforce capability and is not limited to current workforce requirements. This policy also has several key principles, for the purpose of debate he highlighted Workforce planning – Ensure that clinical teaching and training activity is relevant and supports short and long term workforce capability, supply and distribution.

To demonstrate the challenges with regard to teaching and training he shared the following data: In WA from 2011 to 2014: student numbers in higher education health-related courses increased by 15%; 55% of activity occurred within a hospital setting; nearly 90% of all activity occurred in the metro area; nursing and medicine accounted for 59% of activity and over 200 sites provided placements across the state. Consistently, he stated 98% of all placement demand came from the five local universities. Data on clinical placements by profession indicated that medicine, nursing, midwifery and physiotherapy registered the vast majority (55%) of all placement hours occurred in hospitals. Therefore, he stated there is the need to consider how we could be more innovative in where the placements are and importantly, engage both the private sector and community in order to reduce the strain on the system.

Prof Geelhoed reported tremendous challenges in relation to student numbers particularly for medical graduates with growth over the last ten years from 122 interns (2006) to 331 (2017) and projected to be 426 in 2025 related to the new medical school. All of this puts great strain on the system and it is taxing to provide vocational training to these students. There are also issues in nursing where there are societal demands due to an ageing population and increased numbers of people with complex illnesses which puts a strain on nurses who are ageing themselves. Finally, there is pressure to train and keep them employed in the system for when they are needed.

Prof Geelhoed called on clinicians to consider the constraints and resources available, how we can balance the short term service needs and support the elements that are going to take us forward so that we can continue to have a quality health service, attract the right health workforce and continue to provide better outcomes for our patients.

Professor John Challis, Executive Director of the Western Australian Health Translation Network (WAHTN) spoke of ensuring the value add of research and how the use and development of the WAHTN can help achieve this objective.

He highlighted the benefits of health and medical research linking research investment, knowledge creation towards innovation thus leading to knowledge wealth creation, treatments and polices for improved health care and prevention resulting in healthier Australians.

The WAHTN is a consortium of the Department of Health, the Office of Science, WA health teaching hospitals, medical research institutes, private health providers and all WA universities

with a vision to: strengthen the health impacts of our outstanding research discoveries, to build a future legacy of research excellence and translation. Its objectives are to:

- increase the integration, efficiency, success and recognition of health and medical research across WA;
- enhance the translation of outcomes from health and medical research in WA into evidence based practice, policies and innovation opportunities; and
- to achieve national recognition of “Team WA” as an Australian Advanced Health Research Translation Centre (AHRTC).

He stated the National Health and Medical Research Council (NHMRC) defines and AHRTC as “leading centres of collaboration in health and medical research, research translation, research-infused education and training and outstanding health care”. Bringing together the three components of TTR, bringing together training and education, bringing together research and research institutes and bringing together delivery in the hospital and the clinical setting. Importantly, the AHRTC must be operating at an internationally competitive level. Prof Challis mentioned the importance of attracting key researchers to our State; we cannot afford to not have one of these centres in WA.

Prof Challis stated the core principles of the operation of the network is not to conduct research but to provide the underpinning platform to firstly *Catalyse*, new research and new initiatives; secondly to *Facilitate*, conduct of translational health research and thirdly to *Unify*, across the state and build partnerships and partners across the network. He stated WA health had expertise in discovery research and translational research across each of those different themes. The idea is to provide a forum where investigators across WA can see themselves identified within one of those themes and through the activity of the WAHTN promote the research activity, catalyse and unify across the themes.

Prof Challis stated that people and the community were at the centre of research, with four specific areas incorporating enabling people; building translation; promoting research and ensuring health awareness. Around the people are our hospitals and new health boards, the universities and the medical research institutes, and the WAHTN. The network unifies and creates partnerships across the system that will help us to enable people, partnerships to develop research to build translation initiatives and to ensure greater health awareness across the population.

Prof Challis concluded, we need you! This is your network and you are all part of this network. We need your support to increase the integration, we need your support to enhance translation of outcomes and very shortly to ensure recognition of WA as an Advance Health Research Translation Centre (AHRTC).

The final set of six presentations included two presenters for each area focused on: Teaching the next generation presented by Professor Keith Hill and Professor David Atkinson; Training the current workforce presented by Ms Penny Keogh and Professor Jeff Hamdorf; and the value of Research presented by Ms Sue Davis and Dr Nikolajs Zeps. Each presenter was asked to provide a five minute three slide response on their area in relation to the: The Good, The Bad and The Opportunities.

A short summary of the key points from each talk was as follows:

Teaching:

Professor Keith Hill: Multidisciplinary Healthcare Teaching

Professor Keith Hill spoke of multidisciplinary healthcare teaching. He offered the World Health Organization (2012) definition of interprofessional education as where two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes. At Curtin University there is a common first year for all Health Science students (50% of all students, 25% other disciplines, 25% discipline specific). There is good evidence of impact.

Describing what could be improved he stated the need was for vertical integration as well as horizontal integration (across years) to be trained in this way. He highlighted the fact that despite being trained in this way when healthcare students enter the hospitals they are not exposed to similar workplace practices to support embedding translation into practice.

The opportunity/innovation lies in simulation, student led wards, a supportive framework for interprofessional education and research linked to clinical placements that adhere to a conducive philosophy. There is certainly opportunity to introduce and embed this model into rural and remote clinical placements.

Professor David Atkinson: Rural Clinical School of WA

Professor David Atkinson reported that the Rural Clinical School is having a significant impact on rural medical workforce in WA with urban students three times more likely to work in the rural setting, and indeed further out than if they are trained in the metropolitan areas. There is a cultural change as well whereby having students and junior doctors is improving attitudes to evidence based health care in rural and remote WA. There is multidisciplinary training and collaboration suited to rural locations and practical rural research is making a difference.

The challenges outlined by Prof Atkinson related to some hard to staff locations such as the Pilbara; negotiating policy changes across multiple organisations (governments, professional colleges, accreditation bodies) is time consuming and leads to missed opportunities; similarly the lack of large regional centres and Western Australia's Geography doesn't always suit Commonwealth plans and proposals. Importantly, change often depends on individuals in key positions therefore, progress can be patchy.

He reported the opportunities for rural education and research include expanding the Rural Clinical School of Western Australia (RCLSWA) to more of the harder to staff rural areas; substantially expanding rural junior doctor positions; increasing rural registrar posts for specialist training with innovative supervision models; and to build on RCLSWA research experience for translational rural and Aboriginal health research.

Training:

Ms Penny Keogh: Mandatory Competency – Keep calm and complete your mandatory training

Ms Penny Keogh spoke of mandatory competency. She identified several good points about the current situation, such as: investment in staff training to meet standards for quality and safety and associated staff confidence with the training which determines expected levels of competency on the job; reinforces good work practices and supports achievement of compliance with policies and government guidelines resulting in a well-oiled work based education teams.

She outlined the bad as the negative connotation mandatory training implies with staff often questioning the validity of some of the training (waste of time, won't use it). Staff are often unable to attend sessions due to shift work and trainers were expensive. In addition, record keeping of training was inconsistent across WA Health.

Ms Keogh suggested that there is an opportunity to simplify and clarify mandatory training requirements across WA Health. Good examples of this exist in the NHS in the UK and in NSW Health. Reform of the current training could include: developing and implementing a framework across WA Health, with agreed criteria to include mandatory requirements in policy directives; governed by a standing committee; developing standardised curriculum, training material and assessment' in quality assured and evidence based training; a centralised learning management system; and recognising prior learning via various entities accepting each other's training records as staff move across health services.

A most important thing to remember is that mandatory training is still training. Just because an entity mandates the topic requirement doesn't remove our obligation to provide a quality, valuable experience for participants.

Professor Jeff Hamdorf: Simulation training in the acute and primary care settings

Professor Jeff Hamdorf presented on simulation training. He used the example of the Trauma Nursing Core Course (TNCC) as the 'good' of the simulation training program calling it the gold standard for trauma nursing care. This program has trained over 1123 participants. Some difficulty exists with funding as this was originally funded by Health Workforce Australia (HWA).

There are opportunities in future programs such as boot camps for interns where there is evidence of significant improvement in skills, knowledge and importantly, confidence levels with a return on investment of 7:1.

Research:

Ms Sue Davis: Multidisciplinary research – Public investment more provided in the comments

Ms Sue Davis spoke of multidisciplinary research in the public system. She stated the good things are related to research expertise, strong links with the universities and a large multidisciplinary component. Most of the research has had a positive impact on patient outcomes.

In addressing what needed to be improved she highlighted a poor grant success rate in WA of 7% compared to a 13% nationally. The bureaucracy around spending grant money is onerous and at times wasteful. In addition, poor metrics in terms of research outputs and the associated block funding and, the fact that there are no research key performance indicators were also identified as areas for improvement.

In turning her attention to the opportunities she called for: allocated time for research; models for translational research with some direct funding to health services in order to prioritise projects; need for more medical, allied and nursing involvement; infrastructure in health services around biostatistics and education; and the benefit of influencing teaching, training and research.

Dr Nikolajs Zeps: Engaging the private sector (barb remove post editing)

Dr Nikolajs Zeps offered a private system perspective stating research needed to be part of the culture and align with the vision of the organisation. He stated key performance indicators (KPIs) for research must be a priority. Research outputs had doubled recently in the private institution to which he was affiliated.

Dr Zeps identified the key is the focus on exceptional patient experience. You must have a 'can do' culture and there must be support for researchers. They have a valet service to support researchers with preparation and submission of grant proposals.

He did not report on the bad stating there wasn't anything given the position of his organisation. He said the opportunity for the future is to seek variation, interpret this and do something about it. Finally, transformative change can be enabled if clinical research is implemented.

Presentations from the day can be found on the Clinical Senate website:

<http://ww2.health.wa.gov.au/Improving-WA-Health/Clinical-Senate-of-Western-Australia/Clinical-Senate-debates-and-publications/2016-Clinical-Senate-debates>

Following the morning break, Senators engaged in a free flowing plenary debate.

3. Plenary Debate

3.1 Optimising investment and transparency in Teaching, Training and Research

Facilitator	➤ Mr Bevan Bessen
Presenters/ Expert	➤ Dr Paul Armstrong
Witnesses	➤ Dr David Speers
	➤ Dr Owen Robinson
	➤ Professor Lindsay Grayson
	➤ Dr Christopher Etherton-Beer
	➤ Dr Andrew Robinson
	➤ Ms Rebecca McCann
	➤ Dr James Flexman
	➤ Ms Dallas Widmer
	➤ Ms Lisa Nicolaou
	➤ Ms Mary Willimann
	➤ Dr Susan Benson
	➤ Dr Paul Ingram
	➤ Mr Jason Seet
	➤ Dr David McGechie
	➤ Dr Tim Inglis
	➤ Ms Ann Whitfield

Mr Bessen opened the plenary session the focus of which was “Optimizing investment and transparency in Teaching Training and Research”. He called on participants to build on the very good examples shared by the panel of what is happening and then move into what is needed to create blue sky innovation.

The key themes emerging from the plenary with regard to teaching and training were:

- How best to get clinical input on chief executive officers, TTR key performance indicators (KPIS)
- What makes a teaching hospital
- Measureable outcomes from professional development
- How to maximise employment of graduates
- Better clinical collaboration on understanding of workforce requirements

The key themes emerging from the plenary with regard to research were:

- Clarity of terms (TTR) and what funds are available
- How does pure research relate to education
- Capacity for clinical research to happen within the core job of those delivering care
- Streamline ethics and governance processes to allow researchers to assume more responsibility
- Greater consumer involvement in TTR
- Development and measurement of a research culture

Summary

Senators identified the need to develop an organisation wide culture that facilitates development of embedded/integrated TTR practices within core business, including specific measurable key performance indicators that capitalise on and maximise the TTR investment.

They determined there is opportunity to optimise existing and future investment in TTR through innovation both within the DoH organisation and via intersectorial and interprofessional collaboration across institutions (e.g. VET, NGO's and universities) who provide different opportunities/capabilities for workforce training, development, and research.

Senators discussed strategies for investment in TTR that must include longitudinal initiatives and incentives that consider workforce planning, graduate development, and industry retention. In order to manage this investment in our workforce there must be innovation in building workforce capacity and training, such as partnership with non- government agencies and private enterprise along with expanded models of effective and cost efficient interprofessional collaboration.

The impact in WA with regard to TTR in rural areas was highlighted as an area for investment and opportunity. Senators identified the need to expand placements and for increased practical rural research in remote areas. Consideration of rural experience/exposure should be fundamental to any workforce TTR strategies in order to meet the diverse requirements across DoH services now and into the future.

With the establishment of Health Service Boards and changes to service agreements and governance structures across the DoH, senators identified a need to establish ways to participate in development of new strategies/models that drive opportunity, maximise investment dollars, minimise funding gaps, and improve accountability to assist with implementing both the state-wide research and clinical teaching and training framework policies.

The measurement of research and development of a research culture is paramount. There can be transformative change in our healthcare service model if we enable clinical research. Embedding research in the system will encourage a culture, limit waste and improve efficiencies.

At the conclusion of the plenary session Mr Bessen confirmed that the key themes emerging from the full morning session had been captured using mind map software and would inform senators in the afternoon workshops. The Mind Map was displayed and provided as a handout in each of the workshops.

All participants then broke for lunch.

Following the lunch break Senators participated in their choice of the following two workshops: Teaching and training and Research.

What follows are the workshop notes and final senate recommendations.

4. Afternoon Workshop One

4.1 Teaching and Training.

Facilitator	Mr Bevan Bessen
Executive Committee Member(s)	Ms Tanya Basile Dr Sharon Nowrojee Ms Pip Brennan Adjunct Associate Professor Kim Gibson
Expert Witnesses	Adjunct Associate Prof Karen Bradley
Support	Ms Kimberly Olson

Mr Bevan Bessen opened the workshop stating the focus was to consider how best to articulate the value of the investment in teaching and training.

Participants were provided with the mind map from the morning session which included key themes. The full group discussed what might be missing. Two additional themes were suggested with a total of 14 brought forward. Participants were encouraged to select and move to a theme(s) of their choice in order to develop recommendations. The themes brought forward to the recommendation forming phase were:

1. KPIs and Clinical Input
2. Culture – Building an academic health care environment
3. Engagement with Consumers
4. Mandatory Training
5. Quarantining time to do TTR
6. Interprofessional Education (IPE)
7. Community Based (non-Hospital)
8. Visibility and Accountability of health care service providers
9. Funding Model and Capacity
10. Workforce planning/workforce roles
11. Colleges/Education Providers
12. Rural and Remote TT

The following themes were not picked up during the recommendation phase of the workshop.

13. Self-directed teaching and training
14. Increasing graduate employability

At the end of the workshop, each group presented their recommendations. A total of fifteen recommendations were reviewed and it was agreed that two would be merged. Voting occurred on the remaining thirteen with the top five recommendations taken to the final session.

A summary of the group discussions during the recommendation forming stage is provided below.

Group 1-

Participants in this group considered the following two themes:

- Key Performance Indicators (KPIs) and Clinical Input
- Culture – Building an academic health care environment

Participants focused on the importance of culture in relation to building an academic health care environment. They also focussed on the need for clinical input into KPIs.

They identified the importance of providing safety, quality and evidence based health services with accountability in the form of measured performance indicators. These included the need for quarantined time for teaching; quality improvement activities; clinical service provisions inclusive of support and resources to access training and education. They emphasised the need for leadership training and gaining insight through evaluation surveys in relation to the adequacy of teaching and training. They combined their recommendation to include the need for WA Health to ensure all health care professionals are allocated time for both research and education and that they are able to demonstrate outcomes with research publications, workshops etc.

The recommended that health boards to be accountable for the development of their workforce by implementing a suite of KPI's that measure the provision and utilisation of high quality teaching and education .

Group 2 –

Participants in this group considered the following two themes:

- Engagement with Consumers
- Mandatory Training

Senators called for a review of all mandatory training currently available in order to determine effectiveness for target audience, duplication and that is informed by patient safety data. They considered whether WA Health should implement a mandatory training framework modelled after the NHS.

The key recommendation from participants was for implementation of a centralized statewide system that links all existing learning management systems (LMS). All mandatory training systems at service level must be linked to a LMS that is personalized and transferable between services and it must function to track all clinician training with reports to health service executives.

Group 3 –

Participants in this group considered the following three themes:

- Quarantining time to do TT
- Interprofessional Education (IPE)
- Community Based (non- Hospital)

Participants discussed the specific need for quarantining time in order to teach and train; the importance and opportunity through interprofessional education and opportunities for training outside of hospitals.

Drawing on the message from the morning session that IPE is often forgotten when healthcare professionals enter our hospitals they recommendations that all healthcare students undertaking hospital based training undergo quarantining commitment to a community based primary health care service. They also encouraged WA Health to implement a community based interprofessional teaching and training pathway and clinical service models. This they believed could increase the number of training placements, increase employment opportunities and provide patients with care closer to home.

Group 4 –

Participants in this group considered the following four themes:

- Visibility and Accountability of health care service providers
- Funding models and capacity
- Workforce planning/workforce roles
- Colleges/Education Providers

Senators recommended that health service providers (HSPs) should be encouraged to define and articulate the skill set and competencies required across all disciplines. This they agreed should be determined in accordance with the Clinical Services Framework.

They agreed that HSPs should support training networks and encourage widening the opportunities to non-traditional environments of clinical placements, graduate programs and training.

They recommended that HSPs should have a long-term and broad interprofessional education and training plan with defined outcomes, addressing defined needs across all disciplines. They agreed with another group that funding for education and training should be linked to KPIs and must be equitable and transparent.

Group 5 – Rural and Remote TT

Senators considered the specific needs of teaching and training in rural and remote WA. They agreed the need to ensure specialist knowledge is shared state wide and proposed this could be achieved by the Department requiring that in the health service agreements, all metropolitan health services contribute to teaching and training in WACHS.

Participants considered how the department could advise education providers on inclusion of service competencies in entry level curriculum for example: caseload, time management, administration and HR systems as well as employee work conditions and health sector knowledge in order to increase work readiness of graduates.

A key recommendation was the need for the Department to work with key partners in order to increase capacity of rural and regional settings as valid training opportunities for all professionals.

A total of 15 recommendations were developed by participants in workshop one. Two recommendations were merged before voting. A total of 13 recommendations were voted on with the top 5 recommendations taken to the final session.

5. Afternoon Workshop Two

5.1 Research.

Facilitator	Mr Will Bessen
Executive Committee Members	Prof Julie Quinlivan Prof Gary Geelhoed Ms Marani Hutton Ms Geraldine Ennis Dr Dan XU
Expert Witnesses	Mr Babu Simon
Support	Ms Barbara O'Neill

Mr Will Bessen facilitated workshop two. He welcomed participants and stated the focus of the workshop as to consider embedding a research culture.

He outlined the process as to firstly, discuss the issue streams brought forward via the mind map, to unpack the issues and identify any additional issues, group them into themes and finally, develop recommendations. All recommendations would be voted on, with the top five brought forward to the final session.

The full group discussed the themes brought forward and considered additional themes to those brought forward. They proposed an additional theme around research infrastructure and consensus was reached on the following for development of recommendations:

1. Streamlined ethics and governance procedures
2. Data linkage
3. Research infrastructure (biostatistics, clinical trials, data management and biobanks)
4. Building a culture of academic clinical enquiry (research, mentorship and skills learning)
5. Culture across sectors/increased engagement with consumers
6. Patient consent procedures “ platform trials”
7. Safety and quality aspect and inquiry
8. Visibility and Accountability of delivery of the TTR budget
9. Ensuring time is quarantined/available for TTR
10. Ensuring clinical input in relevance of HSP Board TTR KPI
11. Translation of research
12. Collaboration across sectors
13. Engagement of consumers – increased engagement with consumers

Group 1-

- Streamlined ethics and governance procedures
- Data linkage
- Research infrastructure

Participants unpacked the issues related to the need for streamline ethics and governance procedures. They acknowledged the need to support financial structures including the need for sustainable structures to support multiyear clinical trials; to identify and focus more on this as core business; and to move staff from fixed term to sustainable hr in order to flex up and down based on clinical trial activity.

Senators recommended that an identifiable part of the TTR budget must be allocated to research capability. Some of these included: information technology support and software; bio statistics; health economics; dedicated research support staff; streamlined ethics and governance process (valet to assist).

They also called for WA Health as system manager to work with HSPs to ensure a framework is established to meet the needs of both in order to avoid unnecessary duplication in the development of research capability.

Group 2-

Participants in this group considered the following themes:

- Building a culture of academic clinical enquiry (research, mentorship and skills learning)
- Culture across sectors /increased engagement with consumers
- Patient consent procedures- “platform trials”
- Safety and quality aspect and inquiry

Senators considered the current that exists and identified that current practices were disconnected, disjointed, and in some instances elitist.

They recommended this could be achieved by the Health Service Boards establishing joint academic clinical appointments that report to the Chief Executives and who are responsible for: development of relevant, multidisciplinary research portfolios; increase awareness of a work place culture towards improving outcomes through education, training and introduction of new processes/translation of findings. They also included the need for increased collaboration and partnerships with patients and other sector stakeholders and to develop and report research relevant KPIs. Finally, there is the need to streamline the approval and governance processes.

Group 3-

- Visibility and Accountability of delivery of the TTR budget
- Ensuring time is quarantined/available for TTR
- Ensuring clinical input in relevance of HSP Board TTR KPI

Participants discussed issues related to the research budget cycle vs the financial year cycle and the need for chief executives to understand this and importantly quarantine the research budget.

In recommending change senators stated the importance of developing a series of KPIs to demonstrate that research is embedded in clinical practice.

They called for WA Health Services to quarantine the research budget so that it is: identifiable, flexible and rigorously acquitted.

Participants agreed there should be no limit on scope for research. They suggested patients be surveyed when leaving hospital as to whether or not they were involved in a study or clinical trial.

Group 4 –

- Translation of research
- Collaboration across sectors
- Engagement of consumers

Senators in this group addressed the importance of cross sector research and the need to promote partnerships across primary and tertiary care particularly where we can decrease

demand and increase care closer to home. They identified this could be achieved by allocating some research money to cross sector research; specific criteria in research grants could include a cross sector component and consumer partnerships. They identified the WAHTN must include a primary care rep on their Board and that WA Health should support their effort to become a National Centre of excellence.

In addressing better engagement of consumers they proposed to promote consumer participation in research by strengthening consumer involvement in the research policy framework principle they should that Boards should invite inviting consumers to be involved in trials when they attend hospital as part of admission paperwork ; encouraging consumers to access existing evidence-based resources information and research to assist with their management (e.g. better health VIC) ; and embedding consumer perceptual efficiency into intervention trials.

Finally, with regard to translational research they recommended that service agreements with health service boards mandate targeting some funds (not necessarily TTR funds) into research projects that address areas performing below benchmark in quality and safety including high demand areas and sub-optimal adoption of clinical practice guidelines. They agreed it may be necessary to use research fund to bring in external or collaborative expertise.

A total of 11 recommendations were developed by participants in workshop two. Participants agreed to merge one recommendation. The top 5 recommendations were taken to the final session.

In the final session, senators were presented with six recommendations from workshop one and five recommendations from workshop two. A total of eleven recommendations were voted on and ranked forming the final prioritised recommendations from the day. Upon review of all recommendation by the executive sponsors the clinical senate ratified the top nine recommendations.

6. Final Session

In the final session senators reviewed each of the recommendations presented from both workshops. A total of ten recommendations were put forward from the debate for final voting. Recommendations have been ranked in order of vote by the full Senate.

In conclusion, the Clinical Senate highlighted the connection between Teaching and Training and Research finding that both must be supported and valued as vital contributors to our health system. The recommendations align with the policy frameworks and identify the importance of partnerships to assure we can teach the next generation, continue to train the current workforce and continue to promote research so that we can attract and retain the best healthcare workforce and so that the people of Western Australia are provided with the best possible health care system. There is opportunity to make these changes within the devolved governance structure.

The Clinical Senate recommendations provide a foundation for change in order to build a culture both in terms of an academic health care environment and of academic clinical enquiry (research) to ensure that TTR are core business.

A response from the Director General to each of the recommendations of endorsed, endorsed in principle, or not endorsed is requested.

7. Clinical Senate Recommendations

Transforming Teaching Training and Research

1. Implement a statewide Learning Management System (LMS) that links existing LMS and provides service level reports and individual level data that is transferable between services.
2. In order to meet the DOH policy requirement of providing safe, quality evidence based health services; health service accountability will be measured by key performance indicators that should include:
 - Quarantined teaching time
 - Quality improvement activities
 - Leadership Training
 - Evaluation surveys/ in relation to the adequacy of teaching and training
 - Demonstrate outcomes such as research publications, workshops etc.
3. The Health Service Boards should establish multi-disciplinary joint academic /clinical appointments that report through to the Chief Executives who are responsible for:
 - Development of relevant, multidisciplinary research portfolios
 - Increase the awareness of a workplace culture towards improving patient outcomes through education, training and introduction of new processes that translate research findings
 - Increase collaboration and partnerships with patient and other stakeholders
 - Developing reporting research relevant KPIs
 - Streamline approval and governance processes
 - Involve junior clinicians.
4. That Health Service Boards and WA Health quarantine the TTR budget to ensure it is identifiable, flexible in use and rigorously acquitted. The TTR budget can be used to support specific TTR activities such as:
 - Research specific information systems and software
 - Bio statistics
 - Health economics
 - Supportive financial structures particularly for multi year research
 - Dedicated research support staff
 - Ethical and governance processes
 - Library services.

5. Department of Health partner with all relevant stakeholders to increase capacity of rural and regional settings in the provision of valid training opportunities for all professionals.
E.g. Rural Clinical School, Western Australian General Practice Education and Training (WAGPET), WA Primary Health Alliance (WAPHA), Students and Practitioners Interested in Rural Practice Health Education (SPINRPHEX), the Aboriginal Health Council of WA (AHCWA), Aboriginal Community Controlled Health Organisation (ACCHO) and Rural Health West.
6. Department of Health to require in the Health Service Agreements (HSAs) that metropolitan (NMHS, SMHS & EMHS) and children's health services (CAHS) contribute to Teaching and Training for WACHS to ensure specialist knowledge is shared statewide.
7. WA Health encourages cross sector research by promoting partnerships across primary to tertiary care focussed on outcomes that decrease demand and increase care closer to home.
This can be achieved by:
 - Allocating some research funding to cross sector research
 - The specific criteria in research grants require cross sector consumer partnerships
 - WAHTN include primary care rep on the Board
 - WA Health supports efforts for WAHTN become a National Centre of Excellence.
8. WA Health develops a series of Key Performance Indicators (KPIs) to demonstrate that research is embedded in clinical practice.
This includes conduct of research, publishing with co-branding, and translation of research outcomes into clinical practice.
9. WA Health recommends that all health care students that are undergoing hospital based training undergo a quarantined commitment to community based primary health care service.

Appendix 1: Program

Transforming Teaching, Training and Research

Friday 3 June 2016

Banquet Hall

The University Club of Western Australia

Crawley, Western Australia

7.45am	Registration	Tea & coffee	
Executive sponsor:	Professor Gary Geelhoed, Assistant Director General, Clinical Services and Research Adjunct Associate Professor Karen Bradley, Chief Nurse and Midwifery Officer Ms Dianne Bianchini, Chief Health Professions Officer		
Facilitator:	Mr Bevan Bessen		
8.30am	Welcome to Country	Ms Marie Taylor	
8.40am	Welcome and senate update	Professor Julie Quinlivan	
8:50am	Director General's response to recommendations	Dr David Russell-Weisz	
9.05am	Setting the scene for debate	Professor Gary Geelhoed	
9.20am	Ensuring the value add of research	Professor John Challis	
9.30am	Panel Presentations – The Good, The Bad and The Opportunities		
	Teaching	Training	Research
	Professor Keith Hill: Multidisciplinary healthcare teaching	Ms Penny Keogh: Mandatory Competencies	Ms Sue Davis: Multidisciplinary Research
	Professor David Atkinson: Rural Clinical School of WA	Professor Jeffrey Hamdorf: Simulation training in the acute and primary care settings	Dr Nikolajs Zeps: Engaging the private sector
10.00am	Questions		
10.10am	Morning tea	Banquet Hall Foyer	
10.40am	Plenary debate: Optimising investment and transparency in Teaching, Training and Research		
Additional Expert Witnesses:	Professor Louis Landau, Ms Michelle Hoad, Professor Richard Tarala, Professor Peter Leedman, Mr Brendan Robb, Dr Tom Snelling, Mr Daniel Dorevitch, Mr Babu Simon, Mr Tim Shackleton, Mr Graeme Jones, Ms Susan Alexander, Ms Julie Ogle, Professor Di Twigg, Mr Rob Anderson, Professor Helena Liira, Professor David Morrison, Professor Shirley Bowen, Professor Moira Sim and Mr Richard Smirk.		
12.15pm	Lunch	Banquet Hall Foyer	
1.00pm	Workshops		
	Workshop 1 – Banquet Hall South Teaching and Training	Workshop 2 – Banquet Hall North Research	
➤	Facilitator: Mr Bevan Bessen	➤	Facilitator: Mr Will Bessen
➤	Executive Sponsor: Adj Assoc Prof Karen Bradley	➤	Executive Sponsor: Professor Gary Geelhoed
➤	Executive Member Ms Tanya Basile	➤	Executive Member Professor Julie Quinlivan
2.40pm	Afternoon tea	Banquet Hall Foyer	
3.00pm	Final session		
3.00pm	Presentation and prioritisation of recommendations	Mr Bevan Bessen	
3.20pm	Closing remarks	Adj Assoc Prof Karen Bradley	
3.30pm	Close	Mrs Tanya Basile	

Appendix 2: Presenters & Expert Witnesses

- Ms Marie Taylor, Nyungar Elder
- Professor Julie Quinlivan, Chair, Clinical Senate of WA
- Dr David Russell-Weisz, Director General , WA Health
- Professor Gary Geelhoed, Assistant Director General & Chief Medical Officer, Clinical Services and Research, Department of Health WA
- Adjunct Associate Professor Karen Bradley, Chief Nurse and Midwifery Officer, Clinical Services and Research, Department of Health WA
- Ms Dianne Bianchini, Chief Health Professions Officer, Clinical Services and Research, Department of Health WA
- Professor John Challis, Executive Director, Western Australian Health Translation Network (WAHTN)
- Professor Keith Hill, Head of the School of Physiotherapy and Exercise Science, Curtin University
- Professor David Atkinson, Head of the Rural Clinical School of WA, The University of Western Australia
- Ms Penny Keogh, Nurse Director Education, Fiona Stanley Hospital
- Professor Jeff Hamdorf, Director, Clinical Training and Evaluation Centre and Professor of Surgical Education, School of Surgery, The University of Western Australia
- Ms Sue Davis, Nurse Director, Corporate Nursing Research and Education, Sir Charles Gairdner Hospital
- Dr Nikolajs Zeps, Director of Research, St John of God HealthCare
- Ms Susan Alexander, Allied Health Education Director, Fiona Stanley Hospital
- Mr Tim Shackleton, Chief Executive Officer, Rural Health West
- Mr Graeme Jones, Group Director Finance (Chief Finance Officer), Department of Health WA
- Dr Tom Snelling, Scientific Director, Wesfarmers Centre of Vaccines and Infectious Diseases, Telethon Kids Institute
- Professor Richard Tarala, Chair, Postgraduate Medical Council of WA (PMCWA)
- Professor Helena Liira, Head of School, Primary, Aboriginal and Rural Health Care, The University of Western Australia
- Mr Brendan Robb, Director, Workforce Directorate, Department of Health WA
- Professor Louis Landau, Medical Advisor, Medical Workforce, Department of Health WA
- Mr Babu Simon, Manager, Research Development Unit, Clinical Services and Research, Department of Health WA
- Mr Daniel Dorevitch, President, WA Medical Students' Society, The University of Western Australia
- Ms Julie Ogle, Course Coordinator Nursing, South Metropolitan TAFE
- Mr Rob Anderson, A/Director, ABM Reform, Department of Health WA

- Professor David Morrison, Deputy Vice Chancellor, Research and Development, Murdoch University
- Professor Shirley Bowen, Dean, School of Medicine, University of Notre Dame Australia
- Professor Moira Sim, Dean, School of Medicine and Health Sciences, Edith Cowan University
- Professor Di Twigg, Dean, School of Nursing and Midwifery, Edith Cowan University
- Ms Michelle Hoad, Interim Managing Director, North Metropolitan TAFE
- Professor Peter Leedman, Director, Harry Perkins Institute of Medical Research, Perth
- Mr Richard Smirk, Pharmacy Professional Officer, Australian Health Practitioner Regulation Agency WA

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