# Committee of Presidents of Medical Colleges

<table>
<thead>
<tr>
<th>4</th>
<th>7pm-8pm</th>
<th>Governance Session over dinner</th>
<th>RACV City Club</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Chairs report</td>
<td>Noting</td>
<td>✓</td>
</tr>
<tr>
<td>4.2</td>
<td>Minutes previous meeting</td>
<td>Note</td>
<td>✓</td>
</tr>
<tr>
<td>4.2.1</td>
<td>Minutes Executive</td>
<td>Note</td>
<td>✓</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Executive composition</td>
<td>Discuss</td>
<td>✓</td>
</tr>
<tr>
<td>4.3</td>
<td>CEO Report</td>
<td>Noting</td>
<td>✓</td>
</tr>
<tr>
<td>4.4</td>
<td>CPMC financial statements</td>
<td>Noting</td>
<td>✓</td>
</tr>
<tr>
<td>4.5</td>
<td>Changes in Directors</td>
<td>Noting</td>
<td>✓</td>
</tr>
<tr>
<td>5</td>
<td>Sub-Committees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>Collaborative Forum on Indigenous: update from the AIDA process</td>
<td>Note</td>
<td>✓</td>
</tr>
<tr>
<td>5.2</td>
<td>Rural Health: update on SRSA</td>
<td>Prof Truskett</td>
<td>✓</td>
</tr>
</tbody>
</table>

---

### THURSDAY 10 NOVEMBER AGENDA

<table>
<thead>
<tr>
<th>1</th>
<th>9AM</th>
<th>Meeting formalities 116TH MEETING</th>
<th>Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Attendance and Apologies</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>1.2</td>
<td>Conflicts of Interest and Confidentiality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td>Other issues: New Presidents</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2</th>
<th>9AM</th>
<th>Forum Reports</th>
<th>Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Committee of Presidents of Medical Colleges</td>
<td>Prof. N Talley</td>
<td>✓</td>
</tr>
<tr>
<td>2.2</td>
<td>The Australian Medical Council</td>
<td>Prof. J Sewell CEO: Ian Frank</td>
<td>✓</td>
</tr>
<tr>
<td>2.3</td>
<td>Commonwealth Chief Medical Officer</td>
<td>Prof. B. Murphy Dr A. Singer</td>
<td>✓</td>
</tr>
<tr>
<td>2.4</td>
<td>National Health &amp; Medical Research Council</td>
<td>Dr J. Flynn CEO M. Fletcher</td>
<td>✓</td>
</tr>
<tr>
<td>2.5</td>
<td>Medical Board of Australia &amp; AHPRA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.6</td>
<td>Australian Indigenous Doctors’ Association</td>
<td>Dr Kali Hayward</td>
<td></td>
</tr>
<tr>
<td>2.7</td>
<td>Australian Commission on Safety &amp; Quality in Healthcare</td>
<td>Prof. Villis Marshall</td>
<td>✓</td>
</tr>
<tr>
<td>2.8</td>
<td>The Australian Medical Association</td>
<td>CEO Anne Trimmer</td>
<td></td>
</tr>
<tr>
<td>2.9</td>
<td>Medical Deans of Australia &amp; New Zealand</td>
<td>Prof Glasgow Ms Carmel Tebbutt</td>
<td>✓</td>
</tr>
<tr>
<td>2.10</td>
<td>Confederation of Postgraduate Medical Education Councils</td>
<td>Prof. R Tarala</td>
<td></td>
</tr>
</tbody>
</table>

11.00 – 11.30am

Morning Tea for Profession Observers, College Presidents and CEOs

CPMC 10 November 2016 meeting at RANZCOG
Committee of Presidents of Medical Colleges

**Colleges Only**

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
<th>Presenter/Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 noon</td>
<td><strong>ANNUAL GENERAL MEETING</strong>&lt;br&gt;See separate agenda papers</td>
<td>Prof Talley</td>
</tr>
<tr>
<td>3.1 12:15</td>
<td><strong>Guest speaker:</strong> Dr Jenny Alexander, Doctors Health (15 minutes)</td>
<td></td>
</tr>
<tr>
<td>3.2 12:30</td>
<td><strong>Guest speaker:</strong> Teri Snowdon&lt;br&gt;A/g General Manager: Engagement&lt;br&gt;Australian Digital Health Agency (15 minutes)</td>
<td></td>
</tr>
<tr>
<td>1pm</td>
<td><strong>LUNCH</strong></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td><strong>Strategic Items</strong></td>
<td></td>
</tr>
<tr>
<td>6.1</td>
<td>Revalidation Working Group Update</td>
<td>Discuss</td>
</tr>
<tr>
<td>6.2</td>
<td>NMTAN update</td>
<td>Note</td>
</tr>
<tr>
<td>6.3</td>
<td>Clinical pathways project: request from RACS</td>
<td>Discuss</td>
</tr>
<tr>
<td>6.4</td>
<td>AHMAC update on the NTS</td>
<td>Note</td>
</tr>
<tr>
<td>6.5</td>
<td>Senate report on Medical Complaints</td>
<td>Note</td>
</tr>
<tr>
<td>6.6</td>
<td>National Health Summit on Obesity completed</td>
<td>Note</td>
</tr>
<tr>
<td>6.7</td>
<td>National Registration and Accreditation Scheme – Review of accreditation scheme</td>
<td>Note</td>
</tr>
<tr>
<td>7.1</td>
<td>Other Business: Dates for 2017</td>
<td>Decide</td>
</tr>
<tr>
<td>7.2</td>
<td>CPMC premises</td>
<td>Agree</td>
</tr>
<tr>
<td>7.3</td>
<td>Meeting Evaluation</td>
<td>Verbal</td>
</tr>
<tr>
<td>8</td>
<td>Next Meeting</td>
<td></td>
</tr>
</tbody>
</table>

**To Note:**

- College Presidents dinner is at the RACV City Club commencing at 7pm Wednesday 9 November 2016
- NB the National Health Summit on Obesity is convening at RACGP on Wednesday 9 November at 9:30am All Colleges will be present + attendees from stakeholders.
Item 1

Meeting formalities 116TH MEETING

1.1 Attendance and Apologies
In attendance are all of Australia’s specialist Medical College Presidents, and Chief Executives. Ms Helen Morgan-bander is representing the Royal College of General Practitioners, New Zealand as a guest observer.

Profession observers in attendance as follows:
- Professor Jill Sewell, President of the Australian Medical Council and Mr Ian Frank, Chief Executive
- Commonwealth Chief Medical Officer Prof. Brendan Murphy along with Principal Medical Adviser, Dr Andrew Singer.
- Dr Joanna Flynn, Chair, Medical Board of Australia, and Ms Joanne Katsoris
- Dr Kali Hayward, President Australian Indigenous Doctors Association
- Professor Villis Marshall, Chair, Australian Commission on Safety and Quality in Healthcare
- Ms Anne Trimmer, Secretary-General, the Australian Medical Association
- Professor Nick Glasgow, President, Medical Deans of Australia and New Zealand, and The Hon. Ms Carmel Tebbutt, CEO
- Professor Richard Tarala, President, Confederation of Medical Education Councils and Dr Jag Singh

Apologies have been received from Professor Anne Kelso, Chief Executive, National Health and Medical Research Council and Mr Martin Fletcher, AHPRA CEO.

1.2 Conflicts of Interest and Confidentiality
All present must indicate verbally to the Chair if not having sent in writing prior, any conflicts of interest.

1.3 Other issues

New Presidents to report from the 115th meeting are:
- Dr Bastian Seidel, President Royal Australian College of General Practitioners
- Professor Ruth Stewart, president, Australian College of Rural and Remote Medicine

This is the final meeting for:
- Professor Michael Permezel, President, Royal Australia and New Zealand College of Obstetricians and Gynaecologists.
- Dr Bradley Horsburgh, President Royal Australia and New Zealand College of Ophthalmologists

We welcome Professor Bernadette White for RANZCOG at this meeting noting Professor Stephen Robson will assume the Presidency for RANZCOG. Professor Mark Daniell is President, RANZCO.
2.1 CPMC Chair

I welcome you all to the 115th meeting of CPMC here at the Royal Australia and New Zealand College of Obstetricians and Gynaecologists, Melbourne.

I would like to acknowledge the traditional owners of the land upon which we meet, the Wurundjeri people.

CPMC has received apologies from Professor Anne Kelso, CEO National Health & Medical Research Council.

This will be the first meeting for the new Chief Medical Officer for Australia Professor Brendan Murphy.

Since the last meeting of CPMC advocacy statements as agreed by the Committee were produced and can be found at:

CPMC strategic issues focus has included revalidation, Indigenous specialist training, primary care, rural health, sustainability of the system and specialist training.

You will all be aware of the CPMC National Health Summit on Obesity which took place 9 November and tackling the crisis of obesity is a challenge I know is of great interest to health professionals. Recently when meeting the Prime Minister he showed strong interested in looking at ways to reduce levels of obesity.

CPMC will hold its Annual General Meeting today where it is considering a name change.

Given this is the final meeting for 2016 I wish you a happy holiday and I look forward to 2017 CPMC meetings.

Professor Nick Talley

CPMC meeting 10th November 2016 at the RANZCOG Melbourne
1. Directors and Council

1.1 Meetings of the Australian Medical Council Limited

The Annual General Meeting of the Australian Medical Council Limited is scheduled to be held in Canberra on Wednesday 30 November 2016. Members have been advised via formal notice that the meeting will consider a special resolution to amend the Constitution in addition to the general business of the AGM including:

(i) the receiving and consideration of the profit and loss account, the balance sheet and the reports of the Directors and the auditor; and

(ii) the election of the President, the Deputy President and three other Directors.

At each Annual General Meeting, the Directors appointed at the preceding AGM under articles 7.3, 7.4 and 7.5 of the Constitution must retire from office.

The current Principal Office Bearers and Directors are:

- President: Associate Professor Jill Sewell AM
- Deputy President: Professor David Ellwood
- Director: Emeritus Professor Napier Thomson AM
- Director: Dr Greg Kesby
- Director: Dr Kim Rooney

The call for nominations for the Principal Office Bearers and Directors will be circulated to Council members prior to the meeting.

2. National Issues and Initiatives

2.1 National Registration and Accreditation Scheme – Health Ministers’ 2016/17 Review of Accreditation under the Scheme

The Final Report of the Independent Review of the National Registration and Accreditation Scheme, released in August 2015, made 33 recommendations about the Scheme including 7 about accreditation under the Health Practitioner Regulation National Law which includes both accreditation of programs and assessment of overseas trained practitioners. These largely related to the variability of accreditation arrangements across the 14 regulated professions. There were comments about cost, transparency and duplication of existing accreditation arrangements and the overly prescriptive approach in some existing accreditation processes. Ministers expressed concern about these findings, supported the recommendations in principle, and expressed the view that, while the review recommendations would go some way to improve Australia’s accreditation arrangements, more substantive reform of accreditation functions was required to address the issues raised.

The AMC – and all the accreditation councils – publicly indicated their concerns with the accuracy of the cost analysis completed, which for the AMC conflated the AMC...
expenditure on international medical graduate assessments and medical program accreditations as medical program accreditations.

Ministers asked the Australian Health Ministers’ Advisory Council (AHMAC) to commission further advice and undertake a comprehensive review of accreditation functions.

AHMAC has now announced the appointment of the Independent Reviewer, Professor Michael Woods, Professor of Health Economics in the Centre for Health Economics Research and Evaluation at the University of Technology Sydney and former Commissioner of the Australian Productivity Commission. Mr Peter Carver, formerly of the Victorian Department of Health is working with Professor Woods, together with two other Victorian health staff. The appointment of the reviewer and the terms of reference for the review are addressed in the communique at ATTACHMENT 1.

Professor Woods has begun informal discussions with stakeholders, and more formal state-based discussion are planned.

It is proposed that a discussion/consultation paper is available early in 2017, with comments sought by April 2017 and the review finalised by September 2017.

The AMC will be arranging to meet Professor Woods separately, and will continue its significant contribution to the review, through its own submissions about accreditation for the medical profession, in conjunction through its membership of the Health Professions Accreditation Councils’ Forum.

3. Strategy and Policy

3.1 National Training Survey

In reporting to the June 2016 meeting of CPMC, the AMC President raised the issue of a National Training Survey, and work done by the AMC to canvas support for this development. The AMC considers that a National Training Survey has the potential to evaluate and improve the quality of training and through better training, support safe patient care. The experience from the UK, where the General Medical Council runs an annual National Training Survey indicates that National Training Survey has the potential to streamline and inform the AMC’s accreditation processes, and the quality assurance processes of other organisations, such as the colleges.

Since then there has been national workshop on a national training survey (held on 25 August 2016). The workshop participants expressed strong support for a national survey, and the AMC is continuing to advocate for roll out of the survey.

3.2 Specialist Education Accreditation Committee

The AMC Specialist Education Accreditation Committee last met on 18 August 2016 and considered a range of matters as set out below:

3.2.1 Acupuncture accreditation standards

As advised in previous reports, the AMC, on behalf of the Medical Board of Australia, has been developing standards for the assessment and accreditation of programs of study leading to endorsement of registration of medical practitioners for acupuncture. A reference group is assisting AMC staff to revise the draft accreditation standards and process for accreditation in response to stakeholder feedback received.

3.2.2 Memorandum of Understanding (MOU) with Tertiary Education Quality and Standards Agency (TEQSA)

The AMC has just signed an MOU with TEQSA to share information to support quality assurance and accreditation. The AMC has had a very limited MOU with TEQSA to share information about the Australasian College of Dermatologists, which was seeking registration as a higher education provider with TEQSA. The new MOU allows
for sharing of information about providers undergoing accreditation, and where appropriate to work together on an accreditation.

4. **Accreditation Assessments**

**Completed**

**Royal Australian and New Zealand College of Ophthalmologists (RANZCO) 2016 Reaccreditation Assessment**

AMC Directors at their meeting on 20 October 2016 agreed to advise the MBA of its decision to accredit the program for three years to March 2020, subject to satisfying AMC monitoring requirements including progress reports and addressing accreditation conditions. In late 2017, the AMC will undertake a review visit and report on the College’s progress in addressing the 2017 conditions on accreditation.

**Under way**

**Royal College of Pathologists of Australasia (RCPA) 2016 Reaccreditation Assessment**

The team will undertake site visits to a range of accredited training sites from 7 to 11 November 2016 and hold meetings with College committees from 14 to 17 November. The preliminary team meeting was held at the College’s office in Sydney on 1 and 2 September 2016.

**Upcoming**

**Royal Australasian College of Dental Surgeons (RACDS) 2017 Reaccreditation Assessment**

The Royal Australasian College of Dental Surgeons’ (RACDS) Oral and Maxillofacial Surgery training program is accredited by the AMC, the Medical Council of New Zealand (MCNZ), the Australian Dental Council (ADC) and the Dental Council of New Zealand (DC(NZ)). As a joint AMC and ADC assessment, the AMC and ADC will appoint team co-chairs. In March 2016, the Committee appointed Professor David Ellwood as AMC co-chair of the 2017 RACDS team. The College has supported this appointment. The ADC is in the process of selecting its co-chair for the assessment.

The team will undertake site visits to a range of accredited training sites from 5 to 9 June 2017 and hold meetings with College committees from 14 to 16 June 2017.

**Royal Australasian College of Surgeons (RACS) 2017 Reaccreditation Assessment**

In 2017, the AMC will undertake a full reaccreditation assessment of the programs of the Royal Australasian College of Surgeons (RACS). The 2017 assessment will include the education and training programs (including continuing professional development programs) leading to the award of Fellowship of the Royal Australasian College of Surgeons. The fields of specialty practice are:

- Cardio-thoracic surgery
- General surgery
- Neurosurgery
- Orthopaedic surgery
- Otolaryngology – head and neck surgery
- Paediatric surgery
- Plastic surgery
- Urology
Vascular surgery

In August 2016, the Committee appointed Professor Christopher Baggoley AO, as Chair of the assessment team. The College has supported this appointment.

The team will undertake site visits to a range of accredited training sites from 27 to 31 March 2017 and hold meetings with the College’s outgoing office bearers and committees from 3 to 5 April 2017. The team will meet the College’s incoming office bearers and remaining committees from 28 to 30 June 2017.

**Australasian College of Dermatologists (ACD) 2017 Reaccreditation Assessment**

In late 2017 the AMC will undertake a reaccreditation assessment of the programs of the Australasian College of Dermatologists (ACD). In August 2016, the Committee appointed Associate Professor Jenepher Martin, as Chair of the assessment team. The College has supported this appointment.

The team will undertake site visits to a range of accredited training sites from 28 August to 1 September 2017 and hold meetings with the College’s committees from 4 to 7 September 2017.

**Australasian College for Emergency Medicine (ACEM) 2017 Reaccreditation Assessment**

In late 2017 the AMC will undertake a reaccreditation assessment of the programs of the Australasian College for Emergency Medicine (ACEM).

The team will undertake site visits to a range of accredited training sites from 13 to 17 November 2017 and hold meetings with the College’s committees from 21 to 24 November 2017. The meetings with the College committees will be held concurrently with ACEM’s 2017 Annual Scientific Meeting being held in Sydney.

**Royal Australian College of General Practitioners 2017 Progress Report with Visit**

In 2013, an AMC team completed a reaccreditation assessment of the College’s pathways to fellowship. The AMC granted the College accreditation for six years, until 31 December 2019, subject to satisfactory progress reports to the AMC and a review visit in 2017. The 2017 review will consider the College’s progress against the accreditation standards and the remaining conditions on accreditation through discussions with College committees, office bearers and staff.

In August 2016, the Committee appointed Professor John Kolbe as chair of the 2017 review team. The College has supported this appointment.

It is proposed the review visit will take place in August / September 2017.

**Accreditation monitoring**

The Progress Reports Working Party met on 28 July 2016 and considered the progress reports from Australasian College of Dermatologists, Australasian College of Sports and Exercise Physicians, College of Intensive Care Medicine of Australia and New Zealand, Royal Australian College of General Practitioners and Royal Australian and New Zealand College of Radiologists.

5. **Workshops**

The AMC plans to hold a workshop in early 2017 to consider stakeholder feedback (including from trainees, supervisors, health services/jurisdictions, consumers, community groups and Indigenous health organisations) in specialist medical training. The workshop will consider:

- the purpose of stakeholder engagement in specialist medical training
- AMC accreditation standards and findings concerning stakeholder engagement
- stakeholder engagement and feedback methodologies and procedures
- effective techniques and processes for stakeholder engagement in governance, program development and evaluation, and teaching and training.

Ms Fiona Tito Wheatland BA (Hons) LLB has been engaged by the AMC to facilitate the workshop. Ms Tito Wheatland is the consumer representative, Healthcare Consumers of the ACT and health consumer member of the Progress Reports Working Party.

The AMC will contact Colleges about a preferred date.
CHIEF MEDICAL OFFICER’S REPORT

COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES

10 November 2016
CONTENTS

STANDING ITEMS

Specialist Training Program

Health Workforce Planning and National Medical Training Advisory Network

New Digital Mental Health Gateway

Benefits Schedule (MBS) Review Taskforce

Pharmacy Trial Program

Australian National Diabetes Strategy 2016 – 2020

National Strategic Framework for Chronic Conditions

National Cancer Screening Register

Digital Health Update

My Health Record: System Update
Specialist Training Program (STP)

Key Points

Program Funding and Review

- In August 2016, the Minister for Health, the Hon Sussan Ley MP:
  o approved the extension of the STP and the Emergency Medicine Program (EMP) funding agreements with participating specialist colleges at current levels to cover the 2017 academic year;
  o funding arrangements from 2018 onwards will be determined once the Minister has considered the final report of the department’s review of the STP and EMP initiatives.
  o The Minister has also agreed to the allocation of the first tranche of 50 new rural specialist training places to the 10 colleges participating in the Integrated Rural Training Pathway (IRTP)-STP in 2017.
- The department distributed a draft Findings Report on the review of the STP and EMP to all key stakeholders for comment by 20 September.
- The department is planning to hold some discussions in November 2016 with specialist medical colleges and jurisdictions about possible changes to the proposals included in the draft Findings Report. Following consultation, the department will prepare a report for the Minister setting out the findings of the review and possible reforms to the program for her consideration. The report is expected to be finalised in 2016.

Integrated Rural Training Pipeline Implementation

- The Integrated Rural Training Pipeline measure announced in the Mid-Year Economic and Fiscal Outlook statement included an additional 100 STP posts in rural areas over two years. Fifty posts have been allocated for 2017 with a further 50 to be allocated for 2018. Including these new rural places will increase the total number of ongoing STP places to 1,000 by 2018.
- The department is liaising with the specialist colleges about proposed IRTP models of training. This is focused on ensuring the new places meet the policy objectives of this new measure to develop extended models of specialist training in rural and regional areas on a “rotate in” rather than “rotate out” basis.
- On this basis, new positions must be designed to enable a trainee to complete the majority of their training within a rural region (66%); trainees selected for IRTP-funded posts must show a commitment to working in a rural area; and each college’s proposed training model should show a clear, organised training pathway for the trainee.

Expression of Interest Process

- The department is currently developing an on-line Expression of Interest (EOI) process for training settings to register their interest in hosting a training post under the STP, EMP and/or the IRTP.
  o The development of the EOI involved some colleges and jurisdictions providing feedback on the concept proposal and in testing the on-line form.
  o The EOI is aimed at refreshing the College STP and EMP Reserve Lists to help fill vacant posts. It will also help to identify settings interested in the IRTP.
  o Colleges have recently been provided with further guidance on the EOI process, including an updated version of the STP Priority Framework, as well as a guide to completing EOI assessments.
  o The EOI is to be launched in the week 31 Oct to 4 Nov 2016.
Background
Other Components of the IRTP measure
The Integrated Rural Training Pipeline for Medicine measure announced in the 2015-16 MYEFO commits funding of $93.8 million over four years, and has three components: the establishment of up to 30 regional training hubs, a rural junior doctor training innovation fund; and 100 new rurally-based posts in the Specialist Training Program. The IRTP will contribute to building a sustainable Australia-trained future medical workforce for regional, rural and remote communities.

Regional Training Hubs
Up to 30 new regional training hubs will be formed to support the coordination of rural training opportunities across the different stages of medical training (from undergraduate through to vocational training). Universities currently participating in the Rural Health Multidisciplinary Training (RHMT) program will be eligible to apply for funding under this initiative.

The hubs will be based at existing RHMT program sites and will utilise existing physical and educational infrastructure available through the network of 12 University Departments of Rural Health (UDRHs) and 18 Rural Clinical Schools (RCSs).

The hubs will be expected to work with a range of stakeholders including the specialist medical colleges and those implementing the Rural Junior Doctor Training Innovation Fund to foster integrated medical training pathways for students within regions.

Funding will primarily be available for universities to engage additional staff to implement the initiative. The hubs will work with medical professional groups and employers (hospitals and general practice) to enable students to continue rural training beyond university into postgraduate medical training, helping to identify available places and match students with appropriate training opportunities across the various medical specialties.

Current status:
Regional training hubs are being selected through a competitive process – a targeted Request for Proposal (RFP) was released on 11 October 2016 and it invited the 18 universities participating in the RHMT Program to apply for funding. A key priority will be the geographic distribution of regional training hubs across Australia. The application period closes on 22 November 2016 and it is anticipated activity will commence in early 2017. The department will provide advice to colleges on the location of the Hubs once the outcome of the RFP is finalised.

Rural Junior Doctor Training Innovation Fund (RJDTIF)
The RFDTIF will fund general practice rotations for junior doctors undertaking their internship in a rural area. The Fund will be targeted at rural-based interns to enable them to spend time in general practice, building on the rural training networks for junior doctors that are funded by the states and territories.

Approximately 60 FTE places will be supported each year, comprising around 240 rotations (10-12 weeks) into GP settings. Over $10 million per annum will be provided from 2017-18, with places commencing in 2018.

Commencement of RJDTIF places in 2018 allows for organisations to ensure the appropriate accreditation is in place to train medical interns; and to incorporate the RJDTIF into the 2018 intern recruitment process during 2017. The RJDTIF approach to market is expected to commence in early 2017.
Health Workforce Planning and National Medical Training Advisory Network

National Medical Training Advisory Network

Key Points

- The National Medical Training Advisory Network (NMTAN) advises Health Ministers on issues relating to planning, distribution and coordination of medical training.
- The reports on the psychiatry and anaesthesia workforce have been completed and published on the Department’s website.
- NMTAN continues to work towards completion of future reports which include emergency medicine and obstetrics and gynaecology.
- The Committee of Presidents of Medical Colleges (CPMC) is an active contributor to NMTAN through its President, who attends the Executive Committee meetings.
- In 2015, due to an overlap in the functions of the Medical Training Review Panel (MTRP) and the NMTAN, the Minister of Health and the Prime Minister agreed for the MTRP to cease meeting and for the Department to proceed with work towards repealing Section 3GC of the Act to abolish the MTRP. The repeal of the MTRP was also announced as part of 2015-16 Mid-Year Economic and Fiscal Outlook. However, due to the double dissolution of both Houses of Parliament on the 9 May 2016, the Department is continuing to progress the repeal of the MTRP.
- The main function of the MTRP was to provide a comprehensive overview of medical education and training, supplemented with other data on the medical workforce supply, through the annual MTRP report.
- The 19th MTRP report was tabled in Parliament on 5 October 2016. The public release of the report was approved by the Hon Sussan Ley MP, Minister for Health and Aged Care on 14 September 2016.
- With the repeal of the MTRP the publication of the MTRP report will be undertaken by NMTAN.

Background

The establishment of NMTAN was approved on 10 August 2012 by the Standing Council on Health as a mechanism to enable a nationally controlled medical training system in Australia.

NMTAN was established in February 2014. It provides advice to Health Ministers on issues relating to the planning, distribution and coordination of medical training and medical training plans across the medical training pipeline from university through to vocational training.

The Department provides Secretariat support to NMTAN. The operations of the NMTAN include two levels of activity:

- the NMTAN Executive Committee; and
- Standing Subcommittees.

The MTRP report is compiled by the Department as soon as practicable after 30 June each year and provided to the MTRP (NMTAN after the repeal of the Act) for acceptance. Section 3GC (5) of the Act requires the Minister for Health to table a copy of the report before each House of the Parliament.
New Digital Mental Health Gateway

Key Points
- Currently under development, the new digital mental health gateway (‘the gateway’) is a key component of the Government’s response to the Mental Health Commission’s Review ‘Contributing Lives, Thriving Communities - Review of Mental Health Programmes and Services.
- The gateway intends to optimise use of digital mental health services and technology, and is a key part of a stepped care approach helping people get to the right type of service appropriate to their needs.
- The gateway will provide a multichannel platform (for instance, website, social media, and phone line) that will enable the general community, people with lived experience, carers, digital mental health services, and health professionals to access evidence-based information, advice and digital mental health treatment options (and non-digital options if considered more appropriate to need).
- The gateway is being developed and informed through a range of stakeholder engagement activities including a co-design process, recognising consumers and carers as the experts in their own lives, and therefore gaining a deeper understanding of user needs and features required within the gateway.

Background
Eleven co-design workshops have been held with consumers, carers, health professionals, digital mental health services, and the Primary Health Networks including representatives from the National Mental Health Consumer and Carer Forum. A workshop with an Indigenous community was held in Bundaberg, Queensland. Feedback to date has been very positive and enthusiastic, particularly about the co-design process.

The first release of a Minimum Viable Product is expected in the first quarter of the 2017 calendar year and is expected to involve:
- decommissioning mindhealthconnect.com.au web portal,
- a new website of professional curated evidence based information and advice; and
- a decision support tool, designed to assist users in finding tailored information and/or services that will meet their needs.

Healthdirect Australia has been engaged to deliver the service concept and requirements informed by the co-design process and branding for the gateway which in the first stage, is primarily focusing on users with a lived experience of mental illness and their supportive others.

The Department is developing a procurement process to engage a suitable provider to build and operate the online channel/presence (e.g. website, social media channels) of the gateway (the phone-based contact centre will be delivered later in 2017 by a separate provider). Performance metrics will be developed, user satisfaction will be measured, and the gateway will be iterated in response to user feedback ensuring that people with lived experience remain at the centre of service design, delivery and evaluation.

Enhancements to be explored for future releases will include the establishment of a telephone based contact centre, as well as tailoring the gateway’s focus for use by other users, including health professionals.
Medicare Benefits Schedule (MBS) Review Taskforce

Key Points
- The Medicare Benefits Schedule (MBS) Review Taskforce has released reports from its first tranche committees for public consultation. The consultation process was completed over a four week period and closed Friday 7 October 2016. Public survey online submissions of each report are currently being analysed.
  - Diagnostic Imaging Clinical Committee Low Back Pain
  - Diagnostic Imaging Clinical Committee Bone Densitometry
  - Gastroenterology Clinical Committee
  - Ear, Nose and Throat Clinical Committee
  - Obstetrics Clinical Committee
  - Thoracic Medicine Clinical Committee
- In addition MBS Review Taskforce released a report from its Principles and Rules Committee.
- Second tranche committees are currently working through work plans and will be finalising reporting in the coming months. These committees include;
  - Cardiac Services Clinical Committee
  - Dermatology, Allergy and Immunology Clinical Committee
  - Endocrinology Clinical Committee
  - Intensive Care Medicine Clinical Committee
  - Oncology Clinical Committee
  - Renal Clinical Committee
- Third tranche Clinical Committees and Working Groups are currently being established.
  - Anaesthetics Clinical Committee
  - Gynaecology Clinical Committee
  - General Practice and Primary Care Clinical Committee
  - Orthopaedics Clinical Committee
  - Spinal Surgery Clinical Committee
  - Pain Management Clinical Committee

Background
The MBS Review Taskforce is undertaking a program of work across the entire MBS to ensure it is contemporary, reflects current clinical practice and allows for the provision of health services that improve health outcomes.

The Taskforce consulted with practitioners, consumers and professional medical colleges prior to finalising these recommendations to ensure broad support for these measures. These changes will improve the quality and safety of services funded through the MBS by removing a number of obsolete or redundant services funded through the MBS. Patients will be better off as a result of these changes because more effective and clinically appropriate services will remain on the MBS.
Pharmacy Trial Program (PTP)

Key Points
- The Australian Government has provided $50 million through the Sixth Community Pharmacy Agreement for the PTP. The PTP will trial new and expanded community pharmacy programs which seek to improve clinical outcomes for consumers and/or extend the role of pharmacists in the delivery of primary healthcare services through community pharmacy.
- It is intended that a particular focus of community pharmacy programs, including the PTP, will be on activities and services which benefit Aboriginal and Torres Strait Islander peoples, and consumers in rural and remote areas.
- On 17 March 2016, Minister Ley announced the first three trials that will be funded under the Pharmacy Trial Program:
  - improved medication management for Aboriginal and Torres Strait Islander peoples through pharmacist advice and culturally appropriate services;
  - pharmacy based screening and referral for diabetes; and
  - improved continuity in the management of patients’ medications when they are discharged from hospital.
- The Pharmacy based screening and referral for diabetes trial is being conducted by the Pharmacy Guild of Australia in collaboration with the University of Sydney and Deakin University. The trial’s objective is to assess the comparative effectiveness and cost-effectiveness of alternative pharmacy-delivered models of opportunistic interventions for detecting diabetes in an asymptomatic, previously undiagnosed population.
  - The trial is a randomised controlled trial which will be conducted in pharmacies in metropolitan, regional and rural areas across Australia. The trial has a participation quota of 363 pharmacies across Australia. Invitations to pharmacies to express their interest in participating in the trial were issued on 17 October 2016. Pharmacies will then be randomised to achieve the target number and geographic representation.
- The other two trials are being finalised.

Background
The Pharmaceutical Benefits Scheme Access and Sustainability Package is a group of measures which will deliver funding for community pharmacy through the Sixth Community Pharmacy Agreement (Sixth Agreement).

The total funding allocated for community pharmacy programs is $1.26 billion over five years, (2015-16 to 2019-20). This includes:
- $613 million to support community pharmacy programs that are continuing from the Fifth Community Pharmacy Agreement and which are assessed as clinically and cost effective;
- $50 million to support a new Pharmacy Trial Program (PTP). This program will fund a number of trials to improve patient outcomes, and seeks to expand the role of pharmacy in delivering a wider range of primary healthcare services; and
- $600 million to support a range of new and/or expanded programs, based on the recommendations of an independent health technology assessment body such as the Medical Services Advisory Committee about the outcomes of trials.
Australian National Diabetes Strategy 2016 – 2020

Key Points

- The Australian Government developed the Australian National Diabetes Strategy 2016-2020 (the Strategy) to update and prioritise the national response to diabetes across all levels of government.
  - The Strategy was released on 13 November 2015 by the Minister for Health to coincide with World Diabetes Day on 14 November 2014.
  - The Strategy contains a number of goals and potential areas for action that provide a range of ideas for implementation to achieve each goal, while recognising the fiscal outlook facing all governments.
- The Community Care and Population Health Principal Committee (CCPHPC) of AHMAC agreed to establish a cross-jurisdictional Implementation Working Group (IWG) to develop an implementation plan that will recommend ways to direct funding and other resources to agreed actions over the life of the Strategy.
  - The IWG was established in early 2016. The IWG comprises Commonwealth and state and territory government representatives. It is expected that targeted consultation on the draft Implementation Plan will occur in late 2016.
  - The resulting Implementation Plan will be provided to CCPHPC and AHMAC for endorsement in 2017.

Background

The Strategy was informed through public consultation and the independent, expert advice of the National Diabetes Strategy Advisory Group.

The primary audience for the Strategy is policy makers at all levels of government. The secondary audience is non-government organisations including national peak bodies, stakeholder organisations and health professional who advocate for and provide education and care for people at-risk of with diabetes.

Printed copies have been distributed to primary stakeholders and electronic copies are available from the Department of Health’s website.

The Australian Health Ministers’ Advisory Council (AHMAC) agreed, at their 2 October 2015 meeting, that an implementation plan for the Strategy would be developed in negotiation with states and territories.
**National Strategic Framework for Chronic Conditions**

**Key Points**
- The Australian Government, in partnership with states and territories, is currently developing a National Strategic Framework for Chronic Conditions (the Framework) that will supersede its predecessor, the *National Chronic Disease Strategy 2005*.
- The Framework moves away from a disease specific approach and will provide high level guidance to enable all levels of government and health professionals to develop future policy, strategies, actions and services to work towards delivery of a more effective and coordinated national response to chronic conditions and their risk factors. This will improve the health and wellbeing of individuals, and deliver a more sustainable health system.
- The Framework will address primary, secondary and tertiary prevention of chronic conditions, recognising that there are often similar underlying principles for the prevention and management of many chronic conditions. It will better cater for shared health determinants, risk factors and multimorbidities across a broad range of chronic conditions.
- The Framework is currently being finalised and will be submitted for approval through the AHMAC process before publication and dissemination. It is expected that the Framework will be completed in late 2016 and publicly available in 2017.

**Background**
The Framework will better cater for shared health determinants, risk factors and multimorbidities across a broad range of chronic conditions, recognising that there are often similar underlying principles for the prevention and management of many chronic conditions.

The Framework will provide the opportunity to consider how best to facilitate coordinated, integrated and multidisciplinary care, improve utilisation of primary health care organisations, and recognise patient needs across the continuum of care.
National Cancer Screening Register

Key Points

- The National Cancer Screening Register (the Register) is a piece of national digital health infrastructure for the collection, storage, analysis and reporting of cancer screening data for both the renewed National Cervical Screening Program (NCSP) and the National Bowel Cancer Screening Program (NBCSP).
- The Register is an integral part of cancer screening service delivery: it will facilitate invitations for screening, mailing of test kits and clinical decision-making for these two programs.
- The Register will combine nine separate cancer screening registers into a single register, starting 1 May 2017, creating a single view for Australians participating in cervical and bowel cancer screening, meaning for the first time: one participant, one record.
- Telstra was appointed as the Register provider by the Department of Health (Health) following an open competitive tender process which sought a value-for-money outcome in accordance with Commonwealth Government Procurement Rules. While Health has entered into a Services Agreement with Telstra, the Register will be developed and operated by Telstra Health, a standalone business unit of Telstra.
- The Register legislation received Royal Assent on 20 October 2016. This legislation provides the framework to safeguard protected information in the Register by prohibiting its use and disclosure for purposes outside the requirements to operate the Register; and creating an offence arising from the unauthorised recording, use or disclosure of personal information contained in the Register. The legislation also requires notification to the Information and Privacy Commissioner if there is a data breach.
- Health professionals, including pathology providers, will have improved access to their patients’ information. The Register will be integrated with GPs’ desktops, allowing them to identify patients’ screening eligibility and history to support real time clinical decision-making.
- Once the Register is implemented, practitioners and screening participants will not be charged a fee to access their records or the system. Participants will be able to view and manage their contact information and screening status through the Register free of charge.
- The Register will include a Melbourne-based call centre that will provide support for Register users in each state and territory free of charge.
- To support the Register’s development and implementation, consultation has been underway with a broad range of stakeholders. Meetings have occurred with peak bodies and other organisations to inform them of the upcoming changes, integration with existing software, and anticipated timeframes. Telstra Health has been engaging closely with the pathology sector, and consultation with GPs is underway via the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine.
- Engagement with relevant professional colleges is expected to continue through to implementation of the Register in 2017.

Background

The Register operation and data migration from existing registers is enabled by amended legislation. This was passed through the House of Representatives on 11 October 2016 and the Senate on 13 October 2016, receiving Royal Assent on 20 October 2016. Passage of the legislation will now allow for operation of the Register and data migration from the nine existing registers.
Digital Health Update

Legislation and Governance Update

Key Points:

- Digital Health Governance has been strengthened by the establishment of the Australian Digital Health Agency (the Agency).
- The Agency has a whole-of-system, integrated and strategic approach to digital health services, a focus on clinical quality and safety, and real engagement and collaboration with consumers, healthcare providers, governments and industry. The Agency is also now accountable for all digital health activities nationally.
- The Intergovernmental Agreement on National Digital Health, which describes the Commonwealth and State and Territory governments’ agreement to the establishment and on-going financial support for the operations of the Agency was approved by the COAG Health Council on 8 April 2016.
- The Agency is leading the next stages of consultation to finalise the National Digital Health Strategy – setting out shared vision for digital health innovation to drive better healthcare delivery and outcomes over the next three years. Engagement and consultation will complete no later than end of January 2017.
- In the short to medium term, priorities for the Agency include enabling secure point to point messaging between all healthcare providers, increasing use of My Health Record in public and private hospitals, and upload of pathology and diagnostic imaging reports for patients to their record.
- The Agency will also be involved closely with the trial and implementation of Health Care Homes – a crucial element in the Government’s reforms to primary health care.

Governance:

- The Agency is governed by a Board with membership comprising a broad range of skills reflecting the health community.
- The Commonwealth Health Minister (the Minister) appointed the Agency’s Board Chair and members on 20 April 2016 after agreement from State and Territory Health Ministers and the Federal Cabinet.
- The Minister also announced the appointment of Mr Tim Kelsey as the Chief Executive Officer of the Agency on 1 August 2016.

Participation Trials Update

Two trials of an opt-out participation system are currently underway in Northern Queensland and the Nepean Blue Mountains area of New South Wales. In these opt-out trials, individuals had a My Health Record automatically created for them unless they decided they didn’t want one (i.e. they opted out).

As a result of the trials, over 970,000 new My Health Records were created across both opt-out trials in June 2016. Healthcare providers have been able to access these My Health Records since 15 July 2016.
In addition to the two opt-out trials there are two trials exploring accelerated opt-in arrangements. One in Ballarat looking at hospital based registration and the other in Perth looking at registration of people with chronic conditions.

The evaluation of the four trials will inform future government decisions for how best to bring forward the benefits of the My Health Record nationally, including whether to adopt an opt-out system nationally.

**Framework for Secondary Use of My Health Record Data Update**

In June 2016, the Department engaged a consortium led by HealthConsult Pty. Ltd. to undertake public consultations and develop a framework and implementation plan for the secondary use of My Health Record data.

The Department has decided to postpone the release of the public consultation paper and public consultations until early next year, as there are a number of other consultations occurring, including the National Digital Health Strategy that will compete for the attention of healthcare providers and the broader community.

The outcome of these consultations could further inform a discussion paper on secondary use of My Health Record data.
My Health Record: System Update

Key Points:
- A major release of the My Health Record system, Release 7.1 (R7.1) was deployed on 12 June 2016. The release included functionality to improve the My Health Record System through enhancement and expansion of the usability of the system including mobile enablement, simplified Proof of Record Ownership (PORO) identification, Provider First Access and the rebranding of the My Health Record website in line with the establishment of the Agency. The release also included changes to support the removal of Medicare Partitioning, National Prescription and Dispense Repository (NPDR) changes and Security enhancements.
- A My Health Record production system change occurred on 8 October 2016 to:
  1. Align the changes in DHS legislation and systems on the transition from Australian Childhood Immunisation Register (ACIR) to Australian Immunisation Register (AIR) as of 30 September 2016,
  2. Advance Care Planning – changes to allow documents up to 20Mb (current limit 8Mb) to be uploaded to the My Health Record system, and
- Key My Health Record statistics:
  - As at 16 October 2016 there were over 4.2 million individual records and 8,400 healthcare organisations registered in the My Health Record system.
  - Over 348,045 shared health summaries, 564,065 hospital discharge summaries, 117,179 event summaries and 25,128 diagnostic imaging reports have been uploaded to the My Health Record System.

Background
In the 2015-16 Budget, the Australian Government allocated a total funding of $485.1 million over four years for strengthened eHealth governance arrangements, trialling new participation arrangements including opt-out, improving system usability and the clinical content of records, and the establishment of the Australian Digital Health Agency. The Government also allocated three years of funding for the continued operation and redevelopment of the My Health Record system, formerly known as the Personally Controlled Electronic Health Record (PCEHR) system.

The My Health Record system aims to improve health outcomes for Australians through the seamless integration and sharing of their important health information with healthcare providers involved in their care.

The My Health Record system contains clinical, Medicare and personal information, such as: Shared health summary; Event summaries; Hospital discharge summaries; Specialist letters; eReferral letters; Prescription and dispensing information; Pathology and diagnostic imaging reports; Immunisation records; MBS and PBS information; and Patient-entered personal health summaries and notes.
NHMRC CEO Report to the Committee of Presidents of Medical Colleges

November 2016

NHMRC Corporate Plan 2015 – 16

**NHMRC Corporate Plan 2015-16**

NHMRC’s strategy for health and medical research is represented by the themes of investment, translation and integrity.

**NHMRC will:**

- invest in high quality health and medical research and build research capability, supporting the best research and researchers
- support the translation of health and medical research into clinical practice, policy and health systems and the effective commercialisation of research and discoveries
- maintain a strong integrity framework for research and guideline development, underpinning rigorous research and relevant and accurate guidelines and promoting community trust.

**Structural Review of NHMRC’s grant program**

As reported at the last meeting, in recent years, rising application numbers and research costs have resulted in historically low funding rates for NHMRC’s major Project Grants and Fellowships schemes. In addition to wasted effort, concerns are being raised about the impact on early-career researchers and research creativity. We are therefore reviewing the structure of NHMRC’s grant program and exploring alternative models to see whether we can adapt our schemes to suit current circumstances. An Expert Advisory Group of senior researchers, together with NHMRC’s Research Committee, Council and other specialist groups, are providing advice.

The CEO and members of the Expert Advisory Group presented and participated at the Structural Review public forums that ran during public consultation on this issue:

- Canberra: Wednesday 20 July 2016
- Perth: Thursday 21 July 2016
- Melbourne (Parkville and Clayton): Friday 22 July 2016
Public consultation closed 25 August 2016 with 329 submissions received (plus one extension granted). From the submissions received, 151 (46%) are from individuals and 178 (54%) are from organisations. A summary of submissions, as well as individual submissions for which permission to make public was provided, will be made available on the NHMRC website.

The Expert Advisory Group met on 12 October 2016 to discuss the issues raised in submissions and to begin formulating its advice on a possible new structure for NHMRC’s grant program. The proposed model will be reviewed and supported by NHMRC’s Research Committee and recommended to NHMRC Council.


Advanced Health Research and Translation Centres
The translation of health and medical research is an integral theme of NHMRC’s strategy for the period 2015-16 to 2018-19. In March 2015 NHMRC recognised four NHMRC Advanced Health Research and Translation Centres (AHRTCs) that excel in research and the translation of evidence into excellent patient care, and demonstrate a strong research and translation focus in the education of health professionals, at an international level. These Centres are:

- Alfred Health and Monash Health and Partners Advanced Health Research and Translation Centre
- Melbourne Health Care Partners Advanced Health Research and Translation Centre
- South Australian Advanced Health Research and Translation Centre
- Sydney Health Partners Advanced Health Research and Translation Centre.

On 16 September 2016 NHMRC invited further applications for recognition as an NHMRC AHRTC. Also opened at this time are applications for recognition as a Centre for Innovation in Regional Health. The aim of the Centre for Innovation in Regional Health (CIRH) initiative is to encourage leadership in health research and translation of direct relevance and benefit to regional and remote areas of Australia.

Submissions to both schemes will close on 6 December 2016 and further details about the call can be found at https://www.nhmrc.gov.au/_files_nhmrc/file/research/ahrtc/ahrtc_call_for_submissions_2016_0.pdf.
Research Translation Symposium
This year’s NHMRC Symposium on Research Translation will be held in Melbourne on 23 November 2016. Registrations have reached 330. The theme for this year’s symposium is "Embedding research into health care: building a culture of quality”. The symposium aims to inspire, influence and engender a culture in health care that focuses on quality, underpinned by strong research evidence. The four NHMRC Advanced Health Research and Translation Centres will present on how they are delivering this in their various jurisdictions and areas of need.

A detailed program, registration details and plenary speaker profiles are now online at http://www.nhmrc2016.com/.

Medical Research Future Fund
Following nationwide public consultations and a call for submissions, the Australian Medical Research Advisory Board (AMRAB) is close to completing the first 5-year Strategy and 2-year Priorities for delivery to the Minister for Health and Aged Care.

This work is guided by the Medical Research Future Fund Act 2015, which sets out the rules for the development of the Strategy and Priorities by AMRAB. The Strategy and Priorities will inform decisions made by the Government on program level funding from the MRFF. The NHMRC CEO is an ex officio member of AMRAB.

A new priority-setting framework for Targeted Calls for Research
NHMRC has implemented the revised Identification and Prioritisation framework for Targeted Calls for Research (TCRs) (see framework on https://www.nhmrc.gov.au/grants-funding/apply-funding/targeted-and-urgent-calls-research). The framework provides NHMRC with a mechanism to respond to emerging research needs and to prioritise potential calls according to relative need and impact.

The Australian Health Ministers’ Advisory Council previously agreed to develop a process through a working party for identifying national research priorities. Following on from this agreement, ONHMRC has written to Directors-General of State and Territory Health Departments seeking nominations to participate in this working committee. It is anticipated the committee would meet bi-annually, in March and October of each year, to coincide with Research Committee and Council meetings.

Australian Code for the Responsible Conduct of Research
NHMRC, in partnership with the Australian Research Council and Universities Australia, is leading a major overhaul of the Australian Code for the Responsible Conduct of Research (the Code), which provides guidance to Australian universities and other research organisations on ethical research conduct and the management of allegations of misconduct.

Following extensive consultation with the research sector in 2015 and 2016, the new Code will outline the principles of responsible research conduct and the responsibilities of institutions and researchers, supported by a series of guides and reference material that
provide advice about implementation. The new Code and Guides are expected to be released in the second half of 2017.

**NHMRC Annual Report 2015-2016**


**Public consultations**

**Draft Chapter 3.6: Xenotransplantation of the National Statement on Ethical Conduct in Human Research**
Closed 8 June 2016

**Public consultation on the Structural Review of NHMRC’s Grant Program**
Closed 25 August 2016

**Targeted Call for Research - public call for research priorities in Aboriginal and Torres Strait Islander health**
Closed 4 September 2016

**Consultation on the draft NHMRC Report on the Evidence: Parenting/caregiving practices and behaviours to promote the social and emotional development and wellbeing of infants**
Closed 4 September 2016

**Draft NHMRC Information Paper: Effects of water fluoridation on dental and other health outcomes**
Closing 13 October 2016

**Australian Drinking Water Guidelines: Draft framework on microbial health based targets**
Closing 4 November 2016

**Australian Drinking Water Guidelines: Draft fact sheet on lanthanum**
Closing 4 November 2016
## Outcomes announced for the 2016 NHMRC application round

<table>
<thead>
<tr>
<th>Date</th>
<th>Grant scheme</th>
<th>Applications</th>
<th>Awarded</th>
<th>Funded rate</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 July 2016</td>
<td>Partnership Projects - 3rd call for 2015</td>
<td>39</td>
<td>15</td>
<td>38.5%</td>
<td>$10,465,525</td>
</tr>
<tr>
<td></td>
<td>Preventing Obesity in 18-24 Year Olds</td>
<td>30</td>
<td>5</td>
<td>16.7%</td>
<td>$3,494,036</td>
</tr>
<tr>
<td></td>
<td>Centres of Research Excellence - Infectious Disease Emergency Response Research</td>
<td>2</td>
<td>1</td>
<td>50.0%</td>
<td>$4,996,416</td>
</tr>
<tr>
<td>19 October 2016</td>
<td>GACD - Prevention and Management of Chronic Lung Disease</td>
<td>10</td>
<td>3</td>
<td>30.0%</td>
<td>$4,933,454</td>
</tr>
<tr>
<td>27 October 2016</td>
<td>Centres of Research Excellence</td>
<td>102</td>
<td>16</td>
<td>15.7%</td>
<td>$42,441,453</td>
</tr>
<tr>
<td></td>
<td>Development Grants</td>
<td>104</td>
<td>20</td>
<td>19.2%</td>
<td>$12,124,425</td>
</tr>
<tr>
<td></td>
<td>Early Career Fellowships</td>
<td>490</td>
<td>118</td>
<td>24.1%</td>
<td>$38,369,110</td>
</tr>
<tr>
<td></td>
<td>Equipment Grant</td>
<td>46</td>
<td></td>
<td></td>
<td>$5,700,000</td>
</tr>
<tr>
<td></td>
<td>Independent MRI Infrastructure Grant</td>
<td>23</td>
<td></td>
<td></td>
<td>$29,450,665</td>
</tr>
<tr>
<td></td>
<td>Translational Research Projects for Improved Health Care</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>$397,000</td>
</tr>
<tr>
<td></td>
<td>Practitioner Fellowships</td>
<td>55</td>
<td>17</td>
<td>30.9%</td>
<td>$8,024,584</td>
</tr>
<tr>
<td></td>
<td>Research Fellowships</td>
<td>295</td>
<td>77</td>
<td>26.1%</td>
<td>$58,880,535</td>
</tr>
<tr>
<td><strong>Cumulative 2016</strong></td>
<td><strong>competitive grants total</strong></td>
<td><strong>344</strong></td>
<td></td>
<td></td>
<td><strong>$214,280,787</strong></td>
</tr>
</tbody>
</table>

1 July 2016, NHMRC media release  
19 October 2016, NHMRC media release  
27 October NHMRC media release
Policy positions, administrative documents and reports released

Structural Review of NHMRC’s Grant Program, Consultation Paper July 2016

Media releases, updates, speeches and presentations

Commonwealth Health Minister’s Award for Excellence in Health and Medical Research
10 June 2016

Infectious Disease Emergency Response Research funding
01 July 2016

Research Excellence Awards celebrate Australia’s strength in health and medical research
13 July 2016

Amendments to the Australian Immunisation Handbook (10th Edition)
10 August 2016

NHMRC-NIH BRAIN scheme - early notice of funding opportunity
15 September 2016

New AAHMS Fellows inducted
7 October 2016

NHMRC supports global research to reduce chronic lung diseases
19 October 2016

Notice to dispense with consultation requirements for minor amendments to Part C of the Ethical guidelines on the use of assisted reproductive technology in clinical practice and research
25 October 2016

Government invests a further $190 million in health and medical research including $10.6 million to support Aboriginal and Torres Strait Islander health research
27 October 2016

Some thoughts on grants announcements
31 October, 2016
Report

Medical Board of Australia and AHPRA report to the meeting of the CPMC on 10 November 2016

Revalidation

The Medical Board of Australia (the Board) is currently consulting on options for revalidation. The Board had asked its Expert Advisory Group (EAG), chaired by Professor Liz Farmer, for advice about what it should do to make sure that medical practitioners in Australia maintain and enhance their professional skills and knowledge and remain fit to practise medicine.

The interim report proposes a ‘two by two’ approach to revalidation in Australia:

- Two parts: Strengthened CPD + proactive identification and assessment of ‘at-risk’ and poorly performing practitioners.

The core features of the proposed approach are:

- Strengthened CPD: Evidence-based approaches to CPD best drive practice improvement and better patient healthcare outcomes. Strengthened CPD, developed in consultation with the profession and the community, is a recommended pillar for revalidation in Australia.
- Identifying and assessing at-risk and poorly performing practitioners: A small proportion of doctors in all countries are not performing to expected standards at any one time, or over time. Another group of practitioners is at risk of poor performance. Developing accurate and reliable ways to identify practitioners at risk of poor performance and remediating them early is critical, with considerable transformative potential to improve patient safety. It is equally critical to identify, assess and ensure there is effective remediation for practitioners who are already performing poorly.

The Board’s Consultative Committee – established to provide feedback on issues related to the introduction of revalidation in Australia – met in August, when Professor Farmer briefed members on the work of the EAG. Organisations represented on the Consultative Committee, which is chaired by Medical Board Chair, Dr Joanna Flynn AM, include the CPMC, the Australian Medical Council, the Australian Medical Association, Medical Deans Australia and New Zealand, the Health Workforce Principal Committee of the Australian Health Ministers’ Advisory Committee, AHPRA, the Medical Council of New South Wales, health complaints entities, pre-vocational training organisations and professional indemnity insurers. There are also community representatives.

The Committee will next meet in December 2016 when it will discuss the themes of the feedback from the consultation and provide any additional advice. After reviewing all the feedback, the EAG will provide its final report to the Board in 2017, which will include options for piloting proposed approaches to revalidation. The Board will then make a decision about future directions. The Consultative Committee is one element of the Board’s consultation. As well, the Board Chair and the EAG Chair (or a member of the EAG) have met with college representatives in August and September 2016. College representatives have also been invited to attend stakeholder forums being held in every state and territory in November. The Board will continue to seek CPMC’s input as this work progresses.
Social research

Earlier this year, the Board commissioned social research to find out what the profession and the community expect that medical practitioners should do to demonstrate ongoing competence and fitness to practise.

The survey was sent to 15,000 randomly selected registered medical practitioners. More than 3,000 doctors took the time to respond and share their ideas about how doctors should build trust with their patients and what doctors need to do to show that they are competent and fit to practise medicine.

The Board also sought the views of 1,000 members of the community about the same issues. The surveys were conducted by an independent agency commissioned by the Board, and the report (with de-identified results) will be published shortly. The report will help further inform the EAG’s recommendations and the Board’s decision-making.

Specialist college specialist pathway data

The Board has recently published data on the specialist pathway from specialist medical colleges.

Since 1 July 2014, colleges have reported their specialist pathway activity directly to the Board. Reporting is annual by calendar year. The Board has published the data from the first full calendar year of reporting (1 January – 31 December 2015). The first report is available on the Board’s website.

The Board appreciates the colleges’ assistance collating the data so it can be published, in the interests of transparency and accountability.

Specialist college performance benchmarks

Following a recommendation made in the Snowball review of the National Registration and Accreditation Scheme, the Medical Board is now required ‘to evaluate and report on the performance of specialist colleges in applying standard assessments of international medical graduate applications and apply benchmarks for timeframes for completion of assessments’.

The Board consulted with colleges about how performance could be measured and in June 2016 the Board advised colleges of the finalised benchmarks and compliance measures. Colleges will report against these in the next specialist pathway data report which will cover the 2016 period.

The Board will also commission an independent review of each college’s specialist assessment process and performance, looking at the time taken to complete assessments and how the college’s processes comply with the Good practice guidelines for the specialist international medical graduate assessment process. This review will start in 2017, acknowledging that the performance benchmarks were finalised midway through the 2016 reporting period.

Independent review of accreditation systems

The Australian Health Ministerial Workforce Council (AHWMC) has appointed Professor Michael Woods to undertake the independent review of accreditation systems under the National Registration and Accreditation Scheme. Professor Woods is Professor of Health Economics in the Centre for Health Economics Research and Evaluation at the University of Technology Sydney.

The accreditation systems review will provide the further advice requested by the Ministerial Council following the recommendations of the independent review of NRAS.

The terms of reference for this review include:

- cost effectiveness of the regime for delivering the accreditation functions
- governance structures including reporting arrangements
- opportunities for the streamlining of accreditation including consideration of the other educational accreditation processes
- the extent to which accreditation arrangements support educational innovation
- opportunities for increasing consistency and collaboration across professions.
The report of the review is due at the end of 2017. More information is available in the AHWMC communiqué.

**Doctors’ health programs**

Expanded doctors’ health services are now available to doctors and medical students in most states and territories, through the Board’s partnership with the Australian Medical Association (AMA). The AMA administers the health programs at arms’ length from the Board and AHPRA, through the AMA’s subsidiary company, Doctors’ Health Services Pty Ltd (DrHS).

Victoria and Tasmania joined the national network in July this year with services in these states provided through the Victorian Doctors’ Health Program (VDHP). Expanded services commenced for Queensland, New South Wales, South Australia, the Australian Capital Territory, and the Northern Territory earlier this year. Arrangements for services in Western Australia are being finalised.

The services are nationally consistent and available to doctors and medical students across all states and territories. The scope of services provided around the country is comprehensive and includes:

- confidential health-related triage
- advice and referral services
- follow-up services for medical practitioners and medical students who need it, including support and advocacy in returning to work
- education, awareness-raising and advice about health issues for medical practitioners and medical students
- training to support doctors to treat other doctors, and
- facilitation of support groups for medical practitioners and students with significant health problems.

**Revised registration standards now in operation**

The revised registration standards for recency of practice and continuing professional development (CPD) came into effect on 1 October 2016.

To meet the revised recency of practice standard, all registered medical practitioners must now practise a minimum number of hours.

To meet the standard, medical practitioners must practise within their scope of practice, at any time, for a minimum total of:

- four weeks full-time equivalent in one registration period, which is a total of 152 hours, or
- 12 weeks full-time equivalent over three consecutive registration periods, which is a total of 456 hours.

Full-time equivalent is 38 hours per week. The maximum number of hours that can be counted per week is 38 hours. Medical practitioners who work part-time must complete the same minimum number of hours of practice – this can be completed part-time.

Most practitioners who are currently practising will meet the revised standard. The definition of practice is broad and includes both clinical and non-clinical roles in medicine. The standard also allows medical practitioners to meet the minimum hours of practice over a three-year period, so medical practitioners don’t need to work a set number of hours per week or every year to meet the standard.

The revised continuing professional development registration standard has not changed significantly. All registered medical practitioners must continue to participate in regular CPD activities.

Medical practitioners with specialist registration must continue to meet the requirements set out by their relevant college. Medical practitioners with general registration (who do not have specialist registration) must continue to complete a minimum of 50 hours CPD per year.
For medical practitioners with provisional registration or limited registration, the standard more clearly sets out the requirements to ensure their CPD is linked to their training position and/or supervision plan. International medical graduates must now complete a minimum of 50 hours CPD per year.

The revised registration standard for professional indemnity insurance came into effect on 1 January 2016.

Revised limited registration standards and new guidelines for short term training

The Board’s revised registration standards for the four types of limited registration came into effect on 1 July 2016.

The Board also published Guidelines: Short-term training in a medical specialty for international medical graduates who are not qualified for general or specialist registration which came into effect on 1 July 2016.

The guidelines complement the revised registration standard for limited registration for postgraduate training or supervised practice. Both documents define the eligibility criteria for registration for IMGs seeking short-term specialised training in Australia.

Review of the specialist registration standard

Earlier this year, the Board consulted publicly on the revised registration standard for specialist registration.

This standard sets out the Board’s requirements for granting specialist registration. The Board did not propose any significant changes to the current requirements for specialist registration. The changes to the current standard are mostly editorial, restructuring and rewording the standard to make it easier to read and clarify current requirements.

The Board received submissions from colleges, other organisations and individual practitioners. The Board will now finalise the standard for approval by the Australian Health Workforce Ministerial Council.

The Board appreciates the time taken by colleges to review and provide comments on the standard.

At the same time, the Board consulted on the registration standard for granting general registration to medical practitioners in the standard pathway who hold an AMC certificate. This standard will also be finalised and referred for approval by the Ministerial Council.

Further updates will be provided to CPMC as these revisions to the standards are progressed.

Cosmetic surgery guidelines

The Board’s new Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures came into effect on 1 October 2016.

The Board has published guidelines that apply to all medical practitioners, including specialist plastic surgeons, cosmetic surgeons and cosmetic physicians, regardless of their qualifications, to help ensure that all medical practitioners practise within their skill and ability and provide safe care to patients who seek cosmetic procedures.

The Guidelines include:

- a seven-day cooling-off period for all adults before major procedures
- a three-month cooling-off period before major procedures for all under 18s and a mandatory evaluation by a registered psychologist, general practitioner or psychiatrist
- a seven-day cooling-off period before minor procedures for all under 18s, and when clinically indicated, evaluation by a registered psychologist, general practitioner or psychiatrist
• a requirement for the treating medical practitioner to take explicit responsibility for post-operative patient care and for making sure there are emergency facilities when they are using sedation, anaesthesia or analgesia

• a mandatory consultation before a medical practitioner prescribes schedule 4 (prescription only) cosmetic injectables, either in person or by video consultation, and

• explicit guidance on patient assessment and informed consent, and a requirement for doctors to provide clear information to consumers about risks and possible complications and costs.

Renewal of registration for 2015/16

Medical practitioners with general, specialist or non-practising registration were due to renew their registration by 30 September 2016.

At the end of September, 88.5% of medical practitioners had renewed on time and 98.8% of those had renewed online. The registration fee for medical practitioners for 2016/17 is $724 (the same amount as last year).

Medical practitioners who had not renewed by 30 September had a further month to apply to renew their registration but were required to pay a late fee. Data on the number of late renewal applications are not yet available.

This year we added an extra step to the renewal process, to help make sure that the details we publish on the online national register of practitioners are accurate and complete.

When medical practitioners applied to renew their registration, they were asked to check that their qualification(s) were recorded correctly and were complete. Where they were not accurate, we asked practitioners to provide us with the updated information. For those practitioners with specialist registration, we asked them about how they became eligible for specialist registration.

For example, they may have:

• been awarded Fellowship by an accredited specialist medical college

• a specialist qualification from overseas which was recognised by an accredited specialist medical college, or

• transitioned into the National Scheme from a state or territory medical board with specialist registration.

Under section 225(n) of the National Law, the national register includes details of any qualifications that a practitioner relied on to obtain their registration. Before July 2010, previous state and territory medical boards may have recorded other qualifications, diplomas and memberships, some of which may have been published on the national register. Now, any qualifications that did not lead to registration as a medical practitioner are no longer published on the national register.

IAMRA 2016

In Melbourne in September, the Medical Board and AHPRA hosted the International Association of Medical Regulatory Authorities (IAMRA) 12th International conference on medical regulation.

The theme was ‘Medical regulation – making a difference’. The Board and AHPRA were delighted that more than 500 people from 42 countries attended. The conference program was diverse with many thought provoking speakers and many interesting ideas shared. Feedback from attendees was very positive.

The Board and AHPRA appreciate the members and representatives from the colleges who attended and contributed to the success of the conference.

IPAC conference

The International Physician Assessment Coalition (IPAC) conference was also held in September in conjunction with the IAMRA conference.
The purpose of IPAC is to provide a forum for the development and sharing of new concepts and new approaches in performance assessment of physicians.

IPAC was also very successful with more than 70 people from a range of countries attending to present and discuss physician assessment.

**Inquiry into Queensland OHO**

In June 2016, a committee of the Queensland Parliament decided to conduct an inquiry into the performance of the Health Ombudsman’s functions pursuant to section 179 of the *Health Ombudsman Act 2013*. Issues that the committee is considering include:

- the operation of the health service complaints management system
- ways in which the health service complaints management system might be improved
- the performance by the health ombudsman of the health ombudsman’s functions under the *Health Ombudsman Act 2013*
- review the National Boards’ and AHPRA’s performance of their functions relating to the health, conduct and performance of registered health practitioners who provide health services in Queensland, and
- any other matter about the health service complaints management system.

AHPRA and the 14 National Boards made a joint written submission to the inquiry. AHPRA CEO Martin Fletcher appeared before the committee in October, along with Dr Susan O’Dwyer, a practitioner member of the Queensland Board of the Medical Board of Australia and Ms Tracey Stenzel, the Acting Queensland State Manager, AHPRA.

Submissions have now closed and the hearings have concluded. The final report is due on the 2 December 2016. The submissions are available on the [Queensland Parliament webpage](http://www.legislation.qld.gov.au/).

**Senate inquiries re-adopted by new parliament**

Two Senate inquiries that had previously lapsed with the dissolution of the Senate and the House of Representatives for the July federal election have now been re-adopted by the new Senate.

The Senate inquiry into the ‘Medical complaints process in Australia’, focusing on the Medical Board of Australia and the Australian Health Practitioner Regulation Agency, is due to report on 16 November 2016.

The Senate Standing Committees on Community Affairs inquiry into ‘The growing evidence of an emerging tick-borne disease that causes a Lyme-like illness for many Australian patients’ is due to report on 30 November 2016.

**Dr Joanna Flynn AM**

28 October 2016
Implementation of the National Safety and Quality Health Service Standards

In 2016 there are 891 health service organisations in Australia scheduled to be assessed to the National Safety and Quality Health Service (NSQHS) Standards. From January to August 2016, 421 health service organisations were assessed, of which:

- 188 (45%) were assessed to all 10 NSQHS Standards
- 211 (50%) were assessed to Standards 1 to 3
- 22 (5%) new health service organisations were established and undertook an interim assessment
- 74% of all health service organisations met the core requirements of the NSQHS Standards at initial assessment. For comparison, in 2015, 86% met all the core requirements at initial assessment.

Update on version 2 of the NSQHS Standards

Consultation on version 2 of the NSQHS Standards is complete. The number of standards in the final draft of version 2 of the NSQHS Standards has been reduced from 10 to 8, and the number of actions has been reduced from 256 to 148. Approximately 65% of the content aligns with version 1 of the NSQHS Standards, and 35% is new content.

The eight standards in version 2 of the NSQHS Standards are:
- Clinical Governance for Health Service Organisations Standard
- Partnering with Consumers Standard
- Preventing and Controlling Healthcare-Associated Infection Standard
- Medication Safety Standard
- Comprehensive Care Standard
- Communicating for Safety Standard
- Blood Management Standard
- Recognising and Responding to Acute Deterioration Standard

Three Standards from version 1 are no longer separate standards. Key actions from the Patient Identification and Procedure Matching, Preventing and Managing Pressure Injuries and Preventing Fall and Harm from Falls Standards have been incorporated into the eight standards that make up version 2. One new standard has been added: Comprehensive Care.

Version 2 of the NSQHS Standards has been improved by:
- reducing duplication in version 1 of the NSQHS Standards
- addressing safety gaps in cognitive impairment, mental health, end-of-life care, and care of Aboriginal and Torres Strait Islander people
- incorporating content relating to new and emerging safety and quality issues
- updating the evidence base
- adapting and clarifying the language to improve the applicability of the NSQHS Standards to a broader range of health service organisations
- identifying who has primary responsibility for implementing each of the actions in the NSQHS Standards
- improving navigation of the NSQHS Standards document through changes in format.
Version 2 of the NSQHS Standards has been endorsed by the Commission’s Board and will be considered by the Australian Health Ministers’ Advisory Council (AHMAC) at their meeting on 2 December 2016, before being forwarded to the Council of Australian Governments (COAG) Health Council for endorsement in early 2017. Version 2 of the NSQHS Standards and supporting resources are scheduled to be released in November 2017, with implementation to commence from January 2019.

**Australian atlases of healthcare variation**

**Development of the second Atlas**
The second *Australian atlas of healthcare variation* (the second Atlas) is in development and will be published in early 2017. The second Atlas is part of a program of work to map geographical variation in healthcare use across Australia, identify variation that may be unwarranted and recommend actions to reduce unwarranted variation.

The second Atlas will focus on acute hospital services and will include 22 items from the following clinical areas:
- potentially preventable hospitalisations
- maternity and women’s health
- surgery
- cardiovascular conditions; and
- intensive care

Variation for each item will be presented in maps and figures, and data analysis will show variation by socioeconomic disadvantage and remoteness. New for the Atlas, analysis by Aboriginal and Torres Strait Islander status and public/private patient classification will be presented where possible. Analysis and commentary for each data item is currently being developed in collaboration with topic expert groups from the five clinical areas.

As for the first Atlas, development of the second Atlas is being guided by a Jurisdictional Advisory Group and an Atlas Advisory Group. The Atlas Advisory Group is chaired by Professor Anne Duggan and has representation from a number of clinical colleges.

Prior to publication of the second Atlas, Professor Anne Duggan and Commission staff will be visiting colleges and presenting the findings and analysis for discussion.

**Implementation of recommendations from the first Atlas**
The Commission has developed an implementation strategy for recommendations from the first Atlas, which was noted by AHMAC out of session in May 2016.

**Interactive first Atlas**
An interactive online version of the first Atlas has been developed to build on the existing online format. The interactive form will go live in early November 2016 and will allow users to manipulate the maps, including zooming and panning, and to interrogate the data behind the map in various ways, such as downloading or exporting open data in various formats.

**My Health Record clinical safety program**
The Commission has been appointed by the Australian Digital Health Agency to conduct a two-year clinical safety program for the My Health Record and associated national digital health infrastructure.

Under the Agreement, the Commission will undertake eight clinical safety reviews, and four pooled analyses of issues with potential clinical safety implications between 2016 and 2018.

The first four clinical safety reviews will analyse the presentation of clinical documents in the My Health Record, uptake of standard terminologies to improve allergies and adverse drug
reaction functionality, outages of the My Health Record system, and the current clinical functional assurance testing approach.

The Commission operates a round-the-clock clinical incident management unit for the My Health Record system and will continue to provide expert advice on the development and safety of new My Health Record System functionality.

**Clinical Care Standards**

**Launch of the Delirium Clinical Care Standard and Hip Fracture Care Clinical Care Standard**

The Commission has recently completed Clinical Care Standards for Delirium and Hip Fracture Care, with public launches on 15 July and 13 September 2016 respectively.

The Delirium Clinical Care Standard aims to improve the prevention of delirium in patients at risk and improve early diagnosis and treatment in order to reduce the severity and duration of delirium. It applies from presentation to hospital through to transition to primary care.

The Hip Fracture Care Clinical Care Standard aims to improve the assessment and management of patients with a hip fracture and to optimise outcomes and reduce risks of another fracture. The target age is 50 years and over, but also applies to patients under 50 with a suspected hip fracture due to osteoporosis or osteopenia. It applies from presentation to hospital through to completion of treatment in hospital.


**Clinical care standards in development**

The Osteoarthritis of the Knee Clinical Care Standard is being finalised for release in 2017 following a broad public consultation in July 2016. This clinical care standard aims to ensure that patients aged 45 years and over with knee pain that are suspected of having osteoarthritis receive optimal treatment. It applies to all healthcare settings where care is provided to patients with knee osteoarthritis.

The Heavy Menstrual Bleeding Clinical Care Standard commenced development with a topic working group in July 2016. A broad public consultation is planned for late 2016 / early 2017. The draft aim of the clinical care standard is to ensure that women with heavy menstrual bleeding are offered the least invasive, most effective treatment appropriate to their clinical needs. The draft scope identifies that the clinical care standard is applicable in primary care, and gynaecology clinics.

**Shared Decision Making**

**Online training module on risk communication for clinicians**

The Commission is developing two versions of a two-hour online training module for clinicians which addresses statistical and communication principles required for effective risk communication. The module, entitled *Helping patients make informed decisions: communicating benefits and harms*, includes clinical examples relevant to clinical colleges, clinical care standards and items in the *Australian atlas of healthcare variation*.

The first version of the module was developed in partnership with the Royal Australian College of General Practitioners (RACGP) and was released on the gplearning platform on 1 July 2016. The module has been fully accredited by the RACGP and is available for use both by trainees and qualified general practitioners as part of their continuing professional development programs.

The second version of the module is currently under development, in collaboration with Royal Australasian College of Physicians, Royal Australasian College of Surgeons (RACS), Royal
Development and implementation of patient decision aids
The Commission is developing a series of patient decision aids (PDAs) in priority areas related to the Australian atlases of healthcare variation and clinical care standards. The PDAs will support consumers to better understand their health care choices and promote appropriateness of care.

The PDAs are designed to be used by clinicians together with consumers to support shared decision making in the clinical encounter. They present high quality, synthesised evidence about particular conditions or treatments, compare the benefits and harms of each treatment option and assist consumers to clarify what matters most to them.

In late 2016, the Commission will release its first PDAs which are on antibiotic use for middle ear infection, sore throat and acute bronchitis. The PDAs have been developed in conjunction with international experts in shared decision making from Bond University and have been piloted with consumers and clinicians for use in general practice. Further information about the release of the PDAs will be provided to clinical colleges in November 2016.

The Commission has also commenced work on PDAs on osteoarthritis of the knee and heavy menstrual bleeding for release in 2017.

Resources for patient-clinician communication at transition of care
Effective patient-clinician communication is an important aspect of ensuring safe delivery of care and has been shown to positively influence patient care outcomes. In particular, engaging patients in communication at transitions of care is critical to ensuring that information transferred is current, up to date and reflects the patient’s preferences and needs.

The Commission has developed resources to support improving patient-clinician communication at transitions of care in acute settings with support from the Commission’s Clinical Communications Advisory Group. The resources were informed by two research reviews which were commissioned to gain a better understanding of the evidence on patient-clinician communication, and to identify existing strategies, tools and resources to enable patient engagement in communication at transitions of care.


The resources include fact sheets for senior executives and clinical leaders, healthcare providers, consumers and two consumer posters.

These resources will form one part of the package of resources that will be developed to support implementation of version 2 of the NSQHS Standards. Version 2 of the NSQHS require health service organisations to support patients, families and carers to be involved in transitions of care and to act as partners in their own care.

Antimicrobial Use and Resistance in Australia (AURA) Project
The First Australian Report on Antimicrobial Use and Resistance in Human Health
The Report brings together work undertaken by the Commission and its partner passive and targeted surveillance programs for antimicrobial use and resistance. These include the National Antimicrobial Utilisation Surveillance Program (NAUSP); the National Antimicrobial Prescribing Survey (NAPS) and the Australian Group on Antimicrobial Resistance (AGAR). It also includes data from other sources such as the Pharmaceutical Benefits Scheme and NPS MedicineWise.


Appropriateness of prescribing of antimicrobials for surgical prophylaxis was identified as an issue for improvement. The Commission has commenced discussion with the RACS regarding strategies to improve prescribing. The Commission has also supported the National Centre for Antimicrobial Stewardship to implement a Surgical NAPS to obtain data which will assist health facilities’ and surgeons’ understanding of the stewardship of antimicrobials used for surgical procedures and inform resource development.

**National Alert System for Critical Antimicrobial Resistances (CARAlert)**

CARAlert is a new program which was established by the Commission in March 2016 to provide more timely advice on critical antimicrobial resistances (CARs) confirmed in Australia.

CARs are resistance mechanisms, or profiles, known to be a serious threat to the effectiveness of last-line antimicrobial agents. They can result in significant morbidity and mortality in healthcare facilities and in the community. The CARs which are currently monitored by the CARAlert system are:

- Enterobacteriaceae - carbapenemase-producing strains and ribosomal methylase-producing strains
- Enterococcus species - linezolid non-susceptible
- Mycobacterium tuberculosis - multi-drug resistant at least rifampicin and isoniazid resistant strains
- Neisseria gonorrhoeae - ceftriaxone non-susceptible or azithromycin resistant strains
- Salmonella species - ceftriaxone non-susceptible strains
- Shigella species - multi-drug resistant strains
- Staphylococcus aureus - vancomycin, linezolid or daptomycin non-susceptible
- Streptococcus pyogenes - penicillin reduced susceptibility

Laboratories follow a structured process to confirm and report the presence of CARs via a secure web portal. The alert element of the system ensures timely communication of CARs to each state and territory health department.

On 19 October 2016 enhancements to the system were activated to enable authorised state and territory nominees to access the CARAlert database to view records for their jurisdiction, including the name of the public hospital to which a patient was admitted when the isolate was originally collected; and weekly digest email reports commenced in place of SMS messages each time a CAR was reported. The enhancements were introduced in response to feedback from states and territories about the utility and content of SMS alerts.

A planned review of the first six months of operation of the system was conducted in October 2016. Analysis of the responses is in progress. Jurisdictions, originating laboratories and confirming laboratories have been invited to complete a survey to provide feedback.

Over time, the Commission will produce reports showing the number and types of CARs reported at the national level.
Collaboration with Independent Hospital Pricing Authority

Ministerial direction to the Independent Hospital Pricing Authority (IHPA)

On 29 August 2016, the Australian Government Minister for Health made a ministerial direction to IHPA about the performance of its functions under section 226 of the National Health Reform Act 2011.

Under the direction, IHPA must advise the Commonwealth, states and territories (the Parties) on an option or options for:

a) “a comprehensive and risk-adjusted model to determine how funding and pricing can be used to improve patient outcomes and reduce the amount the Commonwealth pays for sentinel events, and a set of preventable hospital acquired conditions, defined by the Australian Commission on Safety and Quality in Health Care and agreed by the Parties, that occur in public hospitals; and

b) a comprehensive and risk-adjusted strategy and funding model to reduce avoidable readmissions to hospital that will adjust the funding to hospitals that exceed a predetermined avoidable readmission rate for an agreed set of conditions and the circumstances in which they occur.”

The Commission's Heads of Agreement work

The Commission is currently leading the following aspects of this work:

i. hospital acquired complications (HACs) list curation, clinical engagement, supporting resources and tools
ii. readmissions – data analysis, providing advice on clinical safety and quality aspects
iii. sentinel events – review of current sentinel events list
iv. clinical considerations around risk-adjustment

Timeframes

The timeframes for the heads of agreement work:

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 July 2017</td>
<td>Model developed for sentinel events, HACs, risk adjustment, readmissions</td>
</tr>
<tr>
<td>1 July 2018</td>
<td>Implement a model for an agreed set of preventable HACs with a preceding shadow year</td>
</tr>
</tbody>
</table>
CPMC Report
November 2016

Medical Schools Outcomes Database National Data Report 2016

Medical Deans recently released the second Medical Schools Outcomes Database (MSOD) National Data Report. The MSOD collects demographic, education and career intentions data on medical students. The information is obtained via an annual questionnaire issued to final year medical students.

The National Data Report found that:

- over 83% of medical graduates are interested in becoming involved in teaching;
- 62% of final year medical graduates are interested in research;
- there has been an increase in those for whom the financial benefits of being a doctor has no impact on their preferred area of medicine as a career;
- the number of graduates who have a partner has increased from nearly 41% in 2011 to 49% in 2015;
- In 2015 36.5% of medical graduates indicated their first preference region of future practice was outside a capital city compared to 32% in 2011. In 2015 over 18% nominated a major urban centre such as Wollongong, Geelong, Cairns or Gosford, 12% a regional city or large town and 6% a smaller town or community.

The report demonstrates a consistently high percentage of final year medical graduates interested in teaching and/or research. Clinical academics are crucial in developing the next generation of doctors and a key challenge for policy makers is to convert the interest medical graduates have in teaching and research into a career choice.


Regional and Rural Issues

Medical Deans welcomes the release of the Expression of Interest for the Regional Training Hubs by the Australian Government. Assistant Minister for Rural Health, Dr David Gillespie recently announced the request for proposals with up to 30 regional training hubs to be established at existing rural clinical schools and university departments of rural health sites. Medical Deans have long advocated for a “flipped” model of joined up, regionally based, specialist training with a city rotation, particularly in general practice and general specialisations, to address medical workforce maldistribution. This would provide greater opportunities for young doctors to undertake specialist training in regional and rural areas and build on the substantial investment in rural clinical schools and UDRH. Medical Deans see great potential for the Regional Training Hubs to strengthen regional training networks, articulate with existing tertiary infrastructure and support viable post graduate training programmes. We look forward to working with the Government on this important initiative.

Independent Review of Accreditation Systems

The Australian Health Ministers Council (AHMAC) has recently announced the appointment of Professor Mike Woods as the Independent Reviewer for the Review of Accreditation Systems under the National Registration and Accreditation Scheme. AHMAC have advised the terms of reference include cost
effectiveness, governance structures, opportunities for streamlining accreditation, the extent to which accreditation arrangements support innovation and opportunities for consistency and collaboration across professions. Medical Deans made a submission to the earlier review of NRAS and will also engage closely with this important process.

**Intern Work Readiness**

A forum on Intern Work Readiness was recently co-hosted by the Health Workforce Principal Committee and Medical Deans. The forum was convened to further consider the Review of Medical Intern Training Report’s recommendation on intern work readiness. The forum brought together key stakeholders including representatives of medical schools, Commonwealth, State and Territory health departments, post graduate medical councils, doctors in training, the Australian Medical Council and the Medical Board of Australia. The forum included presentations from Dr Anne Marie Feyer on the Findings of the Review, and feedback from intern and supervisor surveys. A subcommittee on the Review of Medical Intern Training Work Readiness has been established to continue to progress work in this area.

**Leaders in Indigenous Medical Education (LIME) Network Update**

The LIME Network recently received international recognition by being awarded the ASPIRE Award for Excellence in Social Accountability. The ASPIRE Award is developed under the auspices of the Association for Medical Education in Europe (AMEE) and recognises medical, dental and veterinary schools that excel in assessment of students, student engagement, social accountability of the school and faculty development. This is the first time the international award has been presented to a program representing a collective of schools. The reviewers said the LIME Network was “an impressive bi-national initiative with a focus on a topic of national (and indeed) global priority, within a clear construct of social accountability. Key outcomes and impact have been and continue to be achieved, through a model that is inclusive, participatory and community oriented.” The award was presented at the AMEE Conference in Barcelona.

The LIME Connection: The Future of Indigenous Health Education: Leadership, Collaboration and Curriculum takes place in Melbourne, 4 – 7 April 2017. Further information can be found through the following link: [http://us3.campaign-archive2.com/?u=198604a33aa48629f42c802fb&id=a170bff4bf&e=d8ba159ba7](http://us3.campaign-archive2.com/?u=198604a33aa48629f42c802fb&id=a170bff4bf&e=d8ba159ba7)

**Medical Deans Annual Conference**

Medical Deans recently held its annual conference hosted by the University of Wollongong with medical educators and stakeholders coming together to discuss important issues in medical education and research.

Key sessions included:

- Research Challenges: Funding, Impact and Supporting Clinical Academic Pathways
- Increasing the Number of Indigenous Doctors
- The Impact of Technology on Medical Education
- The Development of a Teaching and Training Classification by IHPA

The conference also included an Indigenous Knowledge Initiative which focused on how medical education can contribute to improved health outcomes for Indigenous people. Thank you to everyone who participated and/or presented at the Conference and helped make it a success.

Professor Nicholas Glasgow  
President, Medical Deans

Ms Carmel Tebbutt  
CEO, Medical Deans
3.1 Presentation on Doctors Health by Dr Jenny Alexander

Jennifer was the Chief Executive Officer of the Royal Australasian College of Physicians from 2009 to 2014. In 2008 she was elected to the Council of the UNSW, and in 2014 as a Pro-Chancellor. She also served on the Board of Governors of the UNSW Alumni Association.

Jennifer’s previous roles have included CEO Australian Institute of Management (NSW & ACT), CEO Health Leaders Network (HLN), General Superintendent (CEO) of Westmead Hospital and Community Health Services and Medical Director and Deputy CEO (St. Vincent’s Hospital, Sydney). She has also undertaken numerous consulting assignments in the areas of strategy, leadership and organisational development, organisational change and institutional strengthening with experience in Australia, NZ, Asia, U.K., Europe and U.S.A.

She has previously been Chairman of the Board of Gondwana Choirs, served as a non-Executive Director on the Boards of the Health Insurance Commission, Medibank Private, Health Communication Network, the NSW Medical Board, Health Leaders Network, Westmead Hospital Research Institute, the Institute of Management (NSW & ACT, and nationally) and the Royal Australasian College of Medical Administrators, of which she was President.

Dr Alexander has been appointed to establish the Doctors Health Service which is funded by the Medical Board and the purpose of her presentation is to provide an update on the service for Colleges. It should be noted that she presented on preliminaries at the 18 August meeting of the CEOs.

Recommendation: That Directors note the presentation
COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES

Item 3.2 PRESENTATION FROM THE NATIONAL DIGITAL HEALTH AGENCY

The Australian Digital Health Agency was established on 1 July this year, an amalgamation of the National eHealth Transition Authority and parts of the Department of Health’s eHealth Branch.

One of their core roles is to work collaboratively with the public, clinicians, clinical representative groups, consumer advocacy organisations, researcher, industry and entrepreneurs to identify how Australia can best use data and technology to support the modernisation of health care.

The Agency is keen to consult widely and are now meeting with organisations until mid-December 2016.

Given this timeline CPMC has offered the agency an opportunity to present to the group. Part of the process is to invite CPMC to contribute to the development of the national digital health strategy 2017-2017 and the future of digital health in Australia.

Dr Monica Trujillo, Executive Manager, Clinical and Consumer Engagement and Clinical Governance will present to the group. Dr Monica Trujillo is responsible for leading clinical and consumer engagement ensuring consumer and clinician centred high quality and safety programs are developed across the Agency. Her role ensures the implementation of a strategic approach to consumer and clinical engagement, clinical governance, safety, system design, functionality and usability of products and services, and contributes to broader development goals by ensuring Australia has a safe and robust digital health system. Her approach to consumer engagement and patient experience provide valuable insight to the planning, design and implementation of the Agency’s work program.

Recommendation: Note the ADHA and presentation.
4.1 Report from CPMC Chair Professor Talley

Since the last meeting of CPMC advocacy statements as agreed by the Committee were produced and can be found at:

Revalidation: A Working Party was convened and the secretariat collated the issues and concerns from around the Colleges. A submission was lodged with the Medical Board and an offer to meet with the Chair, Dr Jo Flynn was made. She will discuss these issues and proposed next steps with CPMC today.

Indigenous: I met with the President of the Australian Indigenous Doctors Association at AIDA 2016 and discussed the major progress which has been occurring across Colleges in relation to supporting and growing the number of indigenous Fellows. The next steps in forming their common Collaborative Agreement Forum were also discussed and it was determined that the CEOs of both organisations would meet. As it is AIDA’s responsibility to then engage with the CPMEC and MDANZ, a report on progress is to be brought forward by the CEO at today’s meeting.

RACGP 2016: I attended the academic session and conference. I had fruitful meetings with the new President, and former President Dr Frank Jones concerning RACGP advocacy and engagement. RACGP 2016 was a successful congress and it notably had a lot of prominence in the press locally.

Renaming CPMC: The proposal to change the company name to Council of Presidents of Medical Colleges has progressed since the August meeting. Following unanimous support in a circular email, over these two months the CEO has worked with a legal adviser to re-construct the CPMC Constitution and make provision for all of the necessary governance and administrative changes that will likely be required. The new name will I suggest help position CPMC more effectively within the broader strategic environment and it also aligns with our colleagues in New Zealand. I plan on making a presentation to the Council of Medical Colleges meeting in Wellington, New Zealand in December on what CPMC has been doing and to launch our new name assuming it is approved today.

Discussions around a slogan have continued and will be discussed today and hopefully finalised. I have suggested “CPMC: the voice of medical colleges for the health of all Australians”. Others have suggested dropping “for the health of all Australians”.

Meeting with the Prime Minister: CPMC determined at its strategic planning forum that wider engagement with relevant stakeholders was only going to benefit the Colleges given the strong interaction between financing and health. At my request the CEO arranged the meeting with the Prime Minister on 24 October in the Sydney office, and liaised with the office concerning the range of issues able to be discussed to ensure maximum impact. Photos were posted to twitter and on the website. I will discuss the issues discussed in more depth verbally. A government relations day is locked in for Monday 21 November 2016 in Canberra where the Executive will meet with the Hon. Ken Wyatt, Senator Nick Xenophon, Senator Richard Di Natale, The Hon. Sussan Ley and The Hon. Catherine King.

CPMC National Health Summit on Obesity: The Summit took about six months to organise so as to ensure the experts in the field of policy concerning the crisis Australia faces in obesity could be present, in addition to government and College representatives. It was an exciting event for all the medical colleges and I will update you today.

CPMC meeting 10th November 2016 at the RANZCOG Melbourne
Rural Specialist Funding Agreement: I have written to you all regarding the SRSA and process. This will be further discussed today.

Thank you for your support
COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES

MINUTES

115th Meeting held at the Royal Australasian College of Physicians on Thursday 18 August 2016

1. Welcome and Apologies

Professor Talley opened the meeting as Chair, CPMC and acknowledged the traditional owners of the land upon which the meeting was held, the Eora Nation.

Professor Talley noted the following Directors were present:

- Professor Nicholas Talley, Chair, CPMC.
- Professor Charlie Corke, President, College of Intensive Care Medicine.
- Professor Anthony Lawler, President, Australasian College for Emergency Medicine.
- Professor Malcolm Hopwood, President the Royal Australia and New Zealand College of Psychiatrists.
- Professor Lucie Walters, President, Australian College for Rural and Remote Medicine.
- Dr Frank Jones, President, Royal Australian College of General Practitioners.
- Professor David A Scott, President, Australia and New Zealand College of Anaesthetists.
- Dr Michael Cleary, President, Royal Australasian College of Medical Administrators.

Professor Talley noted apologies had been received from the following Directors:

- Professor Michael Permezel, President, The Royal Australia and New Zealand College of Obstetricians and Gynaecologists.
- Professor Christopher Baker, President Australian College of Dermatology.
- Professor Phillip Truskett, President The Royal Australasian College of Surgeons.
- Professor Michael Harrison, President Royal College of Pathologists of Australasia.
- Professor Gregory Slater, President Royal Australia and New Zealand College of Radiologists.
- Dr Catherine Yelland, President The Royal Australasian College of Physicians.
- Dr Bradley Horsburgh, President Royal Australia and New Zealand College of Ophthalmology.
- Dr Adam Castricum, President the Australasian College of Sport and Exercise Physicians.

In attendance on behalf the Directors apologised above:

- Professor Mark Lane, President-elect, The Royal Australasian College of Physicians.
- Dr Bruce Latham, Vice-President, President Royal College of Pathologists of Australasia.
- Dr Hamish Osborne, Vice-President, Australasian College of Sport and Exercise Physicians.
- Dr Dion Forster, Chair, Faculty of Radiation Oncology, President Royal Australia and New Zealand College of Radiologists.

Also in attendance:

- Dr Bastian Seidel, President-elect, Royal Australian College of General Practitioners.
- Ms Angela Magarry, Company Secretary, Chief Executive, Committee of Presidents of Medical Colleges.

Professor Talley noted the College Chief Executives in attendance as follows:
Mr Allan Chapman, NSW Regional Manager, Royal Australasian College of Surgeons, on behalf of Professor David Hillis.
Dr Ronald Versteeg, Royal Australian College of General Practitioners on behalf of Dr Zena Burgess.
Ms Kate Simkovic, Chief Executive, The Australasian College of Sport and Exercise Physicians.
Ms Alana Killen, Chief Executive The Royal Australia and New Zealand College of Obstetricians and Gynaecologists.
Ms Sonja Cronje, on behalf of Ms Natalia Vukulovna, Royal Australia and New Zealand College of Radiology.
Mr David Andrews, Chief Executive Royal Australia and New Zealand College of Ophthalmology.
Mr Andrew Peters, Chief Executive Royal Australia and New Zealand College of Psychiatrists.
Mr John Ilott, Chief Executive The Australia and New Zealand College of Anaesthetists.
Mr Phillip Hart, Chief Executive College of Intensive Care Medicine of Australian and New Zealand.
Dr Peter White, Chief Executive Australasian College for Emergency Medicine.
Dr Debra Graves, Chief Executive Royal College of Pathologists, Australasia.
Ms Linda Smith, Chief Executive Royal Australasian College of Physicians.

Apologies had been tendered by the following College Chief Executives:

- Dr Karen Owen Royal Australasian College of Medical Administrators
- Mr Tim Willis, Australian College of Dermatology
- Ms Marita Cowie, Australian College for Rural and Remote Medicine

2.1 Chair Report

Professor Talley reported on the work he had undertaken between the June and current meeting. He reported on the meeting with Minister Sussan Ley, Federal Minister for Health, Aged Care and Sport as constructive with the issues discussed and also because of the outcome in relation to the approval of an extension to the Specialist Training Program. Professor Talley raised the opportunity for CPMC to write to the Minister offering the assistance of CPMC in progressing the review of STP to move it beyond the continual extension. Professor Talley noted the merit in advocating for a three year funding agreement to enable greater certainty in planning.

Professor David A Scott (ANZCA) raised the question of the direction of the program which Professor Talley indicated the Minister had confirmed the value of the STP for the broader education and training of specialists in the system.

Professor Lawler (ACEM) noted the disconnect between elements of the training pipeline and the STP is a factor in the continuum and therefore cannot be considered in isolation. Professor Lawler encouraged more attention be paid to working with the Medical Deans and jurisdictions in terms of the number and distribution of places. Professor Lawler noted the merit in an overarching strategy to address the disconnect in the training pipeline.

Professor Hopwood (RANZCP) noted that while individual negotiations occur with the Commonwealth to cater for differences in training capacity there is merit in constructing a three year plan however it should be recognised that there are differences in capacity amongst the disciplines.
Professor Walters (ACRRM) noted that given the challenges in attracting and retaining trainees in rural and regional areas, perhaps a five year plan should be considered to allow for the lead time required for proper training.

Dr Frank Jones (RACGP) noted the absence of a centralised plan and that there appears to be several sections involved in workforce planning in disparate areas of the Commonwealth Department of Health. The STP is therefore only one piece of workforce planning and he noted the horizontal integration with stakeholders, citing the work of the National Medical Training Advisory Network (NMTAN) as an example of helpful work but occurring in what appears to be isolation of other aspects of planning.

Professor Talley noted all the comments with the most effective approach to continue the ST program over a three year approach.

**Action:** CPMC to write to the Health Minister on the STP and offer assistance.

Professor Talley noted the issues raised with the Minister included the obesity summit, private health insurance review, medical fees and charges including excessive fees and that the issue of big data was a concern for the practice of medicine.

Professor Talley noted that the Executive would meet within the Parliamentary session and likely to be in November, given all the changes to the cross-benchers.

On the matter of workforce planning, it was agreed that the matter was a concern for College Presidents, and Professor Talley offered the opportunity for CPMC to take a lead on the matter of discussing the issues associated with managing the training pipeline. Professor Lawler (ACEM) undertook to provide a discussion paper to the next CPMC on the matter.

**Action:** Professor Lawler to work with the ACEM and CPMC to lodge a discussion paper to the 10 November meeting of CPMC on workforce planning issues

### 2.2 Minutes from the 114th Meeting of CPMC

With the amendment to clarify the name change for the Australasian College of Sport and Exercise Physicians, in addition to amending the Australasian College for Emergency Medicine title the Directors approved the minutes as circulated.

### 2.3 Chief Executive Officers Report

Directors noted the report as circulated and Ms Magarry was invited to flag any issues of relevance for the attention of Directors. Ms Magarry identified the positive progress having occurred with regards to the Support for Rural Specialists in Australia program and the National Health Summit on Obesity.

### 2.4 Change in Directors

The changes were noted by Directors as having been lodged with the Australian Securities and Investments Commission.

### 2.5 CPMC Executive Update

Directors noted the minutes from the 4 August 2016 meeting of the CPMC Executive and action items accordingly. Professor Talley advised Directors that the planned meeting of the Executive for Parliamentary business on 14 September in Canberra would have to be rescheduled due to time...
constraints by MPs and Senators. Ms Magarry to advise Executive of the decision and reschedule for the last Sitting Week of 2016.

**Action:** Reschedule the government relations day for the CPMC Executive

### 2.6 CPMC Audited Financial Statements

Directors noted the audited statements for the 2015-16 as circulated with the papers. Professor Talley and Dr Michael Cleary appointed as the two Directors for signing the audit.

Ms Magarry was asked about the separation of the Rural Health Continuing Education grant monies from the CPMC operating account and explained the requirements of the Commonwealth funding agreements whereby any surplus funds at the conclusion of the program would be returned to the Commonwealth. Ms Magarry also explained that while the surplus was included in the accounts the return of the funds would not impact on the operating position of $245,000 surplus for the company at the end of the financial year.

Ms Magarry advised that the three year financial and risk strategy implemented in 2013 had been achieved with the development of sufficient reserves to enable CPMC to operate for twelve months and pay all fixed costs. Professor Hopwood (RANZCP) enquired as to the 2016-17 projected financial position. Ms Magarry advised that in communication with the Chair the issue of financial reserves and budgeted activity for 2016-17 and beyond would be taken to the October meeting of the Executive and through to the November meeting because there had been increased engagement and consequential expenses along with the need to ensure that the company maintains sufficient reserves to mitigate against any known and unknown risk.

**Action:** Dr Cleary and Professor Talley to sign audited statements. Ms Magarry to lodge the issue of financial reserves and risk strategy on the CPMC Executive.

### 2.7 CPMC Financial Statements

The financial statements for the year ending 30 June 2016 were noted along with the financial position as at the end of July 2016 as follows:

- Main operating account: $141,250
- Maxi Interest account: $297,502
- Rural Grant: $985,116 (RHCE surplus of $230,266 to be returned following audit)

### 3 Ministerial Address

The Hon. Dr David Gillespie, Assistant Minister for Rural Health addressed the College President and Chief Executives highlighting the focus of the Commonwealth on rural health, the reform agenda more broadly and the intention to collaborate with Colleges. Minister Gillespie discussed the expectation that the government will proceed with the reform agenda and highlighted the recent announcements in funding Hepatitis C as examples of driving innovation through evidence based policy.

Professor David A Scott (ANZCA) enquired on whether the government was intending to support generalist training in Colleges through the STP. Minister Gillespie engaged in the discussion concerning the generalist training system. He also referred to the use of Rural Clinical Schools in terms of the resources available and training hubs which will be appointed to manage process.
Dr Frank Jones (RACGP) raised the concerns held by general practice in relation to the MBS freeze and the impact in particular on rural and regional medical practitioners who had begun to make decisions in relation viability of practices given the freeze. The Minister offered to take the matter to the Minister for Health.

Professor Hopwood (RANZCP) raised the issue of maldistribution of specialist in the Australian health system with particular reference to the psychiatry specialty and use of overseas trained doctors to fill areas of need and the issue of assuring quality of care. A short discussion occurred in relation to the topic, noting the preference of the government is to attract and retain suitably qualified medical specialists in rural and regional areas on a more permanent basis.

Professor Lawler (ACEM) raised the issue of the extension of the STP and whether the government had given any consideration to using the private sector for more training opportunities. There was a discussion about the business model of private health care and the desire by them to have more trainees but there was some resistance because of the need for supervision however the government was open to options for how that might happen. There was a discussion about the need for a cultural shift to provide more incentives to train doctors in a mixed public-private context.

Professor Walters (ACRRM) enquired as to the government’s current position in relation to the budget announcement concerning the 150 ‘industry sponsored training positions’ and current situation. Minister Gillespie undertook to provide more information back to the CPMC on this matter but had the view that it would not proceed.

Dr Michael Cleary (RACMA) raised the issue of rural generalists with reference to the Queensland model as a positive approach to attracting and retaining doctors post training into the rural sector.

Dr Bruce Latham (RCPA) raised the issue of pathology with reference to the sustainability of the service given the announcements in relation to bulk billing incentives and impact particularly on the rural sector. Minister Gillespie noted the concerns.

Professor Talley thanked Minister Gillespie on behalf of the CPMC and confirmed CPMC would write to him with issues raised in the discussion.

**Action:** Write a letter of thanks to Minister Gillespie outlining issues raised.

### 4.1 Rural Health Sub-committee update

Professor Walters as Chair of the sub-committee provided an update in relation to the Support for Rural Specialists in Australia funding program noting the administrative infrastructure in place, the website development and the preparatory work in relation to issuing expressions of interest for Directors to participate on the subcommittee amongst other matters. Professor Walters noted the five strategic pillars of the program which would drive the grant funding. Professor Talley noted the update and encouraged Directors to express an interest in participating.

### 4.2 Indigenous Health subcommittee Update

Professor Talley introduced this item as outlined in the paper circulated to the committee. Ms Magarry confirmed the Australian Indigenous Doctors Association had recently written to the CPMC affirming their intention to proceed with the common Collaboration Forum – a joint initiative between the CPMC, CPMEC, Medical Deans and AIDA. Ms Magarry noted the change-over in CEOs at AIDA had impacted on the progress of the Forum however there was the intention of the Chair and CEO to meet with the key stakeholders at AIDA 2016. Professor Talley noted the high-level of representation at AIDA by all Colleges and the positive commitment by them to growing specialists
of Indigenous background. Ms Magarry confirmed an update would be provided to the November meeting of the activities and the approach being taken to the common forum.

4.3 Revalidation Update

Professor Talley introduced this item noting the recent release by the Medical Board of Australia of the Expert Advisory Group’s report on revalidation for Australia. Dr Cleary’s paper summarising the workshop held on 15 August in Melbourne was noted. Dr Cleary was invited to speak to the paper and highlighted the process and intentions by government concerning revalidation. A discussion occurred in relation to the position of CPMC and past work having been undertaken which affirmed the approach to revalidation was that it should be profession-led. Professor Hopwood was invited to comment further on the EAG report and workshop and he added that there was an emphasis on risk management and identifying persons of concern early in the process as opposed to addressing complaints.

Professor Charlie Corke (CICM) noted the relationship between revalidation and big data.

The Committee was advised of the consultation process intended by the MBA and deadline for lodgement of submissions as 30 November 2016.

Professor Talley facilitated a discussion concerning the concept of revalidation which all Directors contributed to covering the issue of mandatory practice visits, dealing with poor practitioners, the roles of the AHPRA, employers and Colleges.

It was decided to ensure the MBA met with members of the CPMC Executive. A policy position was needed and to this end reference was made to the merit in having a consolidated approach to the matter. A working group was determined with the following Directors appointed:

- Dr Michael Cleary (RACMA)
- Professor Malcolm Hopwood (RANZCP)
- Professor Mark Lane (RACP)

RCPA Chief Executive Dr Debra Graves was invited to participate. It was agreed that in the first instance the issues would be identified and past CPMC position revised with the Working Group to meet by teleconference as needed.

**Action:** Form the working group and consolidate a position for agreement by Directors to inform the submission process. Ms Magarry to invite the MBA Chair Dr Joanna Flynn to meet with the CPMC Executive as part of the consultation process.

4.4 Australian Digital Health Agency

The paper was noted.

4.5 Discrimination, Bullying and Sexual Harassment Update

The update was noted.

4.6 National Health Summit on Obesity

Professor Talley introduced the item for Ms Magarry to update the Committee on the current status of the Summit. Ms Magarry made reference to the establishment and progress of the CPMC Scientific Advisory Committee and media engagement, along with the evidence currently being compiled to inform the background paper to support the Summit.
Dr Hamish Osborne (ACSEP) noted the work being undertaken on this matter and was invited to participate on the panel at the Summit.

**Action:** Add the Australasian College of Sport and Exercise Physicians to the expert panel.

**4.7 AHMAC National Training Survey**

The participation by CPMC as a co-partner in the development by the Health principles Workforce Committee of a National Training Survey was noted by Directors, as outlined in the meeting papers. Ms Magarry confirmed the workshop for 25 August and an update would be provided by NSW Health to the Colleges following the workshop.

**4.8 CPMC Statement on Asylum and Children in Detention**

This item was discussed in the context of item 4.9.

**4.9 Policy Development Process**

Professor Talley noted the late paper circulated on the merit of determining a decision-making process to address policy statements in terms of development, clearance and approval.

It was decided to re-circulate the draft Children in Detention position statement with the amendments as noted by the Directors.

It was decided to approve in-principle the decision-making approach as outlined in the Board paper, to be affirmed at the November 2016 meeting of the Committee with the agreement that two thirds of Directors to agree on any statement before it is issued.

**Action:** re-circulate the draft Position Statement on Children in Detention, as amended.

Lodge the policy approval process on the November agenda.

**5. Other Business**

Professor Talley invited Directors to offer any other business not listed on the agenda.

Professor Talley raised the issue of changing the name of CPMC from the Committee of Presidents of Medical Colleges to Council of Presidents of Medical Colleges, to be lodged on the agenda for the Annual General Meeting of Directors in November. All Directors present agreed.

**Action:** Provide an agenda item with accompanying information to enable a change of company name onto the November Annual General Meeting.

**6. Meeting Evaluation**

There was no meeting evaluation undertaken at this meeting.

Meeting concluded at 2pm.
115th meeting of the CPMC
Actions List

Item 2.1
- CPMC to write to the Health Minister on the STP and offer assistance.
- Professor Lawler to work with the ACEM and CPMC to lodge a discussion paper to the 10 November meeting of CPMC on workforce planning issues.

Item 2.5
- Reschedule the government relations day for the CPMC Executive.

Item 2.6
- Dr Cleary and Professor Talley to sign audited statements. Ms Magarry to lodge the issue of financial reserves and risk strategy on the CPMC Executive.

Item 3
- Write a letter of thanks to Minister Gillespie outlining issues raised.

Item 4.3
- Form the working group and consolidate a position for agreement by Directors to inform the submission process. Ms Magarry to invite the MBA Chair Dr Joanna Flynn to meet with the CPMC Executive as part of the consultation process.

Item 4.6
- Add the Australasian College of Sport and Exercise Physicians to the expert panel.

Item 4.9
- re-circulate the draft Position Statement on Children in Detention, as amended.
- Lodge the policy approval process on the November agenda.

Item 5
- Provide an agenda item with accompanying information to enable a change of company name onto the November Annual General Meeting.
CPMC Executive Meeting
MINUTES

Meeting held by teleconference Tuesday 11 October 2016 at 5pm EST.

1. Welcome and apologies

Professor Nick Talley welcomed members of the Executive present, as himself and Dr Catherine Yelland, President the Royal Australasian College of Physicians. Professor Phillip Truskett, President The Royal Australasian College of Surgeons had provided written input to the meeting prior and this is reflected throughout the minutes wherever appropriate. Professor Talley noted that apologies were received from Dr Frank Jones, immediate past President, the Royal Australian College of General Practitioners, and who had therefore stepped down from CPMC Executive, and Dr Brad Horsburgh, President the Royal Australian and New Zealand College of Ophthalmologists.

2. CPMC agenda for the 10th Nov

Ms Magarry spoke to the draft CPMC meeting agenda and advised of the inclusion of Dr Jennifer Alexander, from Doctors Health as having been previously approved. Dr Yelland noted the agenda appeared to be sufficiently reflective of the strategic issues for the company. Professor Talley requested the inclusion of an agenda item in relation to the composition of the CPMC Executive. It was agreed for twenty minutes to be set aside in the Morning Forum for Professor Brendan Murphy new Commonwealth Chief Medical Officer to brief the stakeholders and provide an opportunity for him to engage with the group.

The agenda for the Annual General Meeting was accepted as a reflection of the requirements for the meeting. A short discussion concerning the name change from Committee to Council of Presidents of medical Colleges occurred with reference to the acceptance by all Directors to-date.

3. Indigenous Health Update

Ms Magarry advised that a meeting between the Australian Indigenous Doctors Association (AIDA) concerning the status of the development of a common collaboration forum had been rescheduled due to conflicting diaries between the CEOs, but it was expected that a meeting would be held in the next week. The Commonwealth Department of Health’s official with responsibility for Indigenous health policy had advised CPMC at the AIDA Cairns conference of their intention to consider a funding proposal from AIDA. A further update would be provided at the CPMC Meeting in November.

4. Meeting with the PM 24th October: Sydney office 11am

A discussion occurred in relation to the type of agenda CPMC would have when meeting with the Prime Minister. Ms Magarry noted the office has been provided with a briefing note and biographies of the CPMC Executive. In general, CPMC would be advised to enquire on the PMs vision for health, what level of continued financial support the Commonwealth intended to provide in the May Federal Budget noting the upcoming renewal requirement of the Australian Health care Agreements through the Council of Australian Governments. The STP review and the need for these posts to be secured and successful was agreed as central to any discussion concerning the future of Australia’s health workforce. In addition, the PM was known to have a strong interest in mental health particularly early intervention mental health services for children and young people.
Ms Magarry advised that given the PM had taken all questions without notice in Question Time this week, the benefit of having CPMC visit him as in providing some direct information to any specific queries he may have, but that we should mention a strong relationship exists with the current Federal Health Minister. In addition to the above, the following issues were provided by RACS President for consideration to including in the agenda:

- Better access to Medicare data to look at outliers like what RACS has done with the Medibank project. (MBS review and outliers – minister doesn’t want to spend or resource that enquiry)
- RACS supports revalidation and would like some authority to be in a position to gather frequent flyers from MDUs in order to target for enhanced revalidation. Complaints numbers predict bad behaviour. Perhaps by legislation MDU may be required to inform AHPRA above a threshold?
- Support for a program to detect and treat indigenous child ear disease. Ear health
- Government support to promote a safe working environment within the health work space free from DBHS. To achieve this we need exchange of information relating to poor behaviour

It was recommended that Dr Bastian Seidel be invited to the meeting.

5. **Government Relations Day: 21 November 2016, CANBERRA**

A runsheet had been circulated with the agenda showing the confirmed meetings with several Members of Parliament and Senators. It was agreed that CPMC Executive would be provided with a set of notes similar to the previous government relations day.

6. **National Health Summit on Obesity**

Dr Yelland updated Professor Talley on the teleconference held the 10th October with the Scientific Advisory Committee noting that there were not major issues arising from the final meeting of the SAC and that all of the policy development work, media communications planning and pre Summit preparations had been completed.

The SAC had accepted the final program and Ms Magarry confirmed that work has been progressing in relation to obtaining biographies to complete the program. The logistics support was undertaken by CPMC in liaison with the RACGP. Ms Magarry confirmed that the Summit was on budget. Prof Truskett is unable to attend the CPMC National Health Summit on Obesity but has offered Dr Wendy Brown bariatric surgeon to attend in his stead.

7. **Financial Statements**

The Executive had been provided with the financial statements for the company in the period ending 30 September, 2016. The company had submitted all required tax payments (BAS and IAS) and a copy of the recent BAS was supplied.

Total current assets: $1,061,496.03 reflecting the inclusion of all CPMC operating funds, RHCE surplus and SRSA funds

Total Liabilities: $23,470.96 reflecting operational expenses, provision for leave and LSL

Total Equity of $1,038,025.07
The profit and loss statement showing variance against budget was noted as retaining all income from the SRSA funding agreement. Overspends for the year to-date had occurred in office supplies to support the Obesity Summit, in teleconference expenses, and some travel.

Ms Magarry made note of having made pre-payments from the month of October to support the ability to take leave over the xmas shutdown. These prepayments were in the areas of tax, superannuation, some travel, telephone and rent.

The payment to the RACP to house the program management unit had occurred since the last CPMC meeting of $306,327. CPMC had yet to charge back against the SRSA agreement for management and liaison fee but this would occur in October/November.

CPMC Executive accepted the financial statements.

8. Premises

The Canberra office of the Royal Australasian College of Surgeons had recently reviewed its premises with a view to moving to a more modern and better equipped site. Ms Magarry advised the Executive that RACS regional manager and RACS National Deputy CEO had offered CPMC the opportunity to co-locate with them. The ANZCA premises where CPMC currently sub-leases from is old, the space is 11 square metres, and recently the building flooded. CPMC would gain by having a larger office space, access to a modern well equipped serviced premises, board room and reception. The total annual cost was approximately $15,000, PCMC paying $8,000 per annum currently.

Ms Magarry advised the Executive that until a proper inspection had occurred and proposal put forward the matter was simply an offer. It was agreed to investigate further.

9. SRSA Update on governance

Professor Talley provided an update on the meeting held with the President of the RACGP Dr Frank Jones concerning the SRSA governance arrangements and the inability of RACGP to provide any support to the circulated terms of reference or composition of the governance committee. Ms Magarry provided the background to the SRSA agreement and confirmation by the Commonwealth of the policy intent for the funding to be directed to non GP specialists, with concern having been raised about a GP College chairing the governance committee. It was decided that given the issues raised by the RACGP, the consequences of CPMC not being able to deliver against the funding agreement unless some transitional arrangements applied to the chairing, CPMC would write to Professor Walters and advise her that as of the conclusion of her term as Director, CPMC (20 October) she would no longer chair the CPMC rural health subcommittee or SRSA. This role would transition to a non GP specialist Director. It was agreed that a teleconference would be set up with Professor Walters as well. RACGP would be informed of the decision.

10. Composition of the CPMC Executive

A short discussion occurred in relation to the composition of the CMC Executive given the conclusion of Dr Frank Jones’ term as RACGP President and from the perspective of process. It was agreed that the matter of composition would be placed on the CPMC agenda for November.

11. Other Business

There being no other business raised the teleconference concluded at 5:40pm
4.2.2 CPMC Executive Composition

A meeting of the CPMC Executive occurred on Tuesday 11 October 2016 to discuss the CPMC November agenda, the Annual General Meeting and other relevant issues. The minutes arising from that teleconference are attached.

The current Executive comprises the Presidents of the RACP, RACS, RANZCO and CPMC Chair. The completion of the RACGP President’s term raised the question of composition from the perspective of process. This item provides some background for Directors to discuss the process of replacing Presidents on the Executive, amongst other issues.

Background to the Executive

The membership of the Executive is outlined in the Constitution as having the following structure:

7. EXECUTIVE

7.1.1 The Executive shall comprise –
(a) the Chairperson;
(b) the Chairperson-elect (if any); and
(c) 4 other Committee members elected to the Executive by Committee members at the first meeting of the Committee after the Annual General Meeting.

7.1.2 Subject to them continuing to be the duly nominated representative of a Member, each of the 4 Committee members elected pursuant to sub-clause 7.1.1(c) shall hold office on the Executive for the duration of that Committee and shall be eligible to stand for re-election to that office.

7.1.3 The Committee may delegate to the Executive the supervision of the day to day business of the CPMC and such other functions as the Committee may in its discretion think fit.

7.1.4 The Executive shall during intervals between meetings of the Committee have power to act in accordance with the power delegated to it. The Executive may meet, convene and adjourn its meetings and otherwise regulate its proceedings in such manner as it thinks fit. The quorum necessary for a meeting of the Executive shall be 3.

7.1.5 The Secretary shall ensure that records of all meetings of the Executive are kept and shall forward copies of the Minutes of each meeting to each member of the Committee within fourteen days of the meeting or before the next meeting of the Committee, whichever is the sooner.

Issue

The Constitution is silent on whether there is a natural progression of representation onto the Executive. CPMC gains from having representation on the Executive from the larger Colleges especially when meeting with the Parliamentarians. It is recommended that the basic composition comprise RACP, RACS, RACGP, and a small to medium College.

Recommendation

The Board of Directors notes the background and discusses process for composition of the CPMC Executive.
4.3 CEO Report

This report reflects activity since the meeting held 18 August 2016.

- Preparations for the Annual General Meeting have included working with legal advisor John Topfer to make the necessary changes to support the motion to change the company name from Committee to Council of Presidents of Medical Colleges.
- Coordinating the input from Directors concerning the change to the company name and the slogan for internal marketing purposes. Some advance preparatory work to anticipate all of the administrative changes which will be necessary ranging from ASIC notification through to banks and insurers, service providers, stakeholders and the Government.
- Attended the Australian Indigenous Doctors Association 2016 congress in Cairns which incorporated meetings with AIDA to progress the Common Collaborative Forum as outlined in item 5.1
- Managed the governance establishment and related issues for the SRSA program which is discussed in further details at item 5.2
- CPMC co-convened with NSW Health as the leading agency for Health Principles Workforce Officials to report through to Australian Health Ministers on the concept of a National Training Survey, which was a key recommendation arising from the COAG Review of Internship. A draft report has been prepared which is discussed at item 6.4
- Convening the CPMC National Health Summit on Obesity which is discussed at item 6.6 but which has added at least 0.5FTE to the secretariat workload to manage the stakeholders, Scientific Advisory Committee, event logistics, buy gifts, do catering and deal with the range of interested participants.
- Attended IAMRA 2016 and convened the CPMC Working Group on Revalidation which produced a submission to the Medical Board.
- Prepared and coordinated the meeting with the Prime Minister including all briefings and logistics both to the PMO and the Executive
- Prepared the government relations day for 21 November 2016 in Parliament House featuring a wide range of Parliamentarians.
- Attended the NMTAN, Department of Human Services meetings, launch of the Australian Society for Medical Research launch, ACHS Council meeting, MDANZ, AMC meetings.
- Coordinated the attendances for the CPMC Chair at various College invited events.
- Liaised with the ACT Regional Manager, RACS concerning government relations, and various policy matters. Item 7.2 discusses the intention by PCMC to shift to new premises co-locating with RACS, Canberra.
- Liaison with the new advisers in the various Parliamentary offices.
- The secretariat appreciates the support of the Board and will close for the Dec-Jan shut down period with an approved period of leave from 12 Dec to 12 Jan 2017.

Angela Magarry

CEO, CPMC
4.4 Financial Statements

The financial statements for the period ending 30 September 2016 were lodged with the CPMC Executive and cleared. The company had submitted all required tax payments (BAS and IAS) and a copy of the recent BAS was supplied to them for information purposes.

Total current assets: $1,061,496.03 reflecting the inclusion of all CPMC operating funds, RHCE surplus and SRSA funds

Total Liabilities: $23,470.96 reflecting operational expenses, provision for leave and LSL

Total Equity: $1,038,025.07

The profit and loss statement showing variance against budget was noted as retaining all income from the SRSA funding agreement. Overspends for the year to-date had occurred in office supplies to support the Obesity Summit, in teleconference expenses, and some travel pre-paid.

Ms Magarry made note of having made pre-payments from the month of October to support the ability to take leave over the xmas shutdown. These prepayments were in the areas of tax, superannuation, some travel, telephone and rent.

The payment to the RACP to house the program management unit had occurred since the last CPMC meeting of $306,327. CPMC had yet to charge back against the SRSA agreement for management and liaison fee but this would occur in October/November.

CPMC audited statements for the year ending 2015-16 were circulated to Directors at the 18 August meeting and approved, then subsequently signed by 2 Directors and lodged with ASIC.

Recommendation: Directors note the report
## Profit & Loss [Budget Analysis]
### Committee of Presidents of Medical Colleges

**July 2016 To September 2016**

<table>
<thead>
<tr>
<th>Income</th>
<th>Selected Period</th>
<th>Budgeted</th>
<th>$ Difference</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscription fees</td>
<td>$271,550.00</td>
<td>$294,500.00</td>
<td>-$22,950.00</td>
<td>(7.8)%</td>
</tr>
<tr>
<td>Other Income</td>
<td>$1,176.00</td>
<td>$500.00</td>
<td>$676.00</td>
<td>135.2%</td>
</tr>
<tr>
<td>Project Mgmt from SRSA</td>
<td>$0.00</td>
<td>$13,750.00</td>
<td>-$13,750.00</td>
<td>(100.0)%</td>
</tr>
<tr>
<td>SRSA Grant Funds</td>
<td>$727,272.73</td>
<td>$727,272.73</td>
<td>$0.00</td>
<td>0.0%</td>
</tr>
<tr>
<td>Interest Received</td>
<td>$2,287.17</td>
<td>$2,500.03</td>
<td>-$212.86</td>
<td>(8.5)%</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>$1,002,285.90</td>
<td>$1,038,522.76</td>
<td>-$36,236.86</td>
<td>(3.5)%</td>
</tr>
</tbody>
</table>

### Expenses

| Committee of Presidents       | $600.00         | $540.00   | $60.00       | 11.1%         |
| Accounting fees               | $6,480.00       | $6,000.00 | $480.00      | 8.0%          |
| Administrative Assistance     | $0.00           | $60.00    | -$60.00      | (100.0)%      |
| Audit Fees                    | $5,500.00       | $6,400.00 | -$900.00     | (14.1)%       |
| ASIC fees                     | $4.80           | $62.00    | -$57.20      | (92.3)%       |
| Bank fees                     | $0.00           | $100.00   | -$100.00     | (100.0)%      |
| Computer Expenses             | $3,886.36       | $3,586.36 | $300.00      | 1,195.5%      |
| Conference Fees               | $0.00           | $3,000.00 | -$3,000.00   | (100.0)%      |
| Website Platform Design and De| $0.00           | $630.00   | -$630.00     | (100.0)%      |
| Legal Fees                    | $0.00           | $630.00   | -$630.00     | (100.0)%      |
| Licences and fees             | $500.00         | $0.00     | $500.00      | NA            |
| Meeting Expenses              | $0.00           | $6,000.00 | -$6,000.00   | (100.0)%      |
| Office Supplies               | $726.59         | $125.02   | $601.57      | 481.2%        |
| Professional Development      | $0.00           | $1,125.00 | -$1,125.00   | (100.0)%      |
| Rent                          | $1,189.60       | $3,000.00 | -$1,810.40   | (60.3)%       |
| Salaries                      | $46,396.02      | $46,395.00| $1.02        | 0.0%          |
| Superannuation                | $4,407.63       | $4,410.00 | -$2.37       | (0.1)%        |
| Teleconference Expenses       | $566.68         | $300.00   | $266.68      | 88.9%         |
| Telephone                     | $467.94         | $180.00   | $287.94      | 160.0%        |
| Workcover                     | $1,630.72       | $1,608.00 | $22.72       | 1.4%          |
| Travel                        | $4,262.23       | $6,000.00 | -$1,737.77   | (29.0)%       |
| Accommodation                 | $10,650.30      | $6,000.00 | $4,650.30    | 77.5%         |
| Airfares                      | $435.92         | $1,500.00 | -$1,064.08   | (70.9)%       |
| Parking                       | $1,156.20       | $1,500.00 | -$343.80     | (22.9)%       |
| Taxis                         | $739.95         | $1,200.00 | -$460.05     | (38.3)%       |
| Other Travel Expenses         | $0.00           | $6,000.00 | -$6,000.00   | (100.0)%      |
| **Total Travel**              | $17,244.60      | $16,200.00| $1,044.60    | 6.4%          |

**SRSA Grant Expenses**

| Funding and Management Fees  | $278,660.00     | $174,943.20 | $103,716.80 | 59.3%         |
| CPMC Project Management Costs| $0.00           | $13,750.00  | -$13,750.00 | (100.0)%      |
| **Total Committee of Presidents** | $368,260.94 | $285,128.22 | $83,132.72 | 29.2%         |
| **Total Expenses**            | $368,260.94     | $285,128.22 | $83,132.72  | 29.2%         |
| **Operating Profit**          | $634,024.96     | $753,394.54 | -$119,369.58| (15.8)%       |

**Net Profit/(Loss)**

| Total Other Income            | $0.00           | $0.00      | $0.00        | NA            |
| Total Other Expenses          | $0.00           | $0.00      | $0.00        | NA            |
| **Net Profit/(Loss)**         | $634,024.96     | $753,394.54| -$119,369.58| (15.8)%       |
Balance Sheet  
As of September 2016

<table>
<thead>
<tr>
<th>Assets</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
</tr>
<tr>
<td>Bank Accounts</td>
<td></td>
</tr>
<tr>
<td>COP: Westpac Cheque 42-3262</td>
<td>$64,095.09</td>
</tr>
<tr>
<td>COP: Westpac Maxi 42-3588</td>
<td>$297,913.44</td>
</tr>
<tr>
<td>RHCE AC 688025</td>
<td>$690,780.41</td>
</tr>
<tr>
<td><strong>Total Bank Accounts</strong></td>
<td>$1,052,788.94</td>
</tr>
<tr>
<td>Clearing Accounts</td>
<td>$3,513.41</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>$1,061,496.03</td>
</tr>
<tr>
<td>Other Current Assets</td>
<td></td>
</tr>
<tr>
<td>Paid in Advance</td>
<td>$5,193.68</td>
</tr>
<tr>
<td><strong>Total Other Current Assets</strong></td>
<td>$5,193.68</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>$1,061,496.03</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Liabilities</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
</tr>
<tr>
<td>GST Liabilities</td>
<td></td>
</tr>
<tr>
<td>GST Collected</td>
<td>-$0.31</td>
</tr>
<tr>
<td>GST Paid</td>
<td>-$585.66</td>
</tr>
<tr>
<td><strong>Total GST Liabilities</strong></td>
<td>-$585.97</td>
</tr>
<tr>
<td>Payroll Liabilities</td>
<td></td>
</tr>
<tr>
<td>PAYG Withholding Payable</td>
<td>-$10,156.00</td>
</tr>
<tr>
<td>Superannuation Payable</td>
<td>-$4,407.69</td>
</tr>
<tr>
<td><strong>Total Payroll Liabilities</strong></td>
<td>-$14,563.69</td>
</tr>
<tr>
<td>Other Current Liabilities</td>
<td></td>
</tr>
<tr>
<td>Trade Creditors</td>
<td>$16,101.11</td>
</tr>
<tr>
<td>Provision for Holiday Pay</td>
<td>$14,177.28</td>
</tr>
<tr>
<td>Provision for Long Service Lea</td>
<td>$8,342.23</td>
</tr>
<tr>
<td><strong>Total Other Current Liabilities</strong></td>
<td>$38,620.62</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>$23,470.96</td>
</tr>
</tbody>
</table>

| Total Liabilities                  | $23,470.96   |
| Net Assets                         | $1,038,025.07|

<table>
<thead>
<tr>
<th>Equity</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained Earnings</td>
<td>$385,533.33</td>
</tr>
<tr>
<td>Current Year Earnings</td>
<td>$634,024.96</td>
</tr>
<tr>
<td>Historical Balancing</td>
<td>$18,466.78</td>
</tr>
<tr>
<td><strong>Total Equity</strong></td>
<td>$1,038,025.07</td>
</tr>
</tbody>
</table>

This report includes Year-End Adjustments.
Item 4.5  Changes in Directors

Since the August meeting of CPMC the following changes have been made:

- Cessation of Director, President, RACGP Dr Frank Jones
- Addition of Dr Bastian Seidel
- Cessation of President, ACRRM, Professor Lucie Walters
- Addition of Professor Ruth Stewart
Item 5.1 Indigenous Update

Professor Talley and CEO, CPMC met with the President of the Australian Indigenous Doctors Association Dr Kali Hayward, and their CEO Mr Craig Dukes at the AIDA 2016 conference in Cairns on 26 September 2016. CPMC registered for the event and is also a member of AIDA.

In relation to the request for College updates on activities in relation to Indigenous, which was raised at the August CPMC meeting, there are some points to note:

- CPMC was resourced via the Commonwealth in 2013 for RACS (via service agreement) to undertake a project to raise the number of Indigenous specialists. The Indigenous Health subcommittee was set up to govern that project with funds from the project. [http://natsim.cpmc.edu.au/](http://natsim.cpmc.edu.au/)
- AIDA continues its engagement with specialist medical colleges at the policy officer and management level, and has met with a number of medical colleges to discuss issues affecting Aboriginal and Torres Strait Islander doctors and continue to improve policy and project collaboration; and
- Since the release of the revised Standards for Assessment and Accreditation of Specialist Medical Programs and Professional Development Programs by the Australian Medical Council 2015 – work is currently underway to scope options for the development of a cultural safety training resource by AIDA which is expected to help Colleges looking for such a resource.

National Medical Training Advisory Network (NMTAN) project

The Executive Committee of the NMTAN has asked AIDA to take the lead on and chair a time-limited sub-committee tasked with the following:

- review existing practices of the specialist medical colleges in the area of recruiting, enrolling, and retaining Aboriginal and Torres Strait Islander specialist trainees;
- develop advice to build on ‘what works’; and
- recommend strategies to support the specialist medical colleges in recruiting and enrolling more Aboriginal and Torres Strait Islander specialist trainees for the 2018 intake.

AIDA has since met with the NMTAN Secretariat and is currently in the process of drafting a Project Plan to be put to the NMTAN Executive Committee out of session. Once the above subcommittee has been approved, AIDA will be approaching the CPMC and its member colleges to ask for relevant information and for their support in assisting the subcommittee in its work.

In an initial step, AIDA would appreciate confirmation from CPMC members regarding the timelines for their respective 2018 intake.

The Australian College for Emergency Medicine has written to CPMC to raise the issue of publishing the Indigenous status of Fellows and trainees, and their correspondence is attached.

Common Collaborative Agreement Forum: ‘Collaborative Forum’

- CPMC acquitted the NATSIM project in 2013-14. Since then two AIDA-CPMC Indigenous Health subcommittee meetings have been held.
• Due to a need for sustainable resourcing it was decided that a Common Collaborative Forum would ensure consistency across the training pipeline.
• The recommendation made in April 2015 was to approach for AIDA the Commonwealth seeking financial resources to establish the Collaborative Forum thereby providing for a more sustainable model of engagement.
• In the discussion at AIDA 2016 CPMC confirmed its commitment to the progression of a Collaboration Agreement Forum to further the level of collaboration across the medical education continuum.
• AIDA confirmed it had recently decided to re-invigorate progressing this issue in recognition of the importance of close collaboration between all levels of the medical education sector to grow the number and retention rate of Aboriginal and Torres Strait Islander doctors.
• The purpose of the Partnership with CPMC, CPMEC and Medical Deans is to streamline the administration and raise the efficiency of the three separate collaboration agreements AIDA holds.
• There are significant costs associated with convening subcommittees and the policy preparation and coordination requirements. While much of the necessary activity occurs currently at the College policy officer level, there is merit in having an overarching collaborative structure and this was the focus of a meeting between the CEOs of AIDA and CPMC recently. It included discussion about process and resourcing with an approach to the Commonwealth to be made immediately.
• It is anticipated that a Forum will be convened in the first half of 2017.

Angela Magarry
8 September 2016

Laureate Professor Nicholas Talley
Chairperson, Committee of Presidents of Medical Colleges
6/14 Napier Close
Deakin ACT 2600
Australia

Via email: ceo@cpmc.edu.au

Dear Laureate Professor Talley,

As you will be aware, there is now parity in the proportion of Indigenous and non-Indigenous medical students with that of the Indigenous populations of Australia and New Zealand; however, this parity has yet to flow on to the numbers of Indigenous doctors undertaking specialist training.

The Australasian College for Emergency Medicine (ACEM) supports a number of initiatives that seek to increase the number of Indigenous emergency medicine specialists in Australia and New Zealand. These initiatives include sponsorship of Indigenous medical education conferences, the Joseph Epstein Scholarship for Indigenous Advanced Emergency Medicine Trainees and the ACEM Foundation Conference Grant: Promoting Future Indigenous Leaders in Emergency Medicine.

The College recently published the Indigenous status of our Fellows and specialist trainees (as numbers and percentages) in our report, Specialist Emergency Medicine Workforce and Training Activities 2015 (p.10). The College believes that the collection and publishing of such data is a key component in increasing the Indigenous participation in the emergency medicine workforce in both countries and, indeed, in the whole specialist medical workforce.

ACEM encourages the member Colleges of the Committee of Presidents of Medical Colleges (CPMC) to publish the Indigenous status of their Fellows and trainees, and I would be grateful if this matter could be raised at a meeting of CPMC.

Yours sincerely,

[Signature]

Professor Anthony Lawler
President
Item 5.2 Rural Health subcommittee

The CPMC funding agreement with the Commonwealth has been in place since May 2016, during which time there have been some issues regarding establishment of the governance aspect.

Professor Talley will verbally update the Committee with reference to the various pieces of correspondence circulated amongst Directors and non-Directors in recent weeks.
Item 6.1 Revalidation – to discuss

Revalidation has been a standing item on the CPMC agenda following on from the forum convened by CPMC in November 2014.

CPMC position in relation to revalidation has been to support it but to maintain a brief which confines the process to practical, appropriate processes which link to existing clinical governance and does not impose unnecessary administrative burdens on doctors.

All Colleges will be aware that in 2012 the Medical Board began the policy process about maintenance of competency by doctors with a view to their lifelong service, and from the perspective of safety and ethical practice. A Board commissioned piece of international research occurred in 2013-14 to provide a basis for an evidence-based and practical response. The Board then appointed the Expert Advisory Group to propose models which could be evaluated for effectiveness, feasibility and acceptability. The Interim Report by the EAG was published at: www.medicalboard.gov.au/News/Current-Consultations.aspx.

CPMC established a working group which met to discuss the paper and propose the concerns (as received by all Colleges) and issues to be forwarded to the Medical Board. It should be noted that all Colleges have commenced some form of preparatory work in relation to revalidation and the concerns all differ depending upon the stage at which each College is at. A copy of the submission lodged with the MBA is attached as is the recent response by them.

In recent weeks there has been a change in position by the RACGP concerning revalidation where it has raised the use of profiling as a proxy for identifying at-risk doctors as dangerous and it would be better to use complaints as the means by which under-performing doctors are identified.

A presentation will be provided by Dr Joanna Flynn and Professor Liz Farmer at the meeting today.

An invitation has been extended by AHPRA to all Colleges to attend a consultation event in their respective jurisdictions from the 15th November.

The expectation is that once submissions are received by stakeholders (by 30 November 2016), the MBA will produce a final report.

Recommendation

That the paper be noted updating on status and the Board discusses the issue including next steps.
Dear Dr Flynn

I write to you in relation to the issues outlined in the recently released discussion paper by the Medical Board of Australia’s Expert Advisory Group on options for revalidation in Australia.

The Committee of Presidents of Medical Colleges (CPMC) welcomes the report as a positive step towards the development of a practical and feasible approach to revalidation in Australia. CPMC wishes to raise three key issues for clarification:

1. Will the strengthened CPD still be College controlled (with accreditation by AMC)? One assumes that if this is the case that the programs will need to include requirements for some form of Educational Activity, Performance Review and Outcome Measurements, with the specific approaches to be determined by the Colleges?
2. Will 360 degree reviews be compulsory as part of enhanced CPD or is this only required for poorly performing practitioners?
3. What reporting requirements will there be of Colleges in relation to the enhanced CPD? Will the Practitioners self-reporting be all that is required or is the Medical Board expecting the College’s to report those Fellows who are not complying with College CPD programs?
4. How will the Medical Board identify poorly performing practitioners? What role is the Medical Board envisioning for Medical Colleges in this area?

CPMC supports the concept of revalidation for Australian medical practitioners, which is based on practicality in process and does not impose any additional administrative burden on specialist Medical Colleges. There will be issues which need to be discussed and agreed upon as a result.

I am aware that consultations are occurring with each individual specialist Medical College. I would be pleased to meet with you to share the broader CPMC issues and to work with you in the progression of this important regulatory matter. I can be contacted via the CPMC Secretariat at ceo@cpmc.edu.au or alternatively through my office at The University of Newcastle on telephone (02) 49215855.

Yours sincerely,

Laureate Professor Nicholas J. Talley, MBBS (Hons.)(NSW), MD (NSW), PhD (Syd), MMedSci (Clin Epi)(Newc.), FRACP, FAFPHM, FAHMS, FRCP (Lond. & Edin.), FACP, FACG, AGAF, FAMS, FRCPi (Hon), GAICD

Chair CPMC
19 October 2016

Laureate Professor Nicholas J. Talley  
Chair  
Committee of Presidents of Medical Colleges  
Napier Close  
Deakin ACT 2600  

Email: secretariat@cpmc.edu.au

Dear Professor Talley

Options for revalidation of medical practitioners

Thank you for your letter dated September 2016 addressed to Dr Joanna Flynn, Chair of the Medical Board of Australia regarding revalidation.

As you know, the Board-appointed Expert Advisory Group’s Interim report has been published and the Board is now consulting on the proposed approach.

The Board appreciates the issues that you have raised in your letter and is interested in the views of the Committee of Presidents of Medical Colleges. As you know, the Board has not made any decisions regarding revalidation and the subsequent work and final report of the EAG will be informed by feedback from the consultation.

I understand that Dr Flynn and Professor E Farmer will be attending the meeting of the CPMC in November to discuss the proposed approach with the Presidents. We have also invited you to the stakeholder forum in Sydney on 15 November 2017. It would be helpful to have a face-to-face conversation about these issues and about any other concerns that you and the colleges have.

Professor Farmer and Dr Flynn have met with most of the specialist colleges to date and have had constructive discussions regarding the interim report with office bearers and senior staff. We are also running stakeholder forums in every state and territory to provide opportunity for feedback, discussion and debate.

The Board encourages the Committee of Presidents of Medical Colleges to make a formal submission addressing the broader CPMC issues before 30 November 2016. Submissions can be made via the Board’s website.

The Board looks forward to the feedback of CPMC.

Yours sincerely

Dr Joanne Katsoris  
Executive Officer, Medical  
Australian Health Practitioner Regulation Agency
Item 6.2 National Medical Training Advisory Network

The NMTAN was established in response to the *Health Workforce 2025: Doctors, Nurses and Midwives* report. The report found there were insufficient general practitioners and specialists in regional and rural Australia, some medical specialties were oversubscribed, and there were fewer generalists as a result of increasing specialisation and sub-specialisation of the medical workforce.

NMTAN membership comprises all key stakeholders associated with medical training. CPMC has four places on the NMTAN from the following specialist Medical Colleges

- Royal Australian College of Medical Administrators
- Royal Australian College of General Practitioners
- Royal Australasian College of Physicians
- Committee of Presidents of Medical Colleges

NMTAN last met on 1 September in Melbourne. They discussed emergency medicine from the perspective of developing a report in tandem with ACEM concerning projections into the future mindful of the jurisdictional influence over supply requirements.

NMTAN will revise the membership for the subcommittee focussed on capacity for and distribution of medical training. A new project to address the under-representation of ASTI doctors across all medical specialties was agreed and it will be led by AIDA. It is anticipated this will be a desktop review and aimed at developing a best practice model. AIDA will keep CPMC up-to-date with the project as it is established.

NMTAN has formed a national nursing, midwifery education advisory network chaired by Ms Pauline Ross. Some future collaboration between this group and NMTAN is expected.

A briefing was provided on the emerging digital health initiatives.

The next meeting of NMTAN was to be held on 22nd November however, it was cancelled.

Directors may wish to discuss the NMTAN in terms of what projects may be worthwhile considering including potentially CPMC leading work on behalf of the Commonwealth.

**Recommendation:** For the Information of Directors.
Item 6.3  Clinical Pathways Project

A formal request was received into CPMC Secretariat from the Royal Australasian College of Surgeons working party set up to formalise pathways for clinical academics in Australia and New Zealand. This correspondence is from the Chair of the Working Party Professor Julian Smith, attached along with the advocacy plan and publications relating to this initiative.

It is recommended CPMC gives support to the initiative because it fits with the key advocacy issues CPMC includes in its strategic agenda for government relations purposes. In each Ministerial briefing the issue of clinical academics as essential for bridging the gap between research and improved patient safety is described.

The most effective process for advancing support for this initiative is through a regular report to the CPMC meeting via the lead College, RACS and for practical steps to be encouraged at the individual Medical College level consistent with the RACS advocacy plan.

Recommendation: The Board discusses this issue with reference to the advice provided.
26 September 2016

Professor Nicholas Talley
Committee of Presidents of Medical Colleges
6/14 Napier Close,
Deakin, ACT 2600,
Australia

Dear Professor Nicholas Talley

**CPMC support for the introduction of formalised pathways for clinical academics**

Clinical academics are essential for bridging the gap between research and improved patient outcomes. The proportion of clinical academics has been steadily declining in Australia and New Zealand due in part to the lack of structured posts required to support career progression. A Working Party was established in November 2014, following the First International Summit on Clinical Academic Pathways, tasked with developing a training pathway model to support the career progression of clinical academics in Australia and New Zealand. To succeed in delivering this outcome, it is vital to engage and receive support from key stakeholders.

As a key stakeholder, we believe that the Committee of Presidents of Medical Colleges understands the importance of clinical academics in promoting health and medical research and its translation to improve patient health. We are writing, therefore, to invite all Medical Colleges to support this initiative of implementing training pathways for clinical academics. In doing so, this may require your Medical College’s participation and leadership in consultation processes with government representatives on models for research funding and remuneration, the creation of suitable posts, and in advocating for this initiative amongst key individuals and organisations providing education, training, research and patient care within the healthcare sector. Please find attached the advocacy plan and publications relating to this initiative that detail the progress thus far as well as future strategies to progress key aims.

We greatly appreciate your support and look forward to working together on this key initiative with you. We would be pleased to meet with the Committee if you deemed such to be appropriate.

Yours Sincerely,

![Signature]

Professor Julian Smith, FRACS
Chair, Working Party
Royal Australasian College of Surgeons

Ms Carmel Tebbutt
Member, Working Party
CEO, Medical Deans Australia and New Zealand
ADVOCACY PLAN – REVITALISE CLINICAL ACADEMICS IN AUSTRALASIA (DRAFT)

Project leaders: Working Party on Clinical Academic Pathways and the Research, Audit and Academic Surgery Division

Stakeholders: All jurisdictions – Australian Commonwealth, state and New Zealand health ministers and departments. Medical Research Institutes, Medical Colleges, Teaching Hospitals, Universities and other relevant Medical Organisations.

Members –

Royal Australasian College of Surgeons
Royal Australasian College of Physicians
Medical Deans Australia and New Zealand
Australian Medical Association
Australian Medical Council
Academy of Health and Medical Sciences

Other stakeholders –

Australian and New Zealand University Medical Schools
Australian Research Institutes
Australian Translational Research Centres
New Zealand Medical Association
Health Districts
National Health and Medical Research Council
Health Research Council New Zealand
Medical Colleges of Australia and New Zealand

Associated documents: Creating and Sustaining the Next Generation of the Clinical Academic Workforce
Advocacy goals:

**Raise the profile of clinical academics**
Clinical Academics are limited for time and can find difficulty in promoting their work and achievements. It is vital, however, that all clinicians, the government and the wider community are educated on the benefits of clinical academics and their ability to translate research into clinical outcomes. This will allow the creation of informed perspectives and thus increase the level of advocacy for creating a sustainable clinical academic workforce.

**Identify the areas of success and improvements in current pathways**
The Working Party advocates for the current pathways in Australasian institutes. Furthermore, the Working Party plans to identify areas of efficiency in those current pathways and support improving the areas that requires standardisation.

**Identify willing institutions and develop pilot pathways**
The engagement of institutions willing to fund and support pilot pathways is vital to demonstrate the success of such an initiative. The pilot pathway will be based on the effective parts of current clinical academic pathways and allow standardisation when rolling out across Australia and New Zealand.

**Advocate with governments for potential funding of pathway rollouts across Australia and New Zealand**
Once the pilot pathways have shown to be functional, and the finalised pathway is identified, government funding will be required for expansion across Australia and New Zealand institutions.

**Supporting goal:**

**Create literature on the benefits of clinical academics**
There is not sufficient literature supporting the idea that clinical academics translate benefits to patient outcomes. Therefore, senior clinical academics should be profiled, outstanding results in clinical research identified and improvements in teaching hospitals published.

**Engage the wider public in understanding the benefits of clinical academics**
A broader goal would be to engage the general public to advocate for hospitals and clinicians that are research-centric, and help the general public as healthcare consumers to understand the benefits of choosing clinician researchers.
Jurisdictional status:

Australia and New Zealand

Research in Australasia is struggling with reduced government funding. The National Health and Medical Research Council (NHMRC), the main funding body in Australia, proposed ways of increasing the return on investment for research that included embedding research in the health system. In 2011 the research funding expenditure from the NHMRC was allocated to 45% basic science, 32% clinical medical and science, and 13% public health [1]. An increase in cross-disciplinary research may see an increase in the funding for clinical academics, as they are perfectly situated to bridge the divide between research and patients.

A number of universities are now offering intercalated degrees for Medicine, including the MBBS-PhD offered by the University of Sydney [2], and an intercalated honours degree offered at University of Auckland [3]. Students that completed an intercalated degree were surveyed on their experience. Interestingly, 90% of students surveyed believed that the degree was worthwhile, although 43% would not choose this type of degree again given the opportunity.

A focus group based at the Sydney Medical School identified the length, inflexibility, lack of financial parity compared with full-time clinicians, and the reliance on competitive research funding as the main disincentives to pursue a career as an academic medic. These challenges are increased by the lack of clearly defined progression to Professorships. Furthermore, women were thought to be at a higher risk of succumbing to these challenges than men [4]. The pressures of clinical posts and work life balance have also been identified as a hindrance to research [5].

A questionnaire distributed to final year medical students specialising in psychiatry were surveyed regarding their potential future in academia. Of the 26% that were likely to achieve a higher degree, only 13% had any interest in pursuing a career in academia. This may be due to only 30% believing that there were reasonable role models in research, with a very high 93.3% of students reporting that there had been no discussion regarding a career in academia during their time at university. Furthermore, 33% thought it likely that they would have limited or no involvement in research in the future [6]. The level of higher degree by research for medical students at the completion of their degrees in 2009 was 2.3% (5/218) with PhD and 0.9% (2/218) Masters degrees [7].

To ensure the future of this workforce, it would be beneficial to identify potential academics at the university medical school level and ensure they are supported and mentored in order to pursue a career in academia should they desire it. It is vital to attract clinical academics at universities to create sustainability for this workforce [8, 9]. The New Zealand Medical Association (NZMA) and the Australian Medical Association (AMA) have recommended similar models for clinical academic pathways to encourage those seeking an academic career. These also include exposing students to research at university, as well as creating flexible entry and exit points throughout the pathway and embedding the support for academia in all areas of the health system [9, 10].

A survey conducted by Goldacre demonstrated that the main driving force behind becoming a clinical academic is the varied and stimulating career it offers [11]. Furthermore, a review by McKeon highlighted a protected period of research, designated infrastructure and coordinators for clinical trials as the main requirements for successful research [11].

The benefits of pursuing a career as a clinical academic and increasing the public confidence in research as well as clearly defined academic posts are all vital for building a sustainable clinical academic workforce in Australasia. Surveys conducted by the AIHW demonstrated the number of researchers in 2004 was 1171 (of 53996 total clinicians, 2.0%), 1131 in 2008 (of 64117, 1.7%) and 1220 in 2012 (of 75258 total clinicians, 1.6%) which demonstrates an increase in number, but a decrease in the percentage of overall total clinicians in 2012 performing research [12, 13].
### Canada

Similar challenges have recently been identified in Canada, where the Royal College of Physicians and Surgeons of Canada have highlighted the lengthy training times, lack of funding opportunities for clinical academics, demands from the clinical role and lack of role models as barriers [14]. The number of clinical academics is difficult to measure overall. In Canada, the number of graduates enrolled in the combined MD/PhD program has slowly increased since 2008, but the absolute number is still low [14]. The Canadian College has produced recommendations to improve the future of their clinical academic workforce that include; training that spans all levels of career progression from undergraduate level onwards, to implement flexible pathways, as well as protected time for research, which are all vital for building the academic workforce [14, 15].

### United States

In the US the National Institutes of Health (NIH) have reduced the funding of Research Project Grants (RO1) by 46% between 2000 and 2007, with an additional reduction of 10% between 2010 and 2013. Furthermore, the average age of an RO1 recipient increased from 37 years in 1980 to 45 years in 2010 [16]. An interesting study performed in 2000 surveyed Chairs of medical departments on their time allocations at work. The results demonstrated that a substantial 59% of their time focused on administration work [17]. Interviews conducted with potential clinical academics identified early exposure to research, support from the faculty, and clear pathways as some of the key methods of attracting clinical academics [18].

Clinical academics are expensive to train and thus losing them to other careers is costly. Retention is the most cost effective way of creating a workforce [16], as an estimated 79% of those involved in clinical academia leave research throughout their career [16]. There was also the suggestion that academic institutions need to become more business minded and raise their own funds and use the media to engage the community, which in turn should increase public confidence as information is disseminated more widely and the prestige of clinical academics is increased [16].
United Kingdom

The UK implemented a defined framework for clinical academics known as the UK Foundation Programme in 2007. The success of establishing this program was the robust funding from the government that set up the National Institute of Health Research (NIHR), tasked with distributing the funds to the National Health Service (NHS) and partner institutions. This framework consists of specified pathways for clinicians with an interest in academia that stems from the Walport report on career pathways designed to safeguard the workforce and to develop world-leading academic clinicians for the future [19]. The program begins with the Academic Foundation Program (AFP) for doctors to experience and learn about research including performing systematic literature reviews, submitting research grants and ethics applications, conducting studies and experiments, writing the experiment and presenting the research at conferences [20]. Following on from the AFP is the Academic Clinical Fellowship (ACF). These defined posts allow clinicians to split their time between clinical training and research or education, on average a 75% to 25% allocation, respectively. This 25% can be used as protected time from clinical training for research for completing a PhD or MD [21]. The clinical academic can then apply for Clinical Lectureships which are academic posts for doctors who have completed a higher research degree. During this time the clinical academics should be in a strong position to apply for external funding. These clinical academics are supported by the Academy of Medical Sciences who coordinate a mentoring system for those going through this process [22]. The success of this program was demonstrated early on with an increase of 2% in clinical academics the first year that it was implemented [23]. Interestingly, despite the success in the UK, the number of clinical academic consultants have not increased at the same rate as consultants [24].
### Key activities:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Action</th>
<th>Responsibility</th>
<th>Stakeholders</th>
<th>Costs/resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raise the profile of clinical academics</td>
<td>Identify key clinical academics</td>
<td>Working Party</td>
<td></td>
<td>Time</td>
</tr>
<tr>
<td></td>
<td>Publish profiles in relevant newsletters, social media platforms, and websites.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Remain informed of similar publications that can be highlighted in a similar way</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Engage government in helping to raise the profile</td>
<td>JC/LB</td>
<td>AAHMS (Ian Frazer)/AMA</td>
<td>Time</td>
</tr>
<tr>
<td>Identify willing institutions and develop pilot pathways</td>
<td>Develop a list of institutions willing to support and develop pathways from the survey on Clinical Academic Pathways</td>
<td>TG</td>
<td>Working Party, key universities, health districts, and hospitals. AHTRCs</td>
<td>Time/survey platform</td>
</tr>
<tr>
<td></td>
<td>Consult with these institutions to identify the most ideally suited. Potentially build on a current pathway.</td>
<td>JS/JW</td>
<td>Working Party, key universities, health districts, and hospitals AHTRCs</td>
<td>Time</td>
</tr>
<tr>
<td>Engage relevant spokespeople</td>
<td>Contact like-minded organisations (e.g. AAHMS) to consider joint campaigns and request they endorse funding from government to support implementing pathways</td>
<td>JS/CT</td>
<td>AAHMS (Ian Frazer) AHTRC Heads</td>
<td></td>
</tr>
<tr>
<td>Advocate with governments for potential</td>
<td>Include this on the agenda when meeting with</td>
<td>JC</td>
<td>AMA</td>
<td></td>
</tr>
<tr>
<td><strong>funding of pathway rollouts across Australia and New Zealand</strong></td>
<td>government representatives</td>
<td>Working Party</td>
<td>Medical Research Future Fund (MRFF)</td>
<td></td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------</td>
<td>----------------</td>
<td>-------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Remain informed on government healthcare spending to understand how this initiative fits in the agenda.</td>
<td>Working Party</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Identify areas of success and improvements in current pathways</strong></th>
<th>Contact institutes that currently provide pathways for clinical academics.</th>
<th>TG/JS</th>
<th>Universities, Health Districts, Institutions AHTRCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage the use of a model pathway to be piloted in the institution</td>
<td>JS/JW</td>
<td>Working Party, Universities, Health districts, Teaching hospitals,</td>
<td></td>
</tr>
</tbody>
</table>

| **Create literature on the benefits of clinical academics** | Create and publish literature on clinical academics to disseminate information on their benefits to clinical research and outcomes | LB | AAHMS |

<table>
<thead>
<tr>
<th><strong>Engage the wider public in understanding the benefits of clinical academics</strong></th>
<th>Inform the general public on relevant outcomes related to clinician researchers.</th>
<th>Working Party</th>
<th>Media</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage the public to advocate for institutions that support and fund clinical academics</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
References


7. Willcox, S., Creating and sustaining the next generation of the clinical academic workforce. 2011, Medical Deans Australia and New Zealand: Health Policy Solutions Pty Ltd.


24. Fitzpatrick, S., A Survey on Staffing Levels of Medical Clinical Academics in UK Medical Schools as at 31 July 2014. 2015.
Item 6.4 AHMAC – HWPC National Training Survey

On 25 August 2016, a National Medical Training Survey Workshop was held at the Park Royal Melbourne Airport Hotel. This Workshop was co-sponsored by the Health Workforce Principal Committee (HWPC), the Committee of Medical College Presidents (CPMC) and the Confederation of Postgraduate Medical Education Councils (CPMEC). The agenda is attached. Professor Phillip Truskett chaired the introductory session on behalf of the Chair, CPMC.

The purpose of the Workshop was to identify if there was support for a national medical training survey and what would be the aim for conducting national medical training survey in Australia.

The Workshop was informed by a background paper that included information regarding national training surveys undertaken in the United Kingdom by the General Medical Council (GMC) and in the Republic of Ireland by the Medical Council of Ireland. The paper also included an environmental scan of current surveys undertaken in Australia of the medical workforce. The background paper is available at http://www.coaghealthcouncil.gov.au/MedicalInternReview

There were over 60 participants at the Workshop with representatives from the Commonwealth, State and Territory Health Departments, medical colleges, postgraduate medical councils, doctors in training, the Australian Medical Council and the Medical Board of Australia.

Key Outcomes from the workshop include:

- Unequivocal support for a national medical training survey
- Strong agreement regarding benefits of a national survey
- Strong agreement that the survey include pre-vocational (intern and PGY2), vocational trainees and supervisors
- Strong support that survey results be published, with the level of reporting to be determined
- Strong agreement that a national survey could fully or partially replace existing surveys
- Evenly divided views as to whether a national survey should be voluntary or mandatory
- Further examination of a governance model and structure is required.

Recommendation: The Board note the Co-convening by CPMC of this forum, the issue and key outcomes.
# National Medical Training Survey Workshop

**25 August 2016**  
**Parkroyal Airport Hotel, Melbourne**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker/Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.30</td>
<td>Workshop registration, coffee &amp; tea</td>
<td>Dr. Jo Burnand – Facilitator</td>
</tr>
</tbody>
</table>
| 10.00 | Welcome & Acknowledgement of County                                                                                                     | Professor Phillip Truskett  
Committee of Presidents of Medical Colleges  
Professor Richard Tarala  
Confederation of Postgraduate Medical Councils  
Dr. Jo Burnand – Facilitator |
| 10.15 | Opening Address                                                                                                                           | Professor Phillip Truskett  
Committee of Presidents of Medical Colleges  
Professor Richard Tarala  
Confederation of Postgraduate Medical Councils  
Dr. Jo Burnand – Facilitator |
| 10.15 | Setting the Scene                                                                                                                         | Ms Robyn Burley, NSW HWPC Member  
Dr Alistair Park  
AMA Council of Doctors in Training  
Dr. Sara de Menezes  
Australasian JMO Committee |
| 10.45 | Current State of Play Themes for consideration  
- Reasons and value for undertaking surveys  
- Challenges in undertaking surveys  
- Communicating and acting on results | Table work  
Plenary session |
| 11.45 | Why Not a National Survey? Themes for consideration  
- Benefits and challenges of a National Survey  
- Aim of a National Survey  
- Scope | Table work |
| 12.30 | Lunch                                                                                                                                    | Plenary Discussion |
| 13.15 | Why Not a National Survey?                                                                                                              | Plenary Discussion |
| 13.45 | Survey Oversight Themes for consideration  
- Survey administration  
- Results management  
- Governance principles | Table work  
Plenary session |
| 14.30 | Stakeholder feedback                                                                                                                    | Audience Polling |
| 14.45 | Closing and Next Steps                                                                                                                  | Ms Robyn Burley |
| 15.00 | Finish                                                                                                                                   | Ms Robyn Burley |

Confederation of Postgraduate Medical Education Councils  
Committee of Presidents of Medical Colleges  
Health Workforce Principal Committee
Item 6.5     Senate Standing Committee on Community Affairs

Enquiry into the Medical Complaints Process in Australia

The Committee considered the enquiry as part of the 44th Parliament and at the dissolution of the Senate on 9 May 2016, the enquiry lapsed.

On 15 September 2016, the Senate agreed to re-adopt the enquiry and lodged a reporting date of 16 November 2016. Parliament rises for 2016 on 1 December 2016.

The Committee will have relied on submissions received during the 44th Parliament to make the report and any recommendations. CPMC lodged a submission to this enquiry.

http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MedicalComplaints45/Submissions

Recommendation: The Board note the reporting date and further information will be provided out of session accordingly.
Item 6.6 National Health Summit on Obesity – wrap up

This item simply provides an outline of the process undertaken by CPMC Secretariat to convene a major National Health Summit on Obesity and close off the topic from the CPMC agenda.

At the February 2016 strategic planning workshop and then agreed at the following day’s CPMC meeting, Directors determined to convene a National Health Summit in 2016 on Obesity. With the aim of convening the Summit at a time which did not conflict with major events, Parliamentary commitments, the Federal Election and sporting finals, the date on 9 November 2016 was chosen. The RACGP offered to provide the venue for an invitation-only CPMC sponsored Summit. A proposal was put forward to establish a working group comprising:

- Professor Talley (Chair)
- Professor Malcolm Hopwood, Psychiatry
- Professor Michael Permezel, Obstetrics and Gynaecology
- Dr Catherine Yelland, Physicians
- Dr Frank Jones, General Practice

In the proposal the rationale for focussing on the epidemic of obesity in Australian society was discussed in the context of international literature and any initiatives which have occurred in the previous few years to address the issue from the perspective of regulatory and societal change. The working group met and discussed the issue including the budget and decided to augment into a Scientific Advisory Committee bringing additional subject matter expertise. The following eminent persons were approached to join the SAC:

- Professor Louise Baur, Professor of Child and Adolescent Health at the University of Sydney and Head of The Children’s Hospital and Westmead Clinical School.
- Professor Tim Gill, Professor of Public Health Nutrition at the Boden Institute of Obesity, Exercise and Eating Disorders at the University of Sydney.
- Dr Georgia Rigas, Chair the RACGP Obesity Management Network.
- Ms Jane Martin, Executive Manager the Obesity Policy Coalition.

The augmented SAC received terms of reference which included steering the policy development for the program agenda and helping with evidence collection. A workplan with timelines and budget was prepared and CEO followed that which included creating the stand-alone web page to promote the Summit, the background papers, convening the monthly teleconferences with the associated coordination of advice. The budget included bringing on board media liaison and expert facilitators. To ensure the Summit comprised attendees relevant to the theme an invitation only process occurred. The Summit could best be described as a one day conference and all the associated event logistics and coordination requirements were required which if Board considers doing again in the future, it should be externalised to a conference management company and fees charged to cover the cost.

Professor Talley will update the Board on the Summit in terms of outcomes and whether it was a policy initiative which should be considered as part of the CPMC strategic agenda.

Recommendation: The Board notes the wrap up from the Summit.
Item 6.7 National Registration and Accreditation Scheme - Review of the Accreditation under the Scheme

In August 2015 a final report was released regarding the Independent Review of the National Registration and Accreditation Scheme (NRAS) and thirty-three recommendations were made about the Scheme. Of these seven were relevant to accreditation of the fourteen regulated professions under the Health Practitioner Regulation National Law. The Board will note that the recommendations related to the extent of the variability in accreditation arrangements across them all, and included commentary about the cost, transparency and duplication of existing accreditation arrangements and the overly prescriptive approach in some existing accreditation processes. Some of CPMC stakeholders such as the AMC raised concerns about the cost of accreditation as presented in that review, and argued they were way too high.

Australian Health Ministers reviewed the recommendations and supported them in-principle. They recommended if implemented some improvements would occur but reform was necessary overall. AHMC sent a request to the Australian Health Ministers’ Advisory Council (AHMAC) to commission further advice and undertake a comprehensive review of accreditation functions.

As shown in the attachment, the review has been commissioned with the appointment of the Independent Reviewer Professor Michael Woods, who is an economist the University of Technology, Sydney’s centre for health economic research and evaluation. Informal discussions have taken place but more formal stakeholder consultations will occur towards March 2017.

Recommendation: The Board notes the announcement and the proposed timeline for consultation.

Attachment
Commencement of the Accreditation Systems Review

On 10 October 2016, AHMAC released a Communique which announced the appointment of Professor Michael Woods as Independent Reviewer for the Accreditation Systems Review.

Professor Woods is currently Professor of Health Economics in the Centre for Health Economics Research and Evaluation at the University of Technology Sydney. He has Visiting Scholar status at Australian National University. Professor Woods has extensive experience in economics, the public sector and health policy. He has previously been Commissioner, then Deputy Chair, of the Australian Productivity Commission during which time he presided on over 20 national policy inquiries and reviews. Professor Woods has also been Under Treasurer for the Australian Capital Territory.

Background to the Review

The National Registration and Accreditation Scheme (NRAS) for the health professions came into operation on 1 July 2010. The Scheme was implemented through enactment of the Health Practitioner Regulation National Law in each state and territory (the National Law). The objectives and guiding principles of NRAS are set out in section 3 of the National Law and include:

- to facilitate the provision of high quality education and training of health practitioners
- to facilitate the rigorous and responsive assessment of overseas-trained health practitioners
- to enable the continuous development of a flexible, responsive and sustainable Australian health workforce
- to enable innovation in the education of, and service delivery by, health practitioners.

In 2014, the Australian Health Workforce Ministerial Council commissioned an independent review of NRAS which identified significant concerns with the high cost, lack of transparency, accountability, duplication and approach of the existing accreditation processes. The NRAS Review recommended a number of measures to address these issues, including further exploration of the United Kingdom approach to accreditation.

In August 2015, Health Ministers accepted in principle the NRAS Review recommendations related to ‘Accreditation Functions’ but requested a more comprehensive review of accreditation processes within the National Scheme to inform further consideration.

Scope of the Review

The Accreditation Systems Review’s Terms of Reference require that it consider the findings of the 2005 Productivity Commission Report Australia’s Health Workforce and the NRAS Review and that it undertake further analysis of the Australian, UK and other international accreditation systems.
In particular, the Review is to address:

- the cost effectiveness of the existing systems for the delivery of accreditation functions
- governance structures including reporting arrangements
- opportunities for the streamlining of accreditation including consideration of other educational accreditation processes
- the extent to which accreditation arrangements support educational innovation in programs including clinical training arrangements, use of simulation and inter-professional learning
- opportunities for increasing consistency and collaboration across professions.

Professor Woods’ Report will provide advice to the Australian Health Ministers Advisory Council and the Australian Health Workforce Ministerial Council on options for reform of the accreditation system and structures to support a sustainable health workforce that is flexible and responsive to the changing health needs of the Australian community.

The Report is scheduled to be completed by September 2017.

The full Terms of Reference are at Attachment 1.

Consultation

Feedback from stakeholders about their direct experience within NRAS will play a key part in informing the Accreditation Systems Review; particularly to identify:

- the strengths and limitations of existing procedures and governance arrangements and opportunities for improvement
- key issues and concerns about enabling the continuous development of a flexible, responsive and sustainable Australian health workforce
- priority areas and options for reform.

All stakeholders and interested parties will have the opportunity to contribute to the Review. This includes attending the National Consultations to be held in all jurisdictions in 2017 and providing a submission in response to the Review consultation paper.

It is also recognised that a wide range of stakeholders have already provided feedback on the existing accreditation systems within Australia by participating in the 2014 NRAS Review through consultation forums and/or submissions. Indeed, many of the stakeholders also made significant contributions to the earlier Productivity Commission Report. The current Review will consider, utilise and build on this expert body of knowledge to develop a consultation paper that provides a comprehensive review of accreditation systems and seeks to address the issues raised by Health Ministers.

Further information

Further information on the national consultations and submission process will be announced in later Bulletins and posted on the Review of Accreditation Systems Review website at www.coaghealthcouncil.gov.au/AccreditationSystemsReview

To register your interest in this Review and to receive future Bulletins, or to contact the Accreditation Systems Review team on any other matter, please email: admin@ASReview.org.au
ATTACHMENT 1

Accreditation Systems Review: Terms of Reference

The Review of Accreditation Systems will provide advice to AHMAC on the governance, structure, cost, and reporting arrangements to improve the efficiency, transparency and cost effectiveness of the health professions accreditation system, to support a sustainable health workforce that is flexible and responsive to the changing health needs of the Australian community.

The Review is to address:

- cost effectiveness of the regime for delivering the accreditation functions
- governance structures including reporting arrangements
- opportunities for the streamlining of accreditation including consideration of the other educational accreditation processes e.g. Tertiary Education Quality Standards Agency (TEQSA) and Australian Skills Quality Authority (ASQA)
- the extent to which accreditation arrangements support educational innovation in programs including clinical training arrangements, use of simulation and inter-professional learning
- opportunities for increasing consistency and collaboration across professions to facilitate integrated service delivery.

The Review will:

1. Map current arrangements through which health professions accreditation functions are delivered and the quality of health professions training is assured in Australia. This should include mapping of existing governance arrangements for health professions accreditation across education sectors in which the education providers operate (higher education, vocational education and training, and the specialist colleges system), and examination of the governance arrangements through which:
   - accreditation standards are established
   - qualifying programs of study are assessed
   - the equivalence of qualifications of overseas trained practitioners is determined
   - national examinations and other assessments are conducted, for the purposes of entry to practise in the Australian health professions
   - ‘competent authorities’ in other countries are recognised.

2. Undertake a comparative analysis of key features of the systems for delivery of health professions accreditation functions in selected international jurisdictions. This should include an analysis of the scope, governance, cost and performance of these systems compared with the Australian system.

3. Review the findings and recommendations of previous reports that have addressed governance of health professions program accreditation functions, and other relevant documents, including:
   - the Productivity Commission’s 2005 research report titled Australia’s Health Workforce
   - the NRAS Review Final Report of 2014
   - the Australian Higher Education Standards Framework (Threshold Standards) 2015.
4. Assess how well the accreditation functions are meeting the objectives and guiding principles of the National Law.

5. Identify and analyse a range of feasible options for reform of the governance of health professions accreditation functions in Australia, and undertake a national consultation on these options.

6. Undertake a cost-effectiveness analysis of feasible options for reform of health professions accreditation functions, compared with the status quo, and make recommendations for a preferred option or options.

The advice to AHMAC and Health Ministers will include a report outlining options for reform of accreditation systems and structures. The final report will also include advice on any necessary legislative changes, and policy or administrative actions required to give effect to the preferred option/s and recommendations.
Item 7.1 Dates for 2017 – for decision

The company has a number of options for 2017 when considering hosting the quarterly meetings. These are:

- If CPMC shifts premises as outlined in item 7.2, then several meetings could occur there;
- The Chair has suggested convening a meeting in the Hunter region near to his university and the John Hunter Hospital;
- Sydney and Melbourne are viable options to continue with to assist in convenience for the members, while also considering Brisbane because of the large number of College Presidents residing in that city.

Key Dates to consider:

Thursday 28 February 2017 – to allow sufficient time in 2017 to prepare the agenda with guests

Thursday 25 May 2017 - to allow for the Federal Budget (2nd Tues) and hear from Government

Thursday 31 August 2017 – to provide at least 6+ weeks from the previous meeting.

Thursday 14 November 2017 - to allow for Melbourne Cup (1st Tuesday) in terms of travel.
EXECUTIVE SUMMARY

AREA:  
Level 2 - 505sqm  
Level 1 - 270sqm approx

LOCATION:  
Deakin

TIMING:  
Available Now

TERM:  
5 years plus

RENTAL:  
TBA

2  
KING STREET  
DEAKIN, ACT

Belinda Hedley  
Manager  
0412 622 192  
belinda.hedley@cbre.com.au

James Parkyn  
Negotiator  
0400 516 255  
james.parkyn@cbre.com.au
FOR LEASE

2
KING STREET
DEAKIN, ACT

PROPERTY DESCRIPTION:
This innovative building has attracted high calibre tenants such as Sydney IVF, Aspen Medical, Queensland University of Technology, National Accreditation Authority for Translators & Interpreters (NAATI), Frog Tech Pty Ltd and Rural Funds Management.

LOCATION DESCRIPTION:
Excellent central address, only minutes from Parliament House, Woden, City and an easy 10 kms to the Airport. Close to public transport and amenities, Deakin Shops being 1.4km and Curtin Shops being 1.7km. The building has its own eatery and there are other eateries in the vicinity within easy walking distance.

AVAILABLE SPACE:
Level 2 – 505sqm
Level 1 – 270sqm approx

LEASE TERM:
5 years plus

ASKING RENTALS
TBA

OUTGOINGS:
Increase in Statutory outgoings over a base year

CAR PARKING:
Allocated car parking available @ $1,500 per bay pa plus GST, together with public car parking available directly across the road and surrounding the building.

RENT REVIEW STRUCTURE:
4% annual increases.

PROPERTY FEATURES:
• New A Grade Office Accommodation
• Innovative design
• Central atrium linking both stages 01 & 02 together
• Opportunity for integrated fitout
• Natural light in abundance

FOR MORE INFORMATION PLEASE CONTACT:

Belinda Hedley
Manager
0412 622 192
belinda.hedley@cbre.com.au

James Parkyn
Negotiator
0400 516 255
james.parkyn@cbre.com.au

© 2010 CBRE, Inc. This information has been obtained from sources believed reliable. We have not verified it and make no guarantee, warranty or representation about it. Any projections, opinions, assumptions or estimates used are for example only and do not represent the current or future performance of the property. You and your advisors should conduct a careful, independent investigation of the property to determine its suitability for your needs.
FOR LEASE

2
KING STREET

DEAKIN, ACT

LOCATION MAP

Image Sourced by Google Maps

© 2010 CBRE, Inc. This information has been obtained from sources believed reliable. We have not verified it and make no guarantee, warranty or representation about it. Any projections, opinions, assumptions or estimates used are for example only and do not represent the current or future performance of the property. You and your advisors should conduct a careful, independent investigation of the property to determine to your satisfaction the suitability of the property for your needs.
Item 7.2 CPMC Premises- option to shift in 2017

CPMC has been offered an opportunity to co-locate with the Royal Australasian College of Surgeons, ACT when the regional office shifts to new premises in January 2017. This paper provides the rationale for the recommendation to take up that offer. The CPMC budget provides for the small increase in rent.

The offer is to sub-lease from RACS for a fixed period with an option to renew. There is access to the Board area, expanded seating area, kitchen and office space. Parking in the secure building underneath is also available. IT service agreement has been requested. The floor plan is attached along with relevant photos.

The Board may wish to note the following issues associated with the current premises:

- Space is 10 square metres, or equivalent to very small office;
- CPMC currently has no reception or administrative support capability due to space;
- Access to a board table seating 10 persons;
- Shared kitchen or bathroom facilities inside an ageing building with no natural light, poor security (dark at night, break-ins to cars etc) and is not a clean environment;
- Recently office experienced flooding due to taps having been left on in the kitchenette. CPMC office flooding meant unusable for a week and the carpet smells.
- CPMC pays approximately $8000 per annum for rental via sublease with ANZCA.

The option to shift to 2 King Street, Deakin is based on the following criteria:

- Large modern space, office size is 14 square metres at $13,500 per annum;
- Board room seats 20 and opens up to comfortably seat 50 persons;
- Board room has a totally separate second entrance to the room from the ground floor so Board could meet with people without the rest of the tenants being aware;
- Giant reception desk and amenities there to fit photocopier etc;
- Large professional kitchen and seating area – capable of private dining;
- Own private toilet/shower/change room facilities behind the kitchen area – clean;
- Private secure parking underneath the building for an additional fee.

The rationale for considering the move is that CPMC needs to move to more modern, secure and healthy workplace. The benefits to arise from upgrading to a larger, more modern and professional premises are clear when the photo collage is viewed with reference to the existing space. Several key health organisations are located within the building, thereby enhancing potential strategic engagement. The inclusion of reception space, and additional office space including the capacity to convene the large quarterly meetings is a major incentive. The scope for holding other meetings or Summits is widened accordingly.

The proposal to shift in January is because it would coincide with the shutdown period, and would be convenient to the CEO who would have to undertake the move and make the necessary changes to advise of address and so forth.

Recommendation: Directors approve CPMC moving to modern premises in January 2017 noting the letter from RACS Deputy CEO.
1 November 2016

Ms Angela Magarry  
Chief Executive Officer  
Council of Presidents of Medical College  
6/14 Napier Close, Deakin. ACT 2600

Dear Angela

RE: Sub-lease of new RACS Premises at 2 King Street, Deakin

I refer to recent discussions regarding your desire to co-locate with RACS at the new premises we will lease at 2 King Street, Deakin.

We are presently in lease negotiations with the Lessor and we believe this will be finalised by the end of November with possible move in date in January. The lease is for 10 years with a 5 year extension option.

I understand you have viewed the property and are satisfied it will meet your needs.

RACS would be grateful to receive your commitment as soon as possible and we will proceed to prepare a formal sub-lease between RACS and CPMC in due course.

A floor plan is attached and you have indicated satisfaction with the office shown as 19.45sqm.

The price per sqm charged by the Lessee is $450. This totals $8,752.50 for base rent excluding GST.

The lease is subject to a 3% annual increase with a market review to be conducted at the commencement of year 6.

RACS has an outgoings and overhead rate of 30% which covers occupancy costs and use of shared space (e.g. conference room, kitchen, break out area).

You have indicated you would also like to access to a dedicated parking spot which is $1500 per annum.

The Lessor has offered an incentive of three (3) month’s rent free from the commencement of the lease and inclusion of furniture (subject to final negotiation). These incentives will be passed on to CPMC.

The lease document will cover further detail in terms of administrative charges, however, so you are aware:

Telecommunications. All set-up communication costs are to be paid by the sublessee.

Use of the College’s digital telecommunications infrastructure will incur an annual handset charge of $325 (excl. GST) payable by the sublessee, annually in advance.
Associated call costs are billed on a cost recovery basis, monthly in arrears.

Printing and Photocopying Charges

Access and use of the College’s printing and photocopying infrastructure is permitted for use where approved College desktops/notebooks are used by the sublessee.

Printing and photocopying charges are billed on a cost recovery basis, monthly in arrears.

Information Technology (IT) Support

A per month charge (to be advised shortly) per person is payable by the sublessee, monthly in advance, being for IT Support. This charge is subject to review at time of annual rent review date.

In summary – the indicative annual costs for the first year (excluding IT support to be finalised) are:

Base rent: $8,752.50
Outgoings: $2,625.75
Parking: $1,500.00
Phone hardware: $325.00
$13,203.25 excluding GST

Finally, we can certainly discuss any requirements to have administrative support for the preparation of documents, meeting coordination, etc. I estimate this would be in the $43 - $46 per hour range (subject to annual increase).

Upon your review and discussion with your board, should you wish to proceed with a formal sublease, please indicate acceptance of this proposal by signing and returning a copy of this letter.

Yours sincerely,

Deborah Jenkins

Deborah Jenkins
Director, Relationships & Advocacy Division

cc: Amy Kimber, Manager, ACT Regional Office & Commonwealth Advocacy

********

I, Angela Magarry, being authorised on behalf of the Council of Presidents of Medical Colleges, accept this proposal from the Royal Australasian College of Surgeons to sublease an office at 2 King Street, Deakin, ACT.