<table>
<thead>
<tr>
<th>Item #</th>
<th>Time</th>
<th>Agenda Item</th>
<th>Presented by</th>
<th>Paper</th>
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<tr>
<td></td>
<td>08:45</td>
<td><strong>Professions Forum (Open)</strong></td>
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<tr>
<td>1</td>
<td>09:00</td>
<td>Escort from Marble Foyer</td>
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<td>2</td>
<td>9:00am</td>
<td>Meeting formalities</td>
<td>Chair</td>
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<td></td>
<td></td>
<td>1.1 Attendance and Apologies</td>
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<td>1.2 Conflicts of Interest and Confidentiality</td>
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<td>1.3 Other issues</td>
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<td>2</td>
<td>9:10am</td>
<td>The Australian Medical Council</td>
<td>Prof. R Mortimer</td>
<td>✓</td>
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<td>CEO: Ian Frank</td>
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<td>2</td>
<td>9:20am</td>
<td>Commonwealth Chief Medical Officer</td>
<td>Dr Andrew Singer</td>
<td>✓</td>
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<td></td>
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<td>Prof Baggoley an apology</td>
<td>Dr Anthony Hobbs</td>
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<td>2</td>
<td>9:30am</td>
<td>National Health &amp; Medical Research Council</td>
<td>Note report</td>
<td>✓</td>
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<td></td>
<td>Prof Anne Kelso- apology</td>
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<td>2</td>
<td>9:40am</td>
<td>Medical Board of Australia</td>
<td>Note report</td>
<td>✓</td>
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<td>Dr J. Flynn apology</td>
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<td>&amp; AHPRA update CEO M. Fletcher</td>
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<td>10am</td>
<td>Australian Indigenous Doctors’ Association</td>
<td>Dr Tammy Kimpton</td>
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<td>2</td>
<td>10:10am</td>
<td>Australian Commission on Safety &amp; Quality</td>
<td>Note report</td>
<td>✓</td>
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<td></td>
<td>in Healthcare - Ms Nicola Dunbar to introduce</td>
<td>Discuss issue</td>
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<td>the project <em>recognising and responding to clinical deterioration</em></td>
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<td>2</td>
<td>10:20am</td>
<td>The Australian Medical Association</td>
<td>CEO Anne Trimmer</td>
<td>✓</td>
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<tr>
<td>2</td>
<td>10:45am</td>
<td>Medical Deans of Australia &amp; New Zealand</td>
<td>Prof Peter Smith</td>
<td>✓</td>
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<td>CEO Dr Judy Searle</td>
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<td>11:00 – 11:45am</td>
<td>Morning Tea</td>
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<td>To celebrate the 110th meeting of CPMC</td>
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<td>3</td>
<td>11:45am</td>
<td>General Business commences (introductions)</td>
<td>Chair</td>
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<tr>
<td>3.1</td>
<td>11:45am</td>
<td>Dr Wendy Southern Deputy Secretary Department of Health (confirmed)</td>
<td>Chair</td>
<td>✓</td>
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<tr>
<td>3.2</td>
<td>12:30pm</td>
<td>The Hon. Sussan Ley Minister for Health and Sport (confirmed)</td>
<td>Chair</td>
<td>✓</td>
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**1 – 1:45pm – LUNCH**

**Strategic Business Session (Presidents & CEOs)**

| 4     | 1:45pm | Minutes for Confirmation                                                   | Chair        | ✓     |
|       | 4.1    | Minutes of previous meeting held 19 February                                |              | ✓     |
|       | 4.2    | Business arising from minutes                                              |              | ✓     |

5

Governance

| 5.1   | Chair’s report including duty statement for approval                      | Chair        | ✓     |
| 5.1.2 | Chief Executive Officer’s report                                           | CEO          | ✓     |
| 5.1.3 | Financial Statements: 3rd quarter 2014-15                                  | CEO          | ✓     |
| 5.1.4 | CPMC budget 2015-16 – for approval                                        |              | ✓     |
| 5.1.5 | Changes in Directors                                                      | For noting   | ✓     |

Subcommittee Reports

| 5.2.1 | Education subcommittee (in abeyance)                                      | Dr Gruner    |       |
| 5.2.2 | Indigenous Health subcommittee                                             | Prof. M Hollands | ✓     |

Representatives reports

| 5.3.1 | National Medical Training Advisory Network –note 6.4                       | Chair        | ✓     |
| 5.3.2 | IHPA stakeholder Advisory Committee -minutes                                | To be noted  | ✓     |

Strategy

| 6.1   | Revalidation                                                               | discuss      | ✓     |
| 6.2   | CPMC Strategic Plan “Towards 2017”                                         |              | ✓     |
| 6.3   | RACGP: Homeopathy position statement                                       | Dr Frank Jones | ✓     |

6.4 3pm

Discussion with Chair, National Medical Training Advisory Network- Professor John Horvarth (Ms Tarja Saastamoinen will also be in attendance)

| 6.5   | Health impacts of climate change – proposed global advocacy initiative (RACP agenda item) | Prof Catherine Yelland | ✓     |

6.6

Review of the MBS

| 7.1   | Other Business: Meeting Evaluation                                         | ✓             |       |
| 7.2   | Next Meeting: ANZCA Melbourne 6 August 2015                                 |              |       |

Concludes before 4pm
110th Committee of Presidents of Medical Colleges

Thursday 14 May 2015

YOUR NAMES ARE ON A LIST AT THE SECURITY DESK MARBLE FOYER.

YOU NEED TO SHOW PHOTO ID WHEN YOU SIGN IN.

1. Meeting Formalities

1.1 Attendance and Apologies Received (★ denotes apology)

**CPMC Member Presidents**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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</thead>
<tbody>
<tr>
<td>Professor Michael Hollands</td>
<td>Chair</td>
</tr>
<tr>
<td>A/Professor Stephen Shumack</td>
<td>President, Australian College of Dermatologists</td>
</tr>
<tr>
<td>Dr Anthony Cross</td>
<td>President, Australasian College for Emergency Medicine</td>
</tr>
<tr>
<td>A/Professor Lucie Walters</td>
<td>President, Australian College of Rural and Remote Medicine</td>
</tr>
<tr>
<td>Dr Genevieve Goulding</td>
<td>President, Australia and New Zealand College of Anaesthetists</td>
</tr>
<tr>
<td>Professor Bala Venkatesh</td>
<td>President, College of Intensive Care Medicine</td>
</tr>
<tr>
<td>A/Professor Frank Jones</td>
<td>President, Royal Australasian College of General Practitioners</td>
</tr>
<tr>
<td>Dr Lee Gruner</td>
<td>President, Royal Australasian College of Medical Administrators</td>
</tr>
<tr>
<td>★ Professor Nick Talley</td>
<td>President, Royal Australasian College of Physicians</td>
</tr>
<tr>
<td>Professor David Watters</td>
<td>President, Royal Australasian College of Surgeons</td>
</tr>
<tr>
<td>Dr Brad Horsburgh</td>
<td>President, Royal Australasian College of Ophthalmologists</td>
</tr>
<tr>
<td>Professor Michael Permezel</td>
<td>President, Royal Australasian College of Obs-Gynaecologists</td>
</tr>
<tr>
<td>Professor Malcolm Hopwood</td>
<td>President, Royal Australasian College of Psychiatrists</td>
</tr>
<tr>
<td>Professor Chris Milross</td>
<td>President, Royal Australia and New Zealand College of Radiologists</td>
</tr>
<tr>
<td>Professor Peter Stewart</td>
<td>President, Royal College of Pathologists Australia</td>
</tr>
<tr>
<td>★ Dr Michael Jamieson</td>
<td>President, Australasian College of Sports Physicians</td>
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**Profession Observers**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>★ Professor Chris Baggoley</td>
<td>Commonwealth Chief Medical Officer</td>
</tr>
<tr>
<td>Dr Andrew Singer</td>
<td>Principal Medical Advisor, Acute Care Div. Department of Health</td>
</tr>
<tr>
<td>Professor Robin Mortimer</td>
<td>President, Australian Medical Council</td>
</tr>
<tr>
<td>Mr Ian Frank</td>
<td>CEO, Australian Medical Council</td>
</tr>
<tr>
<td>★ Dr Joanna Flynn</td>
<td>Chair, Medical Board of Australia</td>
</tr>
<tr>
<td>★ Mr Martin Fletcher</td>
<td>CEO, Australian Health Practitioners Regulatory Authority</td>
</tr>
<tr>
<td>Dr Tammy Kimpton</td>
<td>President, Australian Indigenous Doctors’ Association</td>
</tr>
<tr>
<td>★ Professor Anne Kelso</td>
<td>CEO, National Health &amp; Medical Research Council</td>
</tr>
<tr>
<td>Dr Brian Owler</td>
<td>President, Australian Medical Association</td>
</tr>
<tr>
<td>Ms Anne Trimmer</td>
<td>Secretary General, Australian Medical Association</td>
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<tr>
<td>★ Professor Villis Marshall</td>
<td>Chair, Australian Commission on Safety and Quality in Health Care</td>
</tr>
<tr>
<td>Professor Peter Smith</td>
<td>President, Medical Deans Australia and New Zealand</td>
</tr>
<tr>
<td>Professor Judy Searle</td>
<td>CEO, Medical Deans Australia and New Zealand</td>
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**CPMC CEOs:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Mr Tim Willis</td>
<td>CEO, Australian College of Dermatologists</td>
</tr>
<tr>
<td>Ms Alana Killen</td>
<td>CEO, Australasian College for Emergency Medicine</td>
</tr>
<tr>
<td>Ms Marita Cowie</td>
<td>CEO, Australian College of Rural and Remote Medicine</td>
</tr>
<tr>
<td>Ms Linda Sorrell</td>
<td>CEO, Australia and New Zealand College of Anaesthetists</td>
</tr>
<tr>
<td>Mr Phillip Hart</td>
<td>CEO, College of Intensive Care Medicine</td>
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</tbody>
</table>
Dr Zena Burgess  CEO, Royal Australasian College of General Practitioners  
Dr Karen Owen    CEO, Royal Australasian College of Medical Administrators  
Ms Linda Smith   CEO, Royal Australasian College of Physicians  
Ms Lyn Johnson A/CEO, Royal Australasian College of Obstetricians and Gynaecologists  
Mr Andrew Peters  CEO, Royal Australasian College of Psychiatrists  
Dr Debra Graves  CEO, Royal College of Pathologists Australia  
Dr David Andrews  CEO, Royal Australasian College of Ophthalmologists  
Ms Michelle Thompson CEO, Royal Australasian College of Sports Physicians  

In Attendance:  
Ms Angela Magarry   CEO & Company Secretary  
Mr Michael Davidson  RHCE PMU - CPMC  

Apologies Received  
- Professor Chris Baggoley – Chief Medical Officer, replaced by Dr Anthony Hobbs, TGA  
- Professor Anne Kelso – CEO, National Health & Medical Research Council  
- Professor Villis Marshall – Chair Australian Commission on Safety and Quality in Health Care (Ms Nicola Dunbar in attendance for Villis)  
- Professor Nicholas Talley – RACP (replaced by Dr Catherine Yelland)  
- Professor Mark Daniell – RANZCO (replaced by Professor Brad Horsburgh)  
- Dr Michael Jamieson – ACSP ( replaced by Dr Adam Castricum)  
- Dr Joanna Flynn (MBA)  
- Mr Martin Fletcher (AHPRA)  

1.2 Conflicts of Interest to be noted at the meeting  
1.3 Other Issues  
- This is the first meeting for Professor David Watters, President, RACS and Professor Malcolm Hopwood is the President, RANZCP  
- This is the final meeting for Professor Stephen Shumack.  
- Dr Adam Castricum is replacing Dr Jamieson for this meeting.  
- Minister for Health and Sport to address the Presidents after morning tea at 12:30pm. Photographs will be taken.
1. Directors and Council

1.1 Next Meeting of the Australian Medical Council Limited

The next Meeting of the Australian Medical Council will take place in Toowoomba, Queensland on June 25 and 26. The AMC is keen to build on its work supporting the delivery of well-trained medical practitioners to rural and regional Australia, and to leadership in Indigenous health and the needs of its practitioners. To assist the AMC to understand and address the challenges faced, from time to time the Council holds meetings in regional locations.

The Council has identified a number of areas for exploration through a program of site visits and discussions including:

- recruitment, retention and appropriate distribution of the health workforce;
- demography, health outcomes, and health care priorities for rural and regional communities;
- the health and health care of Aboriginal and Torres Strait Islander people;
- models of generalist medical practice and of multidisciplinary health teams; and
- medical education and training that prepares practitioners for the challenges of rural and regional health care, and education and training in rural and regional areas.

The AMC regards the meeting in Toowoomba as a unique opportunity to engage with Queensland Health officers, health services, local practitioners, educators, and community leaders in a process that aims to strengthen stakeholder and community understanding of not only the work of the AMC but also how that work supports good quality medical education and training to meet the needs of rural and regional communities and healthcare services.

Ms Angela Magarry, as Chief Executive Officer of the CPMC, has been invited to attend the two days as an Observer.

2 National Registration and Accreditation Scheme

2.1 Three Year Review of the Scheme

As noted in the AMC’s February report the review of the National Registration and Accreditation Scheme (NRAS Review) initiated by the Ministerial Council and undertaken by an independent reviewer, Mr Kim Snowball, the former Director General of Health in Western Australia, has been completed. The report by Mr Snowball was presented to the Ministerial Council at its meeting on 17 April 2015. Further discussion about the report and its recommendations has been postponed until August 2015.
3.  Accreditation

3.1  Specialist Education Accreditation Committee
The AMC Specialist Education Accreditation Committee recently considered a range of matters regarding accreditation of specialist medical programs, as outlined below.

3.1.1  Australian College of Rural and Remote Medicine 2014 Follow-up Assessment
The Medical Board of Australia approved the College’s programs as providing a qualification for the purposes of specialist registration until 31 March 2018.

3.1.2  Royal Australasian College of Physicians 2014 Reaccreditation Assessment
The Medical Board of Australia approved the College’s programs as providing a qualification for the purposes of specialist registration until 31 March 2021.

3.1.4  Review of accreditation standards for specialist training programs
The AMC undertakes reviews of the accreditation standards for specialist medical programs and continuing professional development programs every five years. Under the Health Practitioner Regulation National Law, the AMC develops accreditation standards and the Medical Board of Australia approves them. Since the introduction of the National Law, in reviewing the accreditation standards the AMC is obliged to take account of the Australian Health Practitioner Regulation Agency Procedures for Development of Accreditation Standards.

The current Standards for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs by the Australian Medical Council were produced in 2009, following a wide ranging review (with minor changes in 2010 when the Medical Board of Australia wrote national registration standards). In 2013 the AMC began its review of the standards for specialist medical programs with a consultation on the proposed scope of the review. The consultation document indicated that the AMC did not believe the accreditation process and the structure of the accreditation standards required major change or a re-writing of the standards but that what was required, in most areas, was an updating of the standards. The stakeholder feedback largely supported the proposed scope.

Directors established a Standards Review Working Party, chaired by Associate Professor Jill Sewell AM, to oversee the review of the standards. The working party commenced its detailed review in August 2014. The working party’s revisions have been in line with the overarching scope of the review, stakeholder feedback and relevant national and international policy initiatives. The revisions to the standards were agreed by the Specialist Education Accreditation Committee. AMC Directors commented on the revised standards at the 11 March 2015 meeting.

The revised standards were then released for initial stakeholder consultation in March 2015. When the consultation period concludes on 4 May 2015, the working party will consider the feedback on the draft proposals for change to the standards and develop a final set of revised accreditation standards. The AMC is planning to conduct a second consultation on these revised standards in May 2015. The expected completion date of the review is mid-2015, with implementation of the revised standards from 2016.
3.2 The Prevocational Standards Accreditation Committee
The AMC Prevocational Standards Accreditation Committee, chaired by Professor Liz Farmer, takes responsibility for oversight of the AMC’s work to finalise the standards, guidelines and procedures necessary to support the implementation of the national framework for intern training. In 2015 the Committee will continue with its work in assessment of intern training accreditation authorities for Queensland, Western Australia and Victoria.

3.3 International Medical Symposium
The AMC’s President, Professor Robin Mortimer, presented to the 2015 International Medical Symposium ‘The Future of the Medical Professions’. The symposium hosted by the Royal Australasian College of Physicians, the Royal Australasian College of Surgeons and the Royal College of Physicians and Surgeons of Canada was held on 13 March 2014.

4. Assessment and Examinations
4.1 Benchmarking Project with Medical Deans
The 2010 Medical Deans conference considered a proposal to develop a benchmarking project for medical schools based on the development of a shared bank of MCQ items. Although the Medical Deans benchmarking project was developed independently of the AMC, the AMC was invited to participate in a number of meetings and to contribute some expertise on assessment to the project. The project was later funded by HWA to conduct a trial benchmarking examination with all Australian medical schools, using a common bank of items jointly developed for the project. In 2014, with the decision to dismantle HWA, Medical Deans were advised that funding for the benchmarking would not continue beyond the current project.

In August 2014, the AMC approached Medical Deans with a proposal that the AMC calibrated item bank be used to source material for further benchmarking tests. The item bank consisted of over 5,000 items covering the major medical disciplines each fully calibrated with supporting Item Response Theory (IRT) data. In return for providing access to the items, the AMC would ask to be given de-identified IRT data on item difficulty to be used to re-calibrate the standard of the AMC MCQ examinations. A meeting with the Executive of the Medical Deans in November 2014 confirmed that the Deans supported the AMC initiative and would invite their members to participate in a trial of the proposed benchmarking using AMC-sourced items.

On 15 April 2015, Medical Deans conducted a workshop on collaboration in assessment, at which the data from the HWA-funded benchmarking project was presented. Even with allowances for the various limitations in the test design and delivery, the overall IRT results indicate that medical students in the participating schools demonstrated levels of performance well above the item difficulties of the benchmarking test components. The workshop agreed to pursue further collaboration on assessment and related issues of common concern to all medical schools.

Immediately following the workshop a small meeting was held on the issue of benchmarking using the calibrated AMC item bank. It now appears that some 12 of 21 medical schools will agree to participate in a pilot using the AMC sourced items. If successful this initiative may have significant implications for benchmarking and validation of standards in medical education.
5. **Indigenous Planning Advisory Group**

In 2014 AMC Directors agreed to prioritise Recommendation 7 of the external review of the AMC concerning Indigenous health so that the AMC could raise the quality and responsiveness of its leadership in Indigenous health and the needs of its practitioners. The AMC Directors supported the establishment of an Indigenous Planning Advisory Group to take forward the AMC’s work in this area. The membership of the Group includes both Indigenous and non-Indigenous representatives. The group is co-chaired by Associate Professor Noel Hayman and Dr Greg Phillips. The membership is at ATTACHMENT 1. The membership includes a representative from CPMC – Associate Professor Brad Murphy.

The Terms of Reference for the Group are at ATTACHMENT 2.

The Indigenous Planning Advisory Group will discuss and develop:

- A plan to enable the AMC and the Indigenous organisations to have a shared understanding of each other's purpose and functions to support joint projects and collaboration;
- An Understanding of the issues of concern to members of the group, as a way of defining what the AMC might contribute to those agendas as part of the AMC agenda;
- A more formal process/processes to support an AMC strategy for Indigenous health or Indigenous medical education that fits with the AMC’s mission and purpose;
- Protocols that can/will raise the quality and responsiveness of the AMC’s leadership in Indigenous health and the needs of practitioners.

The first meeting of the Group was held on 19 March 2015, with the second meeting of the Group planned for 12 May 2015. See ATTACHMENT 3 for communique from AMC.


The Directors agreed in November 2013 to consider the AMC contribution to the generalism debate. In 2014, a working party of AMC Directors as members, discussed plans to hold a workshop on generalism with the aim of improving the interface between primary and secondary care to better care for people with complex medical problems. A working group, led by Professor John Collins, was established in February 2015, to oversee the planning.

On 14 March 2015, the AMC hosted the first workshop on the topic of ‘Generalism in Patient-Centered Care and its impact on Medical Education, Workforce Development and Deployment and Health Care Systems’. This workshop examined the drivers for change in the delivery of patient-centred care and examples of emerging innovative models of medical practice and medical training. It also considered the barriers to and enablers of these developments following a case study approach, with exemplar models from various areas of clinical practice.

A report of the workshop will be circulated shortly. The outcomes of this initial workshop will feed into a second workshop to identify what more needs to be done in this area, with particular reference to matters of relevance to the AMC’s role as the national standards and accrediting body across the continuum of medical education.
7. **AMC contribution to Interprofessional Education:**
In May 2014, AMC Directors agreed to support a workshop on interprofessional education. The AMC has proceeded on this work by working with a small group of the other health professions accreditation councils, including the Council on Chiropractic Education Australasia, the Australian Nursing and Midwifery Accreditation Council, and the Australian Pharmacy Council to develop a workshop program. The workshop is planned for 9 and 10 June 2015.
The workshop will explore a common understanding of what is meant by interprofessional education, present and discuss examples of good interprofessional education and assessment, and examine how accreditation of health profession programs can be an enabler of good practice through accreditation standards and accreditation processes.

8. **Assessing medical students’ professionalism and fitness to practise**
In October 2014, Directors agreed to convene a multi-stakeholder working party, with Professor David Ellwood the Chair of the AMC Medical School Accreditation Committee as Chair, to explore medical students’ professionalism and fitness to practise, and develop potential solutions. The AMC identified four key theme areas to structure the working group’s task:
- Admission and Assessment and Supervision:
- Continuum of Medical Education / Role of Employers (Health Sector)
- Curriculum and Definition of Professionalism
- Legal Issues including sharing of Information (including MBA and employers)
The working group held its initial face-to-face meeting on Friday 1 May 2015.

9. **Australasian College of Cosmetic Surgery – Cosmetic Medical Practice**
On 28 April 2015, the AMC appeared before the Federal Court in Sydney as a respondent to a matter raised by the Australasian College of Cosmetic Surgery concerning their application for recognition of cosmetic medical practice as a medical specialty. The matter concerns the completion of the AMC recognition review report and a subsequent independent review of the assessment of the case, requested by the College. The matter was heard within the day. The judge has reserved her decision, and an outcome is expected within the next two to three months.

10. **Recognition of medical specialties**
The Health Practitioner Regulation National Law (‘the National Law’) as in force in each state and territory states that a National Board (in the case of medicine, the Medical Board of Australia) can make a recommendation to the Australian Health Workforce Ministerial Council to approve a specialty and associated specialist titles. That is, the Ministerial Council recognises specialties, on the recommendation of the National Board. The National Law also states that the Board, in making such a recommendation to the Ministerial Council, may have regard to relevant advice provided by the accreditation authority for the profession (for medicine, this is the Australian Medical Council), or a specialist college for the profession. In June 2014, the Ministerial Council issued National Boards with guidance on submissions to the Ministerial Council for specialist recognition. This advice became publicly available later in 2014.
In the Ministerial Council’s guidance, the National Board has the responsibility for preparing and making a submission to the Ministerial Council for approval of a specialty under section 13 of the National Law. The Medical Board has asked
the AMC to advise it on a process for recognition that will satisfy the Ministerial
guidelines.
## Indigenous Planning Advisory Group

### 2015 Membership List

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<thead>
<tr>
<th>Nomination Body/Category of Membership</th>
<th>Member</th>
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<tbody>
<tr>
<td>AMC Directors</td>
<td>Associate Professor Noel Hayman (co-chair)&lt;br&gt;<a href="mailto:noel.hayman@health.qld.gov.au">noel.hayman@health.qld.gov.au</a>&lt;br&gt;<a href="mailto:joanne.desouza@health.qld.gov.au">joanne.desouza@health.qld.gov.au</a></td>
</tr>
<tr>
<td>AMC Directors</td>
<td>Dr Gregory Phillips (co-chair)&lt;br&gt;<a href="mailto:gregory@abstarr.com">gregory@abstarr.com</a></td>
</tr>
<tr>
<td>National Aboriginal Community Controlled Health Organisation</td>
<td>TBC</td>
</tr>
<tr>
<td>Māori Medical Practitioners Association (TE ORA)</td>
<td>Dr Rawiri Jansen&lt;br&gt;<a href="mailto:TrishBK@nhc.maori.nz">TrishBK@nhc.maori.nz</a></td>
</tr>
<tr>
<td>Leaders in Indigenous Medical Education</td>
<td>Professor Shaun Ewen&lt;br&gt;<a href="mailto:shaun.ewen@unimelb.edu.au">shaun.ewen@unimelb.edu.au</a></td>
</tr>
<tr>
<td>Australian Indigenous Doctors Association</td>
<td>Dr Tammy Kimpton&lt;br&gt;<a href="mailto:president@aida.org.au">president@aida.org.au</a>&lt;br&gt;<a href="mailto:samc@aida.org.au">samc@aida.org.au</a>&lt;br&gt;Mr Artiene Tatian (Student)&lt;br&gt;Dr Kali Hayward (Observer)&lt;br&gt;<a href="mailto:vicepresident@aida.org.au">vicepresident@aida.org.au</a></td>
</tr>
<tr>
<td>Committee of Presidents of Medical Colleges (CPMC)</td>
<td>Associate Professor Bradley Murphy</td>
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<tr>
<td>AMC Secretariat</td>
<td>Karin Oldfield&lt;br&gt;Theanne Walters</td>
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1. **ESTABLISHMENT/PURPOSE**
   The AMC is a national standards, accreditation and assessment body for medical education. Its purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.

   The Indigenous Planning Advisory Group is established by AMC Directors and will report to the AMC Directors.

   Through this advisory group, the AMC wishes to develop a more visible and effective strategy to engage with Indigenous health organisations, students and medical practitioners across its accreditation, standard setting, policy and assessment functions to support the AMC purpose. The AMC strategy will develop based on a shared understanding of priorities and opportunities.

   The Advisory Group will ensure Indigenous knowledge, experience and values are respected and worked with during the term of the Advisory Group.

2. **TERMS OF REFERENCE**
   The Advisory Group is asked to provide high-level advice on the following:

   a. A plan for shared understanding by the AMC and the Indigenous organisations about each others’ purpose and functions to support joint projects and collaboration;
   b. An understanding of the issues of concern to members of the group, as a way of defining what the AMC might contribute to those agendas as part of its agenda;
   c. Recommendations for a more formal process/processes to support an AMC strategy for Indigenous health or Indigenous medical education that fits with the AMC’s mission and purpose;
   d. The development of protocols that can/will raise the quality and responsiveness of the AMC’s leadership in Indigenous health and the needs of its practitioners - i.e. what are the ‘big ideas’ that represent the core principles of professional collaboration and advice in this sector? How do we use these principles? How do we ensure sustainability of the principles so that they become embedded in the AMC work?

3. **COMPOSITION**
   The Advisory Group will consist of those persons appointed by the AMC Directors in consultation with the working group chairs. Membership will include both nominees of key stakeholder organisations, and members chosen for their individual expertise.

Terms of Reference as – 30 April 2015
Members able to contribute on behalf of the following organisations:

- National Aboriginal Community Controlled Health Organisation
- Māori Medical Practitioners Association (TE ORA)
- Leaders in Indigenous Medical Education
- Australian Indigenous Doctors Association

Members able to contribute on behalf of the following AMC stakeholders and partners in the setting of standards for medical education:

- Committee of Presidents of Medical Colleges (CPMC)
- Medical Deans Australia and New Zealand
- Australian Health Professions Accreditation Councils Forum (as observer)
- Medical Board of Australia

Members of the Australian Medical Council appointed after expression of interest:

- AMC President; Dr Joshua Francis; Professor Lisa Jackson-Pulver

4. Co-CHAIRS – as selected by AMC Directors
Two persons with a record of leadership in strategic and policy development relating to Indigenous higher education and/or medical education— that is, Associate Professor Noel Hayman and Dr Greg Phillips

5. SECRETARIAT
AMC secretariat

6. TERM OF OFFICE
For the period February to November 2015

7. QUORUM
Half the members plus one (including four Indigenous members, two of whom should represent the Indigenous organisations) of the Advisory Group present constitutes a quorum.

8. MEETINGS
The Advisory Group will meet at least four times – twice face to face. If the Advisory Group considers more meetings are required in order to fulfil its responsibilities, it may ask the AMC Directors for additional resources to support the request. The deliberations of the Advisory Group will be confidential but the Advisory Group may choose to issue a communiqué after its meetings. The Advisory Group recognises the commitment made by all members and will ensure that its deliberations are robust, respectful and collaborative.

9. RESOLUTIONS
The purpose of the advisory group is to give advice to AMC Directors. It is not a decision making committee. It is expected that any matters requiring a resolution by the Advisory Group are to be determined by consensus of the members present.

10. ADMINISTRATION
The AMC paper titled Administrative Matters: AMC Working Parties sets out AMC policy for members of AMC working parties.

Terms of Reference as – 30 April 2015
Indigenous Planning Advisory Group – Communication 1

The Australian Medical Council Limited (AMC) has established an Indigenous Planning Advisory Group to help develop a more effective and visible strategy for engagement with Indigenous health organisations, students and medical practitioners. This will support the AMC purpose across its accreditation, standard setting, policy and assessment functions.

The Advisory Group is co-chaired by Dr Noel Hayman, Director of Inala Indigenous Health Service, and Associate Professor, School of Medicine, the University of Queensland and Dr Gregory Philips, Executive Director of ABSTARR Consulting, and an adjunct senior lecturer in Aboriginal health in the Faculty of Medicine, Nursing and Health Sciences, Monash University.

The AMC is an independent national standards and assessment body for medical education and training. Its purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community. It is the accreditation authority for the medical profession appointed under the Health Practitioner Regulation National Law as in force in states and territories. It accredits medical programs in New Zealand in collaboration with the Medical Council of New Zealand.

Since 2005, when the Medical Deans Australia and New Zealand asked the AMC to adopt its Indigenous Health Curriculum Framework and reflect it in the accreditation standards for basic medical education, the AMC’s accreditation of medical schools has explicitly included Indigenous health. The AMC acknowledges that Australia’s responsibilities to Aboriginal and Torres Strait Islander people should be reflected in the medical education process. In its joint accreditation role with the Medical Council of New Zealand, responsibilities to Māori people in New Zealand are also acknowledged. Medical practitioners in Australia and New Zealand must be aware of the impact of their own culture and cultural values on the delivery of services, and have knowledge of, respect for and sensitivity towards the cultural needs of Indigenous people.

Since 2005, the AMC has engaged Indigenous doctors and educators and non-Indigenous educators and medical practitioners with expertise in Indigenous health in the review of accreditation standards, membership of AMC accreditation teams and the development of other professional and accreditation guidelines. The AMC’s accreditation and policy functions have expanded since then, and the context in which it operates has changed. For this reason, it is seeking the Indigenous Planning Advisory Group’s advice on:

a. A plan to enable the AMC and the Indigenous organisations to have a shared understanding of each other’s purpose and functions to support joint projects and collaboration;

b. Understanding the issues of concern to members of the group, as a way of defining what the AMC might contribute to those issues as part of the AMC agenda;

c. A more formal process/processes to support an AMC strategy for Indigenous health or Indigenous medical education that fits with the AMC’s mission and purpose;

d. The development of protocols that can/will raise the quality and responsiveness of the AMC’s leadership in Indigenous health and the needs of practitioners.
Members of the Indigenous Planning Advisory Group are drawn from Indigenous stakeholder organisations, such as the Australian Indigenous Doctors Association, Māori Medical Practitioners Association (Te Ora), National Aboriginal Community Controlled Health Organisations, as well as the Leaders in Indigenous Medical Education, members of the Australian Medical Council, and peak bodies that are stakeholders in the AMC major accreditation and assessment functions.

The Indigenous Planning Advisory Group held its first meeting on 19 March 2015. The meeting developed a draft workplan, beginning with a review of the existing work of the AMC, and the impact of accreditation, together with a review of the successful relationships, partnerships and strategies in place. The Advisory Group agreed to produce a short communique after each meeting, which it will supplement with formal consultation of stakeholders once it begins to develop advice to the AMC.

The AMC governing body, the Directors, have indicated their strong support for this work.

The group will meet again in May 2015.

Further enquiries:
Email: executive@amc.org.au
Phone: 02 62709708

Date 7 April 2015
CHIEF MEDICAL OFFICER’S REPORT

COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES

14 May 2015
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VERBAL REPORT ON HEALTH MEASURES IN THE 2015 BUDGET

NATIONAL DIABETES STRATEGY

Background
Recognising the social and economic burden of diabetes, the commitment to develop a new National Diabetes Strategy was made by the Australian Government in the context of the 2013 federal election.

Developing a new National Diabetes Strategy provides a valuable opportunity to take stock of approaches to diabetes services and care, consider the role of governments at all levels and other stakeholders, look at where efforts and investments are currently being made and how well this matches needs, and articulate a vision for prevention, detection, management and research efforts. The Strategy will seek to better coordinate and target existing health resources across all levels of government.

A National Diabetes Strategy Advisory Group (NDSAG) co-chaired by the Hon Judi Moylan and Professor Paul Zimmet AO has been established.

The NDSAG members have a wide range of experience in diabetes-related health care, research and population health and links to key stakeholder groups. The NDSAG is also supported by a number of expert advisers. The Terms of Reference and NDSAG membership list are available at:


Seven face to face consultation sessions with key stakeholders were held from August to October 2014 in Melbourne, Canberra, Perth, Brisbane, Sydney, Alice Springs and Hobart.

Update on Public Consultation
- Public online consultation on a consultation paper developed by the NDSAG for the National Diabetes Strategy opened on 15 April 2015.
- Key stakeholders were notified by email on 15 April, including the organisations represented by the Committee of Presidents of Medical Colleges.
- Comments received through this consultation will inform the National Diabetes Strategy, due for release in late 2015.
DEVELOPMENT OF THE NATIONAL ANTIMICROBIAL RESISTANCE STRATEGY

The discussion paper: Developing a National Antimicrobial Resistance Strategy for Australia was provided to around 160 stakeholders (including the CPMC) for comment in October 2014. Sixty-two responses were received, with approximately two thirds from the human health sector and one third from the animal health/agriculture/food sectors.

This feedback has helped inform the development of the draft National Antimicrobial Resistance Strategy (the draft Strategy). The draft Strategy is intentionally high level and aims to provide an enduring framework for action. It identifies broad areas where action can be taken to address seven objectives covering: appropriate use of antibiotics; surveillance; infection prevention and control; communication and education; research and development; international engagement; and governance.

Of particular interest to the CPMC, a priority area for action in relation to Objective Five – Increase awareness and understanding of antimicrobial resistance, its implications and actions to combat it, through effective communication, education and training notes that:

Communication and education initiatives on antimicrobial resistance, antimicrobial stewardship principles and infection prevention and control need to be included through all stages of a health professional’s formal training and be regularly reinforced by workplace-based education initiatives, including staff orientation and reminder and feedback systems. This needs to include a strong inter-professional focus and reinforce the message that responding appropriately to antimicrobial resistance is a shared responsibility and all team members have an important role to play.

Reviewing the antimicrobial resistance content of courses offered by universities, colleges and professional bodies would identify gaps and the need for new content. Options to promote national consistency of curricula content should be explored, as well as ways to ensure the competency of prescribers.

The draft Strategy is has been reviewed by the Australian Strategic and Technical Advisory Group on Antimicrobial Resistance and the Australian AMR Prevention and Containment Steering Group (co-chaired by the Secretaries of the departments of Health and Agriculture). The Strategy will be considered by the Minister for Health, the Hon. Sussan Ley MP and the Minister for Agriculture, the Hon. Barnaby Joyce MP, and publicly released following their approval.
Once the Strategy is finalised, a national forum will be convened to consult with stakeholders on the Implementation Plan. The purpose of the Plan is to outline the roles and responsibilities of stakeholders in relation to action on AMR in Australia, and identify concrete, measurable actions, responsibility for implementation and timeframes.
PRIMARY HEALTH NETWORKS

The Minister for Health and the Minister for Sport, the Hon Sussan Ley MP, announced the outcome of the assessment for 28 of the 31 Primary Health Networks (PHNs) in her media release on 11 April 2015. Arrangements for the remaining three PHNs will be announced soon.

PHNs will become operational from 1 July 2015, with an establishment and transition period from April 2015.

Background
PHNs are being established with the key objectives of:

- increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- improving coordination of care to ensure patients receive the right care in the right place at the right time.

PHNs will work directly with GPs, other primary health care providers, secondary care providers, hospitals and the broader community to ensure improved outcomes for patients.

In addition to their work for all patients, the Government has agreed to six key priorities for targeted work. These are mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care.

Successful PHN operators are expected to meet performance expectations and improve health outcomes for their communities. Flexible funding will be provided to enable PHNs to respond to national and local priorities which may include, improving health outcomes for people with complex chronic conditions, and reducing avoidable hospitalisations and emergency department presentations. Key performance indicators aligned with national, local and organisational priorities will be used to monitor and assess performance.

Many of the successful 28 applicants are consortia of both Medicare Locals and private organisations including universities, private health insurers and health providers. This involvement of the private sector will support the delivery of innovative approaches and further encourage cross-sector collaboration.

Minister Ley announced that an additional PHN will be established in south-western NSW, to be called the Murrumbidgee PHN. The Western NSW PHN will be split into two – creating a smaller Western NSW PHN, and the new Murrumbidgee PHN. This decision will enable the two regional PHNs to be more closely aligned to the Local Hospital Districts and the needs of local populations, building on existing service networks and relationships within their specific regions.
Another small, but important, revision to the PHN boundary is the inclusion of the city of Albury within the Murray PHN in Victoria. This reflects the existing integrated health service arrangements between Victoria and NSW delivered by the Albury Wodonga Health Service.

The department will undertake further work with applicants for the Western NSW and Murrumbidgee PHNs in New South Wales and also the Country SA PHN in South Australia. Announcements regarding the organisations selected to operate these PHNs will be made once this work has been completed.

PHNs will be operational from 1 July 2015, and will work closely with the Medicare Locals to ensure a smooth transition for patients. Continuity of health services is a key issue in the transition from Medicare Locals to PHNs to ensure that services to communities are not jeopardised. As part of the transition, strategies are being put in place for the continuity of care of patients, by ensuring minimal disruption to primary health care services.

Further information about PHNs is available on the department’s website (www.health.gov.au).
REBUILDING GENERAL PRACTICE EDUCATION AND TRAINING BUDGET MEASURE

On 9 April 2015, Minister Ley announced the new training regions and governance arrangements for the future delivery of GP specialist training. These geographic boundaries for 11 new training regions were developed by the government in consultation with GP stakeholders. This information is available at: http://www.gpet.com.au/News-and-events/News-Articles/MINISTER-ANNOUNCES-CHANGES-TO-GP-TRAINING-BOUNDARIES.

This announcement included the establishment of a new profession-led General Practice Training Advisory Committee to provide advice to government on GP training policy and training delivery, and undertake continuous improvement and evaluation activities in relation to general practice. The proposed Advisory Committee membership is RACGP and ACRRM, General Practice Registrars Australia, General Practice Supervisors Australia, an independent Aboriginal or Torres Strait Islander GP, two independent clinicians, the Department of Health and an independent chair.

The 2014-15 Budget Measure committed the Government to conducting an open competitive approach to market, to secure the services of a smaller number of organisations with the capacity to coordinate training across private GP practices replacing the existing regional training provider network, from 1 January 2016. The approach to market is expected to open shortly.

The Budget Measure included the cessation of the Prevocational General Practice Placements Programme (PGPPP), with this funding re-directed to expanding the AGPT programme. Options for junior doctor training were considered by the independent expert panel which reported to the Government in January 2015 and the Government is considering its recommendations.

The department is continuing to work with both Colleges to determine their role in the delivery and administration of the AGPT programme, and continues to consult with key GP stakeholders regarding the implementation of the Budget measure.

Background

In the 2014-15 Federal Budget, the Government announced the Rebuilding General Practice Education and Training measure. This included expanding the AGPT programme by 300 training places, from 1,200 to 1,500 commencing places per year, from 2015.
NATIONAL MEDICAL TRAINING ADVISORY NETWORK (NMTAN)

Background
The NMTAN has been established to develop a nationally consistent approach to medical training. The main function of the NMTAN is to guide the development of a series of rolling medical training plans to inform government, health and education sectors. In addition, the NMTAN will provide policy advice about the planning and coordination of medical training in Australia, in collaboration with other networks involved in the medical training space. From 2016, the NMTAN will also oversee the development of an annual report on medical education and training (currently the Medical Training Review Panel report).

Current Activity
The NMTAN currently has three subcommittees:

- The ‘changing work with the increase in burden of chronic disease’ subcommittee examines the implications of the increasing incidence of chronic disease and increased delivery of chronic disease management in the primary care setting. Modelling of the medical workforce will be undertaken, based on three to four models of care. It is expected this work will be completed in 2016.

- The ‘capacity for and distribution of the medical training’ subcommittee makes recommendations to the NMTAN Executive Committee on changes to policy and practices that could improve geographic distribution of medical training to produce the number and proportion of general practitioners and other medical specialists needed to provide specialist healthcare to Australians. The focus is initially on a small number of specialties seen to be at risk of workforce shortage and where there is capacity to address these issues with training. Currently work is being done to model the psychiatry workforce, to be followed by general practice and anaesthetics.

- The ‘employment patterns and intentions of prevocational doctors’ subcommittee aims to improve the modelling undertaken for the prevocational years in medicine and use this improved modelling to better inform career planning for junior doctors. The subcommittee has developed an internal report that provides a snapshot of the existing prevocational doctor workforce in Australia. This information will be used to develop a series of fact sheets on each of the medical specialties, to be made available on the Department’s website. It is expected the factsheets will become available from June 2016.

The president of CPMC attends the NMTAN meetings. The next NMTAN meeting will be held on 19 May in Melbourne.
SPECIALIST TRAINING PROGRAMME

The Minister for Health and Minister for Sport, the Hon Sussan Ley, MP, announced on 19 March 2015 that the STP and EMP will have funding extended for 2016. The Minister also announced that the Department would commence a consultation process with specialist colleges and other key stakeholders about reforms to the STP and EMP from 2017.

The Department intends to vary existing Funding Agreements to deliver the STP and EMP to extend these to cover the 2016 academic year. This extension will be completed through Deeds of Variation (DoV) with the Medical Specialist Colleges and their development will be managed through the Department’s Grant Services Division (GSD). The extension of STP funding for an additional year will be at existing levels. The Department has also asked the Colleges to develop new support project proposals as part of the funding extension process.

The Department will soon commence the consultation process with colleges and other stakeholders about future reforms to the STP and EMP from 2017. This process will guide any future reforms to these programmes to ensure they are targeted to better meet Australia’s future specialist medical workforce needs from 2017. The Department will write to Colleges in the near future with the proposed consultation approach and timing.
GOVERNMENTS RESPONSE TO THE REVIEW OF THE PERSONALLY CONTROLLED ELECTRONIC HEALTH RECORD

The Personally Controlled Electronic Health Record (PCEHR) is an electronic summary of an individual’s health information that can be shared between registered health professionals involved in the care of a patient to improve continuity of care and support decision making. The PCEHR has been available to individuals since July 2012 and accessible by healthcare providers since August 2012.

As at 8 April 2015 there were over 2.1 million individual records and 7,693 healthcare organisations registered in the PCEHR system. Over 44,800 shared health summaries, 122,000 hospital discharge summaries and 10,000 event summaries have been uploaded.

A review of the PCEHR was undertaken in late 2013 to examine issues with the existing PCEHR system including take-up by healthcare professionals. The final report of the PCEHR Review was released in May 2014.

The Review found strong support for a national shared electronic health record system which is usable and delivers real benefits and made 38 recommendations aimed at realising the full benefits sooner. Key recommendations include changes to national eHealth governance; moving from an opt-in to an opt-out model of participation by individuals; improving usability and core clinical content of records; and reviewing incentives to encourage uptake by healthcare providers.

Next Steps
The review of the PCEHR is the first step in making the system work better for the Australian public, as well as for doctors, nurses and other frontline health care providers.

Since the review, the ability to upload pathology and diagnostic imaging reports has been added, along with improvements made to the system’s usability.

The Government is currently considering the Review recommendations and will announce its plans for the future of eHealth, including the PCEHR, as part of the 2015-16 Budget.
REVIEW OF MEDICINES AND MEDICAL DEVICES REGULATION

The Review of Medicines and Medical Devices Regulation was announced on 24 October 2014 to examine the Therapeutic Goods Administration’s regulatory framework and processes with a view to identifying:

- areas of unnecessary, duplicative, or ineffective regulation that could be removed or streamlined without undermining the safety or quality of therapeutic goods available in Australia; and
- opportunities to enhance the regulatory framework so that Australia continues to be well positioned to respond effectively to global trends in the development, manufacture, marketing and regulation of therapeutic goods.

The Review is being conducted by an independent panel comprised of Emeritus Professor Lloyd Sansom AO (Chair), Professor John Horvath AO, and Mr Will Delaat AM. The Panel is to report to government in two stages. The first report, covering the regulatory frameworks for medicines and medical devices, was provided to the Minister for Health on 31 March 2015. It will be a decision of the government if and when this report will be made public. The second report, addressing the regulatory frameworks for complementary medicines and the advertising of therapeutic goods, is due to be delivered to the Minister in mid-2015.

The Review Panel has released two discussion papers to help facilitate consultation with stakeholders. The first discussion paper, relating to prescription medicines, over-the-counter medicines and medical devices, was released on 21 November 2014. The Review Panel received 103 submissions from stakeholders in response, and conducted a range of consultations with industry, consumers and health professionals to discuss issues raised in submissions.

The second discussion paper, relating to complementary medicines, was released on 20 February 2015. Submissions in response to this paper closed on 8 April 2015, with a total of 47 being received from stakeholders. Targeted consultations will be conducted in the near future.
REVIEW OF AFTER HOURS PRIMARY HEALTH CARE SERVICES

Background
The Review of After Hours Primary Health Care Services (the Review) was undertaken in response to recommendations made in the Review of Medicare Locals. The Review provided an opportunity to reflect on the current after hours delivery arrangements and determine the most appropriate and effective delivery mechanisms to support ongoing after hours primary health care services nationally.

The Review focused on existing after hours primary health care arrangements, including services that are currently funded and supported by Medicare Locals, and the after hours GP helpline. After hours Medical Benefits Schedule items were not included as part of the Review.

Professor Claire Jackson was appointed by the then Minister for Health, the Hon Peter Dutton MP to conduct the Review. The Review commenced on 19 August 2014 and the report was presented to Government on 31 October 2014.

Current Status
• A decision regarding the outcomes of the Review is currently with Government. Announcements in relation to the future arrangements for after hours primary health care funding will be made in due course.
• The Government is committed to maintaining frontline services that meet community need, this includes the ongoing provision of after hours services. Current after hours service provision will be maintained and supported through existing arrangements with Medicare Locals until 30 June 2015.
• From 1 July 2015 new funding arrangements will be in place to ensure continuity of after hours service provision in the community.
REVIEW OF MENTAL HEALTH PROGRAMMES AND SERVICES

The Australian Government is committed to building a world class mental health system that delivers appropriate services to support people experiencing mental ill health. That is why the Australian Government tasked the National Mental Health Commission to do a thorough review of all existing services, state and federal and non-government. The review was to assess the efficiency and effectiveness of programmes and services in supporting individuals and their families. Of interest to health professionals, the review was also to consider workforce development and training. The Final Report of the Review, which was provided to Government in December 2014, is substantial and has profound implications for the future of the mental health sector. The final report is available for download at www.mentalhealthcommission.gov.au. The report will require detailed analysis and consideration in moving forward.

Current Status

- The Commission’s Final Report has concluded and been provided to Government.
- The Government is currently considering the Report and its recommendations and will respond to the Review after appropriate deliberations.
- As part of these deliberations, targeted consultations with key stakeholders over coming months on issues and recommendations in the Report will be undertaken. This will look at programme and service redesign which is needed to achieve better outcomes for people with mental illness, their families and their communities.
- To support a joined up system and better outcomes for Australians, work will include:
  - development of a successor to the Fourth National Mental Health Plan;
  - shifting the focus towards prevention and early intervention to reduce pressure on acute care and welfare support;
  - the best approach to integrating services at a regional level including how best to maximise partnerships between Local Hospital Networks, Primary Health Networks and the National Disability Insurance Scheme.
- Minister Ley announced a 12 month extension, worth almost $300 million, for the continuation of frontline mental health services.
- Extending funding for another 12 months will provide frontline mental health services with clarity and certainty while the Government works through complex issues raised in the Final Report of the National Review of Mental Health Programmes and Services.
MBS REVIEWS

The MBS has more than 5,500 services listed, not all of which reflect contemporary best clinical practice. Commonwealth expenditure on Medicare has more than doubled from about $8 billion in 2003-04 to more than $20 billion in 2014-15.

The Minister for Health, the Hon. Sussan Ley recently announced an accelerated programme of work to review the MBS to ensure it is contemporary, reflects current clinical practice and allows for the provision of health services that improve health outcomes. Further, it will identify services that are considered unsafe or ineffective.

The work will be clinician-led and undertaken by the MBS Review Taskforce and membership will include clinical experts, health economists and academics. The taskforce will be chaired by Professor Bruce Robinson, Dean of the Sydney Medical School, University of Sydney.

The Government will also work with clinical leaders, medical organisations and patient representatives to develop clearer Medicare compliance rules and benchmarks. The vast majority of medical practitioners provide quality health care, but a small number do not do the right thing in their use of Medicare. Their activities have a significant impact on Medicare and may adversely affect the quality of care for patients.

This work is in alignment with international programmes, such as the clinician-led “Choosing Wisely” programme in the USA, and the work on practice variation that is being done internationally and here through the Australian Commission on Safety and Quality in Health Care (ACSQHC).

All healthcare providers, including governments, have an integral role in reducing waste and inefficiency in the healthcare system. This includes refocussing resources to meet areas of most need, ensuring healthcare services are evidenced based to provide the best possible health outcomes and embedding cultural change through the education of clinicians.

Background
The announcement made by Minister Ley on 22 April 2015, aligns with an existing smaller scale programme of work within the Department. This evidence based programme of work has been in place since 2009.
NHMRC Advanced Health Research and Translation Centres

Around the world, it is widely recognised that advances in research and its translation into evidence-based patient care needs to come more powerfully from collaboration of researchers, health practitioners and administrators, working together in the interests of patients.

There has been a strong international move towards encouraging “Centres” of collaboration between leaders in healthcare and academia in recent years in the UK, Europe and the USA. Such Centres encourage and support clinical leadership in both academia and in the health system. Importantly, such Centres can also help overcome the centrifugal effects of different funding mechanisms for patient care, education, training, and research.

To help foster this, NHMRC introduced a new initiative to encourage, recognise and celebrate those Australian collaborations of local health networks, universities, medical research institutes and community centres that already excel.

Announced on 28 March 2015, four Centres have been recognised as being of top quality internationally and have been recognised as NHMRC Advanced Health Research and Translation Centres (AHRTC). These 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

Further detail from this announcement and about the AHRTC recognition process can be found at http://www.nhmrc.gov.au/research/nhmrc-advanced-health-research-and-translation-centres.

Statement on Homeopathy

On 11 March 2015 the final NHMRC Statement on Homeopathy and the NHMRC Information Paper - Evidence on the effectiveness of homeopathy for treating health conditions were released. The release was followed by a broad range of national and international media attention.

The reports conclude that there is no good quality evidence to support the claim that homeopathy is effective in treating health conditions. The conclusion is based on the findings of a rigorous assessment of more than 1800 papers. Of these, 225 studies met the criteria to be included in NHMRC’s examination of the effectiveness of homeopathy.
The review found no good quality, well-designed studies with enough participants to support the idea that homeopathy works better than a placebo, or causes health improvements equal to those of another treatment. Although some studies did report that homeopathy was effective, the quality of those studies was assessed as being small and/or of poor quality. These studies had too few participants, poor design, poor conduct and reporting to allow reliable conclusions to be drawn on the effectiveness of homeopathy.


**NHMRC Statement: Evidence on Wind Farms and Human Health**

On 11 February 2015 the *NHMRC Statement: Evidence on Wind Farms and Human Health* was released that concluded ‘there is currently no consistent evidence that wind farms cause adverse health effects in humans.’ The statement is based on a rigorous independent assessment of the existing scientific evidence on wind farms and human health. The release of the statement received extensive national media and political coverage.

NHMRC’s internationally recognised processes were used to conduct the review: Independent reviewers with expertise in evidence review methodology were commissioned by NHMRC to comprehensively search the existing literature. The review identified over 4000 papers, however of those, only 13 studies were found to be of sufficient scientific quality to consider possible relationships between wind farms and human health.

Further information about the review and the statement can be found at http://www.nhmrc.gov.au/guidelines-publications/eh57.

**NHMRC CEO Statement on e-Cigarettes**

On 25 March 2015 Professor Anderson, NHMRC CEO released a statement summarising the evidence on the safety, quality and efficacy of e-cigarettes. The statement was developed in consultation with, and is supported by Chief Health Officers from all Australian states and territories. In part the statement says:

*There is currently insufficient evidence to conclude whether e-cigarettes can benefit smokers in quitting, or about the extent of their potential harms. It is recommended that health authorities act to minimise harm until evidence of safety, quality and efficacy can be produced...* 

Further research is needed to enable the safety, quality and efficacy of e-cigarettes to be assessed. The full statement can be accessed at http://www.nhmrc.gov.au/guidelines-publications/ds13.

**Women in Health Sciences**

NHMRC’s revised Administering Institutions (AI) policy released on Wednesday 18 March 2015 now states that all institutions must ‘have policies and procedures to implement NHMRC’s requirements to support the progression and retention of women in health and medical..."
research’. This is in response to many specific issues that women researchers face in health and medical research in their career progression and retention. While NHMRC welcomes feedback on this change, it is expected that Institutional policies will be in place by the end of 2015.

The AI policy now specifies seven requirements that need to be addressed in new or revised institutional policies by the end of 2015. Institutions will be expected to provide their policies to NHMRC at the end of 2015/early 2016 for NHMRC to review and will work with institutions that do not have ‘adequate’ policies in place. Institutions that fail to have adequate policies in place by the end of 2016 may lose their chance to administer NHMRC research funds in 2017.

Public consultation on aspects of the Fellowship Scheme

NHMRC’s Fellowship schemes are intended to ensure that Australia has the researchers and translational capabilities to meet the challenges of the future. Current research funding pressures raise a number of questions about the balance of grant and fellowship schemes and how the NHMRC can best continue to support the best research and researchers, while ensuring we are building and maintaining capacity in strategic areas.

Following consideration of the draft paper at Research Committee at the February 2015 meeting, NHMRC is now seeking feedback on the following current and emerging issues for NHMRC’s Fellowships schemes:

1. The changing balance between the number of research grants available and the number of Fellowships
2. The structure of the Fellowship schemes
3. Future strategic approaches
4. The responsibilities of employing institutions and the health and medical research sector.

The closing date for submissions is 3.00pm on 18 June 2015. The consultation paper is available on the NHMRC consultation website at: https://consultations.nhmrc.gov.au/public_consultations/nhmrc-fellowship-schemes.

NHMRC Grant rounds

Open Rounds

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Report

Medical Board of Australia and AHPRA report to the meeting of the CPMC on 14 May 2015

Three year review of the National Scheme

Federal and state and territory health ministers had their COAG Health Council meeting in April to discuss a range of national health issues, including the final report of the National Registration and Accreditation Scheme (NRAS) Review. The independent review was conducted by Kim Snowball, the former Director General of Health in WA. More than 1,000 individuals participated in consultation forums which were held in each capital city and the reviewers received more than 230 written submissions.

According to the report of the meeting, health ministers will consider the recommendations from the NRAS Review and discuss them further at their meeting in August 2015.

Good practice guidance for the assessment of specialist IMGs

The Board has recently undertaken confidential, focused consultation on the draft Good practice guidelines for the specialist international medical graduate assessment process.

The guidance was drafted by a working group of the Board’s National Specialist International Medical Graduate Committee (NSIMGC).

The guidance aims to support specialist medical colleges in their role in assessing specialist international medical graduates (IMGs) and to ensure a consistent approach across colleges in the application of the assessment process.

The draft guidelines do not change the current specialist pathway assessment process or the Board’s requirements for specialist registration.

The working group will consider the feedback received from the colleges and other key stakeholders before making a recommendation to the NSIMGC and Board.

The Board appreciates the time taken by colleges to provide their feedback and will advise CPMC of the outcome of the consultation.
Public consultation on cosmetic surgery

The Board is consulting on the best way to protect consumers seeking cosmetic medical and surgical procedures provided by medical practitioners.

The Board has put forward four options to better protect consumers in this area of medical practice. The options range from doing nothing, developing consumer education material, through to providing general guidance to medical practitioners or specific guidance to medical practitioners who provide cosmetic procedures.

The issues and options are outlined in the [public consultation paper and regulation impact statement](#).

Before the Board could commence consultation, the Board had to outline detailed background information on this issue, including evidence, regulatory context, non-regulatory and regulatory options and the associated impacts, costs, benefits and risks in a regulation impact statement (RIS).

The RIS must be approved by the Commonwealth’s Office of Best Practice Regulation before being released for stakeholder feedback.

Guidelines for registered medical practitioners who provide cosmetic medical or surgical procedures are the Board’s preferred option for managing risk to patients. The draft guidelines propose:

- a seven-day cooling off period for all adults before procedures other than minor procedures that do not involve cutting beneath the skin
- a three-month cooling off period before procedures for all patients under 18, along with mandatory assessment by a registered psychologist or psychiatrist
- explicit guidance on informed patient consent, including clear information about risks and possible complications
- explicit responsibility for post-operative care by the treating practitioner, including emergency facilities when sedation or analgesia is involved
- mandatory face-to-face consultations before prescribing schedule 4 (prescription only) cosmetic injectables
- detailed written information about costs, and
- limits on where cosmetic procedures can be performed, to manage risk to patients.

The consultation paper (including the RIS) is available on the Board’s website under [Current consultations](#). The consultation closes on 29 May 2015. The Board would welcome feedback from the colleges.

Workshop with the AMA - Improving the practitioner experience of notifications

As advised in previous reports to the CPMC, the Board is continuing its work to improve the practitioner experience in relation to notifications. The Board understands that medical practitioners who are the subject of a notification can find the assessment and investigation process difficult and stressful.

A workshop was recently held with the Board Chair, senior leaders from AHPRA and representatives from the AMA. The workshop identified further actions AHPRA can take to improve the experience of practitioners who are subject to a notification, while maintaining patient safety. The Board is grateful to the AMA for sharing their ideas and working together to make things better for practitioners.

Key issues we are working on include the time it takes for a notification to go through the process; the tone and clarity of our communication; the need to better explain how the process works and why; and greater transparency about what information can be legally released.
The specific areas which we are now focusing on include:

- clearer information in letters to practitioners who are the subject of a notification
- providing the regulatory principles, which guide the Board’s decision making, with all initial notifications correspondence
- more frequent communication when investigations are subject to lengthy delays, which may be linked to a coronial inquest or court case
- seeking feedback from practitioners when the notification process ends, to help identify further opportunities for improvements.

The Board will continue to provide further updates to the CPMC as this work progresses.

**AHPRA is working with RACS to streamline registration for scholarships**

AHPRA has been working with RACS to streamline registration processes for a small group of IMGs who come to Australia on scholarships to further develop their surgical skills. Coming to Australia for a short period allows these IMGs to undertake professional development activities and learn new techniques - skills which they then take back to their home country.

AHPRA has centralised the application process so that all applications from scholarship recipients are processed by one AHPRA office. AHPRA has also looked at how else the application process can be streamlined for this small group of doctors while ensuring that all the required documentation is received and appropriate checks take place before registration is granted.

RACS is also working with the Australian Medical Council (AMC) to see if there are opportunities to expedite any steps during the AMC primary source verification process.

**Steps to strengthen AHPRA and the Board’s drug screening processes**

AHPRA has published a proposed *Drug and alcohol screening protocol*. The protocol provides a clear framework across professions about the management of registered practitioners with drug-related impairment. It will ensure drug screening in the National Scheme is evidence based, effective and up to date.

The drug screening protocol is part of a wider, national strategy to effectively manage compliance and monitoring across the National Scheme.

Under the protocol, all health practitioners who have restrictions on their registration linked to past substance abuse will have routine hair testing in addition to urine testing.

National Boards will continue to make decisions about individual practitioners with impairment case by case, based on testing standards set out in the protocol. This includes:

- nationally consistent threshold limits, so all pathology providers conducting the tests use consistent testing baselines (e.g. will report all positive alcohol readings over 30pg/mg in hair)
- agreed ‘critical events’ – in addition to positive test results – requiring action and follow-up (e.g. unexplained delayed screening tests or results, failure to attend screening, diluted or unsuitable samples, etc.), and
- agreed triggers for National Boards to consider disciplinary action (e.g. positive test results, non-compliance with screening requirements, etc.).

AHPRA has established an expert panel to provide ongoing advice on the testing and monitoring of applicants and registrants with drug and/or alcohol misuse, including impairment. The panel includes Professor Olaf Drummer, Professor Jenny Martin and Dr Robert Ali.

AHPRA has sought expressions of interest from pathology providers to provide drug screening services to AHPRA to support ongoing monitoring of practitioners known to have drug-related impairment.
The proposed protocol is based on AHPRA’s interim protocol which was reviewed by Professor Olaf Drummer from the Victorian Institute of Forensic Medicine, to ensure the approach to biological testing in the National Scheme was evidence based and up to date. His report is published on the Monitoring and compliance page. The protocol will be further refined, fully implemented and published when AHPRA has selected an ongoing provider of pathology testing services.

**International Criminal History Checking (ICHC)**

A new process for checking practitioners’ international criminal history was introduced in February 2015.

Since then, 2,369 checks have been requested. 1,713 have been returned, with 656 checks currently pending. There have been five results returned with a disclosable court outcome. To date all (five) offences have been identified with applicants using Trans Tasman Mutual Recognition (TTMR).

The average time taken for an ICHC to be returned from all countries has been 10.75 days.

We are developing a process to manage ICHC requests when a country is experiencing civil unrest or natural disasters preventing access to the police records (e.g. cyclone in Vanuatu), or when a change to government policy prevents access to citizen records (e.g. South Korea).

**Misleading website taken down**

A potentially misleading website that republished information from AHPRA’s register of practitioners without permission is no longer published online.

Some practitioners had raised concerns with AHPRA that the ‘Doctor inspector’ website was publishing selective information sourced from the public register of practitioners without practitioners’ consent.

AHPRA had not given permission for the use of information from the public register by the website. Its operators appeared to have used technology known as screen scraping to automatically pull information from the public online register and republish it in a different context.

The ‘Doctor inspector’ website is no longer published on the internet.

In a media release, AHPRA reiterated to the community that the online register is the only accurate and up to date source of information about the registration status of Australia’s 633,500 registered health practitioners.

**Awareness of the National Register**

AHPRA is implementing strategies to raise awareness of the online register of practitioners for employers, after a man who was not a registered health practitioner was employed as a nurse in a remote Queensland community.

We have produced an electronic flyer, *Top tips on using the register for public safety checks*, and have published the tips on the website to promote the use of the register. This reminds the people responsible for recruitment that the online register is the single, reliable source of accurate and up to date information about the registration status of every registered health practitioner.
Summaries of tribunal cases available on the Board’s website

The Board now publishes summaries of tribunal cases on the Board website.

When a case about a medical practitioner is referred to a state or territory tribunal, the full decision is available on the AustLII website. The Board publishes a summary of each matter on the Board website, with an emphasis on learnings from the case. A link to each summary is provided in the Board’s monthly electronic newsletter that is sent to all registered medical practitioners who have provided an email address.

Dr Joanna Flynn AM
4 May 2015
Paper for CPMC Meeting

To be presented by
Dr Nicola Dunbar on behalf of Professor Villis Marshall AC
Chair of the Australian Commission on Safety and Quality in Health Care

Update on activities

Implementation of the National Safety and Quality Health Service (NSQHS) Standards

At the November 2014 meeting, the Australian Commission on Safety and Quality in Health Care (the Commission) provided information on assessment of health services to the National Safety and Quality Health Service Standards (NSQHS) to July 2014. This update provides information on all health services assessed in 2014.

In 2014, a total of 1051 health services were assessed to the NSQHS Standards. Of these:

- 609 undertook an assessment to all 10 Standards
- 421 undertook a mid-cycle assessment to Standards 1 to 3
- 21 new services commenced operation and undertook interim accreditation
- 56% were from the public sector and 44% in the private sector
- 37% of health services had core actions that needed to be addressed within 90 days at organisation wide assessment when core only actions were reviewed. This is a significant drop when compared with the 57% of health services with core actions not met at initial assessment in 2013.

The areas where health services continue to have difficulty meeting the NSQHS Standards are:

- Auditing of compliance to aseptic technique
- Providing information to consumers on the organisation’s safety and quality performance
- Taking action to increase compliance to aseptic technique
- Taking action to improve antimicrobial stewardship
- Monitoring of antimicrobial usage and resistance
- Monitoring of antimicrobial usage and resistance

Review of the National Safety and Quality Health Service Standards

Under the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme, the Commission has responsibility for maintenance and implementation of the NSQHS Standards, in consultation with state and territory health departments. The Commission commenced the review of the NSQHS Standards and the AHSSQA Scheme in late 2014, with completion expected in 2017/18.

The review’s overall objective is to examine the appropriateness and effectiveness of NSQHS Standards V1 and their application as part of the AHSSQA Scheme, to determine if they have achieved their aim of protecting patients from harm and
improving the quality of care provided. The project will seek to address issues that have been recognised during implementation of the NSQHS Standards, including any duplication identified.

The Commission has created a consultation web page for the review of the NSQHS Standards to provide updates to stakeholders on the process of the review.

The deliverables for the review of the NSQHS Standards will include:

- version 2 of the NSQHS Standards;
- guides for the implementation of the NSQHS Standards;
- guides to support health services undergoing accreditation;
- translation of the NSQHS Standards into a resource for consumers;
- identification of the skills and knowledge needed for health professionals to deliver care in accordance with the NSQHS Standards;
- safety and quality measures for each standard; and
- training for surveyors on assessment to the NSQHS Standards.

Identification of skills and knowledge associated with the NSQHS Standards

As noted earlier, it is proposed that one of the deliverables from the review of the NSQHS Standards is to identify the skills and knowledge required for health professionals to provide care in accordance with the NSQHS. For each of the NSQHS Standards, the focus will be on the skills and knowledge:

- that are needed for health professionals entering the workforce
- that need to be maintained by the health professional as part of continuing professional development
- that need to be taught and refreshed by the health service organisation.

Some preliminary work was undertaken in 2014 looking at the skills and knowledge required to provide care in accordance with the current version of the NSQHS Standards. Also in 2014, the Commission undertook a consultation that included medical colleges about the training and competencies for one specific area of the NSQHS Standards: the ability to recognise and respond to clinical deterioration.

The Commission is now proposing to build on this work to get a better understanding of what would be useful for education and training providers to assist them to train health professionals that are able to provide care in accordance with the NSQHS Standards.

General Practice Accreditation Project

In 2013, the Commission commenced work on a project in collaboration with the Royal Australian College of General Practitioners (RACGP) to review the quality of general practice accreditation.

The RACGP and the Commission agreed at its meeting in March 2015 on:

- a framework for accreditation that would be the basis of consultation with stakeholders
- processes for approval of accrediting agencies assessing general practices and data collections from the assessment process.

A report is being prepared for the Australian Department of Health and consultation is expected to commence soon after the submission of that report.
The Commission is continuing work on the development of the *Australian atlas of healthcare variation*. The Atlas will highlight how patient need in geographic areas match the distribution and use of resources in those areas, and identify tangible opportunities for improvement in healthcare quality and cost.

The current focus of work is on data extraction and analysis. Next steps include:

- generating maps and graphs for each data item
- working with clinical experts to write clinical commentary to accompany the maps and graphs
- epidemiological verification of the maps, graphs and commentary
- working with the clinical and jurisdictional atlas advisory groups.

In response to the significant variation for knee procedures across Australia outlined in the OECD-led study, the Commission established an expert advisory group on knee pain in late 2014. The group has reached a strong consensus that knee arthroscopy in people with osteoarthritis is unwarranted except for specific clinical scenarios. They are developing advice on a number of system-level, clinician and consumer strategies to address unwarranted variation in both knee arthroscopies and knee replacements.

**Project to improve care for Aboriginal and Torres Strait Islander people using the National Safety and Quality Health Service Standards**

A project to improve health care for Aboriginal and Torres Strait Islander people in mainstream services using the NSQHS Standards commenced in December 2014. The project was initiated by the National Aboriginal and Torres Strait Islander Health Standing Committee (NATSIHSC) and is expected to be completed by December 2015.

The project will involve:

- March to April: consultations with stakeholder groups
- May: analyse consultation outcomes and recommend changes to be incorporated into version 2 of the NSQHS Standards
- June: complete a literature review
- July to December: develop resources for use with the NSQHS Standards version 1 by mainstream health services.

A survey has been developed to seek input from a broader range of stakeholders. CPMC and members of their organisations are invited to participate in the survey. An email link has been provided to the Secretariat for distribution. This survey will be open until 30 April 2015.

**Clinical Care Standards for Acute Stroke, Hip Fracture Care and Delirium**

The Commission will be launching the Acute Stroke Clinical Care Standard in June 2015. Its release follows the launches of the Clinical Care Standards for Antimicrobial Stewardship and Acute Coronary Syndromes in late 2014.

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The Acute Stroke Clinical Care Standard aims to improve the early assessment and management of patients with stroke to increase their chance of surviving the stroke, to maximise their recovery and to reduce their risk of another stroke.

The Commission is currently developing two new Clinical Care Standards for Delirium and Hip Fracture Care. The Commission has been working with expert groups of clinicians, researchers, health service planners, health care organisations and consumers in developing these Clinical Care Standards.

The drafts of the Delirium Clinical Care Standard and the Hip Fracture Care Clinical Care Standard and their indicator sets will be released for public consultation from 18 May 2015 to 3 July 2015. Information about the consultation process will be available on the Commission’s website. CPMC and members of their organisations are invited to participate in this consultation.

Launch of the end-of-life care consensus statement

The Commission has developed the National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care (the Consensus Statement) to describe suggested practice for the provision of safe and high-quality end-of-life care in settings where acute care is provided. It sets out fifteen guiding principles and ten essential elements to describe the systems and processes that are needed to deliver safe and high-quality end-of-life care.

The Consensus Statement relates to situations where end-of-life care is indicated for adults who are identifiably approaching the end of their lives, and is especially targeted at the care of people in the last 12 months of life.Clinicians, health service executives and managers, policy makers, educators and training providers can use the principles and elements within the Consensus Statement to guide their work to improve the safety and quality of end-of-life care.

The key messages of the Consensus Statement are that:

- the health care that people receive in the last years, months and days of life can help to minimise the distress and grief associated with dying for the individual, their family, friends and carers
- a patient-centred, compassionate, and goal-directed approach is critical to the delivery of timely, safe and high-quality end-of-life care
- patients, and their families and carers need to be supported to participate in making decisions about end-of-life care
- doctors, nurses and other people delivering acute health care need to be trained and supported to deliver safe and high-quality end-of-life care
- services providing acute health care need to take a systematic approach to support clinicians to deliver safe and high-quality end-of-life care
- it is important to take opportunities to help people to plan for their care at the end of life, even though the timing of death may be uncertain and these conversations may be difficult.

The Consensus Statement reflects the views of health consumers and carers, experts in the field, and the Commission. It was derived from expert experience, published evidence, and was developed in partnership with carers and consumers, representatives from public and private hospitals and health services, professional colleges, state and territory health departments, and other government agencies. It has been submitted to Health Ministers for endorsement.

The Consensus Statement will be launched at St Vincent’s Private Hospital, Brisbane on May 28th, 2015, in partnership with Palliative Care Australia and as part of
Palliative Care week. Speakers at the launch will include Professor Villis Marshall and the Honourable Sue Boyce.

Shared Decision Making

Risk communication online module

The Commission is developing an online module on best practice risk communication for doctors.

To guide this project, an expert steering group has been established, comprised of representatives from a number of clinical colleges and representatives from the Consumers Health Forum of Australia and the Confederation of Postgraduate Medical Education Councils.

Based on the recommendations from the steering group, two versions of the online module will be developed:

- A pilot version developed in collaboration between RACGP and content experts, initially targeted at International Medical Graduates. Piloting and testing of the content will be undertaken to ensure that the module can be adapted to be suitable for broader use by members in Continuing Professional Development.

- An adapted version of the module will also be developed for use by the specialist colleges, targeted at Post Graduate Years 1-4. Clinically-specific examples relevant to particular disciplines will be included in all versions of the module, in consultation with the steering group.

A request for quote process is underway for the content development. It is expected that content development for the pilot version will be completed by 30 June 2015. The production of the module, including multimedia elements, will be undertaken in the next phase of the project.

Development of patient decision aids in antibiotic use

The Commission is working with a specialist group with expertise in this field to develop three, paper-based patient decision aids on antibiotic use for three common conditions: sore throat; middle ear complaints; and acute bronchitis.

The development of these patient decision aids seeks to support approaches to giving people better information about their health care choices, reducing the overuse of antibiotics and promoting appropriateness in care.

Once developed, the patient decision aids will be piloted with consumers, and relevant colleges and clinical groups. An evaluation plan will also be developed. The patient decision aids may also be used as examples or referenced in the risk communication online module for doctors. It is expected that the patient decision aids will be completed by December 2015.

Australian Infection Control Guidelines

The Australian Guidelines for the Prevention and Control of Infections in Health Care were published by the National Health and Medical Research Council (NHMRC) and the Commission in 2010. The Guidelines provide a basis for healthcare workers and facilities to develop detailed protocols and processes for infection prevention and control specific to local settings.

The Guidelines form the foundation for many of the elements in Standard 3 of the National Safety and Quality Health Service Standards: including systems and governance; infection prevention and control strategies; risk assessment; hand hygiene; health and safety of the workforce; management of invasive devices;
aseptic technique; standard and transmission based precautions; antimicrobial stewardship; cleaning, disinfection and sterilisation; and, information for patients and consumers.

The Commission has identified a number of areas within the Guidelines requiring revision to bring the information in line with current best practices. Two consecutive projects will be undertaken in relation to the update of the infection control guidelines. The first project will address areas requiring minor revision, while the second project will identify other topic areas that require more detailed review of the evidence and current guidelines developed since 2009.

Work has to date identified four topic areas for minor revisions, to bring the information in line with current best practice recommendations. The content for project one includes aseptic technique, droplet precautions, P2 masks and fit testing as part of airborne precautions and glove use relating to standard and transmission based precautions.

Several topics have been identified through feedback from advisory committees and working groups as requiring review in line with new evidence, changes in clinical practice, or more detailed information to enhance the guidance to practice. One such example is specific guidance for infection prevention and control in the care of infants and children. The Commission initiated contact with a number of national organisations with paediatric oversight. The Commission has commenced preliminary discussions with the Australian New Zealand Paediatric Infectious Diseases special interest group (ANZPID) of the Australasian Society of Infectious Diseases (ASID) to identify additional topic areas for inclusion in, or amendment to, the Australian infection control guidelines as part of further revision. ANZPID is currently conducting a survey of its members to gain further perspective on the topics and evidence around topic areas relating to paediatrics for consideration. At the present time, the Commission is discussing a process with neonatal and paediatric special interest groups for the identification of infection issues pertaining to neonates and infants.

To inform the Commission on other topic areas that might require review or updating to maintain currency of the infection control guidelines, the Commission will undertake further consultation. The initial step in project two will include a review of reputable international infection control guidelines such as Epic3 (United Kingdom) and the Healthcare Infection Control Practices Advisory Committee (HICPAC) in the United States published since 2009.

Following the review of international infection control guidelines, the Commission will undertake a mapping exercise to compare new evidence with the 2010 version of the Australian guidelines. This process should provide the Commission with the identification of areas where clinical variation exists or where there are areas of emerging issues in infection prevention and control, and where systematic reviews of the literature would be required to provide the evidence.
AMA REPORT TO THE
COMMITEE OF PRESIDENTS OF MEDICAL COLLEGES
MAY 2015

This report provides an overview of some of the major activities of the AMA subsequent to the last CPMC meeting.

Medicare co-payments & MBS Indexation

Following sustained advocacy by the AMA and other medical associations, the Government announced in March that its Medicare co-payment model would be abandoned, including proposed MBS rebate cuts for most visits to a GP for general patients. However, the Government decided to retain its freeze on MBS rebates.

The AMA has consistently highlighted the impact of the Government’s decision to freeze the indexation of MBS rebates. Practice costs will continue to rise and there is no doubt that GPs and other specialists will need to pass these costs on to patients through higher out-of-pocket costs.

On the day the Minister announced the three Medicare reviews and re-emphasised that it would retain the four-year freeze of MBS indexation, the AMA website was revised to include a suite of materials for medical practices to use to explain the impact of the freeze to patients.


The indexation freeze gaps poster illustrates to patients the predicted impact of the freeze on their Medicare rebate compared to the increasing cost of medical services.

As with the successful defeat of the $7 co-payment, the $5 rebate cut and the reduced MBS fee for short GP consultations, it is critical that doctors assist their patients to lobby the Government to lift the indexation freeze.

The President has made it clear to the Minister for Health that the AMA supports the MBS Reviews but not if their purpose is to find savings, and that the continued indexation freeze threatens to undermine the good intention of these reviews.


Sexual Harassment in the Medical Workforce

The AMA held a Forum to discuss the above issue on 1 April 2015. Invited participants included State AMAs, Colleges, the Medical Board of Australia (MBA), the Australian Medical Council (AMC) and trainee organisations, with the main messages emerging being that:

- Sexual harassment is different to other forms of harassment and needs to be tackled separately;
- Sexual harassment is not just limited to the medical profession, but we do need to play a leadership role in addressing the issue;
- Education is critical to changing culture, and this needs to commence early - from medical school onwards;
- Colleges and jurisdictions should adopt policies that promote the intentional inclusion of females so that they are able to fully participate in the medical workforce (eg flexible employment and training opportunities);
- There is a willingness on the part of jurisdictions (employers) to do more to address sexual harassment in the workplace and the profession (including colleges) needs to work closely with jurisdictions put in place the right policies, process and culture;
- There must be clearly articulated policies and process on sexual harassment to engender greater confidence that sexual harassment complaints will be treated seriously and fairly;
- Processes must offer a 'safe space' for complainants so that they can raise issues of sexual harassment, free of shame, stigma or repercussions;
- Employers need to have good performance management processes in place to avoid reasonable management actions escalating into harassment complaints;
- Changing the culture of the profession must start with senior male members of the profession taking a leadership role and making it clear that sexual harassment is unacceptable.

The AMA is considering what steps it needs to take to address this issue and will shortly write to the CPMC to see what role the CPMC might play, particularly in coordinating work among Colleges to establish best practice policies and processes.

Medical registration and notifications

On 5 March four senior members of the AMA with experience in practitioner regulation participated in a workshop with Dr Joanna Flynn (MBA) and senior Australian Health Practitioner Regulation Agency (AHPRA) staff to identify where processes could be refined to improve the practitioner experience in investigation of notifications.

There was common commitment to constructive change and a spirit of goodwill, borne out by the common views on what a good system would look like from the practitioner perspective:

- Timely and sensible vetting of notifications and complaints;
• Arrangements for dealing with vexatious complaints quickly, and an alternative mechanism for assisting the complainant to resolve their dispute where there is otherwise no risk to the public;
• An early and personal contact with the practitioner to advise that a notification had been received, acknowledging the impact this can have on practitioners, and explaining how the process will work;
• Recognition by colleagues and employers that notifications are not evidence of sub-standard practice but are a ‘fact of life’ of medical practice, with investigations being carried out in the interest of public safety;
• A process that assists the practitioner to gain insight and supports them to remedy their practice if it is lacking;
• A process that quickly addresses unsafe and poor practice, fairly and appropriately;
• Practitioners are afforded confidentiality during the investigation and decision making.
• Clear and accessible information about the notifications process to inform practitioners about what to expect.

At the workshop, de-identified case examples were used to identify where processes fail practitioners and to explore improvements. Extensive background information – decision making protocols, guidance and policies, as well as current data on timelines, volumes and outcomes were used as reference material during the analysis.

In general there were no surprises for the MBA and AHPRA in the issues identified by AMA members that make the notifications process difficult for practitioners. The work to improve the practitioner experience will in turn improve the notifier experience and vice versa.

The summary below sets out the actions that can be taken to improve the practitioner experience.

Regulatory principles

The regulatory principles that the MBA and AHPRA staff use to guide their investigations and decision making will be included in the guide for practitioners and be attached to the initial letter that the practitioner receives about a notification. The principles are available on the AHPRA website at http://www.ahpra.gov.au/About-AHPRA/Regulatory-principles.aspx.

Initial assessment response

The letter that invites the practitioner to provide an initial response to the notification will include information about when they will be advised that there will be no further action or an investigation will take place, or any other action that is available to the Board. The letter will also provide contact details for a person that the practitioner can follow up with.

The letter will provide the practitioner with reassurance that the process is not intended to punish practitioners, that the notifications process is part of the arrangements for protecting the public, and that due process will be followed.
**Reflective lessons**

In cases where investigations result in no further action, the MBA will look at the factors that were known when the notification was received and consider how these might inform the notifications vetting process.

The Board will also consider what other methods it can use to assist the practitioner to understand the issue that contributed to the notification being made and steps that he or she could take to improve the quality of practice.

**Investigations beyond 12 months**

The workshop identified that there can be several reasons why investigations may not be completed within 12 months, such as waiting for the outcomes of simultaneous investigations, coronial inquiries, court cases etc. In these situations the practitioner will be provided with more frequent information about how their matter is progressing, which will help them to understand the reasons for the delays.

General information for the public will be published about the most common reasons that matters will be delayed for lengthy periods.

**Transparency about decisions where a board member is professionally associated with the practitioner being reviewed**

The MBA and AHPRA have clear processes in place to manage potential conflicts of interest. AHPRA and the Board will explain to the practitioner how these issues are dealt with by the MBA when concerns about this arise.

**Expert reports**

A policy will be developed to generally provide the practitioner with export reports obtained on them, except when there are specific risks associated with doing so.

**Assessment costs**

The MBA will clarify that travel costs of the practitioner to attend assessments required by the Board are paid by the Board.

**Reworking letters to practitioners**

The AMA and AHPRA to continue to work together to improve the letters that are sent to practitioners.

**Feedback from practitioners**

AHPRA will explore a cost effective mechanism for systematically obtaining feedback from practitioners about how they feel they were treated during an investigation.

**Information about options for the public**

AHPRA will develop information for the public that sets out the options that people have if they have a grievance, and how they can pursue them.
Update the Guide to Notifications

The AMA and AHPRA will work on updates to the A Guide for Practitioners: Notifications in the National Scheme to provide practitioners with more information about the investigation and decision making processes.

The AMA acknowledges that even before the workshop the MBA and AHPRA were making improvements to the scheme. The workshop has meant that those changes can be consolidated along with the changes identified at the workshop.

The AMA is very appreciative of Dr Joanna Flynn’s and Martin Fletcher’s efforts to work with the AMA, including their participation in the workshop for the full day. On behalf of the medical profession, the AMA will continue to work with the MBA and AHPRA over the coming months to improve the practitioner experience.

Private health insurance pre-approval arrangements

Since the CPMC meeting in February the AMA has met with RACS and the ASPS, and the Department of Health about the pre-approval arrangements that Medibank Private and BUPA have initiated for plastic and reconstructive services. The President has also written to the Minister for Health asking her to intervene in these practices, as the health insurers have no legal right to reject the payment of a health insurance benefit where a Medicare benefit has been paid. The AMA provided the Minister with Medicare data that demonstrates that utilisation of plastic and reconstructive items has not increased, except for the known case of services to replace PIP breast implants, and for blepharoplasty items, and therefore the insurers’ activities are completely unfounded.

Doctors’ Health

The MBA and the AMA have announced a collaboration on a national health program for doctors and medical students in Australia.

The MBA and the AMA have signed a contract for the national delivery of health services to medical practitioners and medical students. The Board will fund the program and a subsidiary company of the AMA, Doctors Health Services Pty Limited (DHS), to roll out nationally consistent services in every State and Territory.

The Board will not be involved in the establishment or running of the services, which will:

- be nationally consistent and readily available to all doctors and medical students, no matter where they live;
- combine face-to-face health-related triage, advice and referral with telephone help line and online tools and resources where appropriate.

Over time services might expand to also include resilience training and early intervention.
Specialist Training Program

Colleges would be aware that earlier this year the funding for the STP program was under a cloud from 2016 onwards. The AMA raised this issue with the Health Minister as well as through the media and was pleased to see the Minister announce that funding for 2016 STP places would proceed.

The AMA strongly supports the STP and will continue to push for its continuation, noting the Minister’s statements that she will consult further regarding its future form.

Community Residency Program for Junior Medical Officers

The 2014/15 Federal Budget saw the abolition of the Prevocational General Practice Placements Program (PGPPP), effective from the end of 2014. This decision left general practice in the position where it is the only major medical specialty unable to offer junior medical officers (JMOs) a structured prevocational training experience before they make a career choice.

The AMA has called on the Government to rethink its approach to prevocational training in general practice and has recommended the establishment of a Community Residency Program to fill the gap left by the abolition of the PGPPP.

The AMA has sent the Government a proposal setting out the design and funding principles that would support opportunities for JMOs to undertake rotations of up to 13 weeks in general practice - helping them to experience life as a GP and to enhance their clinical experience. Details of the proposal are at:


National Medical Training Advisory Network

The AMA had been concerned with the lull in NMTAN's activity and the Government's medical workforce planning overall since Health Workforce Australia was closed last year and its functions moved to the Department of Health. However, we are now more optimistic that the situation is improving.

NMTAN has responded AMA correspondence on the under-employment and unemployment of specialists and a joint letter on the anaesthetist workforce signed by the AMA, ANZCA and the ASA. Some initial discussions have been held on these issues. This has included a teleconference that the AMA Vice President, Dr Parnis, and the Federal Secretariat convened on 31 March with the NMTAN Chair Prof Horvath and officials from the Department of Health's workforce division and its principal medical adviser on workforce matters Dr Andrew Singer.

NMTAN has advised that it is updating workforce modelling for each specialty, with priority given to anaesthesia, psychiatry and general practice.

Unemployment and underemployment of newly graduated fellows

As previously advised to the CPMC, the AMA is getting increasing anecdotal evidence of under-employment and unemployment of newly graduated medical specialists in some specialties. Of particular concern is the incidence of "exit block" – the situation where registrars continue to occupy senior registrar posts despite completion of their fellowship.
The extent of the problem of exit block is unclear and appears to vary between the specialist training streams. Much of the evidence of an emerging problem is based on anecdotal reports from AMA members, medical colleges, individual hospitals and the jurisdictions. This is a complex issue, with multiple factors affecting and driving the employment of newly graduated fellows.

In response to correspondence from the AMA, nine Colleges have provided their perspective on the issue and this information is now being considered by the AMA’s Medical Workforce Committee.

**Specialist Trainee Survey**

The AMA Specialist Trainee Survey Report was released during the AMA Trainee Forum on 21 February 2015. An embargoed copy was provided to all Colleges prior to its release.

The survey shows that medical colleges are performing well in most areas of vocational training. Career choice, level of supervision, standard of training, clinical experience, and access to safe working hours are areas where trainees continue to have a high level of confidence.

However, there are also significant areas where colleges have fallen short of their trainees’ expectations, many of which have remained unchanged since 2010. This includes responsiveness to cases of bullying and harassment, training feedback, and appeals and remediation processes. The cost of training remains an issue for trainees. The STS results are at


**Position Statements & Guidelines**

Subsequent to the last CPMC meeting, the AMA has issued the following position statements and Guidelines that can be accessed via the links below.

**Employment processes for prevocational trainees - 2015**

**AMA Guide to 10 Minimum Standards for Medical Forms**
HOT ISSUES

Federal Government March Budget
Like others Medical Deans will digest the content of the May Federal Budget and analyse the implications for medical workforce, education and research.

Intern Review

Review of Rural Clinical School funding and reporting

Announcement of Fellows to the Australian Academy of Health and Medical Sciences
Medical Deans congratulates its members who are the inaugural Fellows of the Australian Academy of Health and Medical Sciences. Medical Deans attended the announcement event in Canberra in March. A copy of our press release can be found at [http://www.medicaldeans.org.au/deans-congratulate-outstanding-medical-researchers.html](http://www.medicaldeans.org.au/deans-congratulate-outstanding-medical-researchers.html)

Announcement of the first tranche of Advanced Health Research and Translation Centres
Medical Deans congratulates the four inaugural recipients of the recognition as an Advanced Health Research and Translation Centre and acknowledges the support of NHMRC and the Australian Government.

Federal Government potential legislation
- Higher Education Reform
Medical Deans continues to monitor the Governments next steps around this potential legislation. Our members continue to develop business models that cover a number of scenarios.

Collaboration with AMC
Medical Deans is working closely with the AMC on a number of key initiatives including policy development in the area of fitness to practice and professional behavior, quality assurance in assessment particularly at the time of exit from medical school and sharing expertise in clinical assessment and assessing.

Collaboration with AIDA
Medical Deans and AIDA have just undertaken a positive review of their 2012-15 collaboration agreement in preparation for a new 3 year agreement later this year.
MEDICAL DEANS UPDATES

Quality Assurance in Assessment Benchmarking
Medical Deans held a successful bi-national workshop in Sydney on 15 April 2015. A copy of the workshop communique can be found at http://www.medicaldeans.org.au/communique-bi-national-assessment-collaboration-workshop.html

MSOD and Data Linkage Project update
Medical Deans is pleased to announce the signing of a new two year funding agreement with the Commonwealth Department of Health to take the Medical Schools Outcome Database to its next stage as a workforce planning tool. Funding will be for data linkage across the relevant national workforce datasets and ongoing delivery of an annual student survey in the final or penultimate year of medical studies. Further information can be found at http://www.medicaldeans.org.au/exciting-workforce-planning-development-medical-schools-outcomes-database-to-realise-its-potential-through-data-linkage.html

LIME Network update
Medical Deans has just received informal notice of approval to extend funding to the LIME Network for a further 12 months until 30 June 2016.

UPCOMING EVENTS

- Standing Committee and AGM – Parliament House, Canberra, 23 June 2015 * A new 2 year term Executive will be appointed at this meeting
- LIME Connection VI Conference – Townsville, 11-13 August 2015

This will be my last CPMC meeting as President of Medical Deans and I wish to thank all of you for your strong collegiality and support over the last 2 years.

Professor Peter Smith
President, Medical Deans

Professor Judy Searle
CEO, Medical Deans
COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES
110TH MEETING CELEBRATORY MORNING TEA
Speaking Points for Chair, Professor Michael Hollands

Good morning everyone and welcome to our 110th meeting celebratory morning tea.

I would like to warmly welcome all College Presidents and their Chief Executives, to the Hon. Catherine King, members of the Department of Health, to Professor Jane Halton Secretary Department of Finance, Mr Gordon Gregory, Executive Director National Rural Health Alliance and Ms Ruth McGowan from the Member for Indi in Victoria and to anyone I have not noticed.

You may like to know that on 4 July, 1986 at 9am at the headquarters of the RACGP in Sydney, 15 Colleges met for the inaugural meeting of the Presidents of Medical Colleges. Mr DG Macleish from the College of Surgeons, was elected unopposed as the Chairman, and he opened the meeting by stating it was “an historic occasion for bringing all Colleges together to exchange information between the colleges at this time in the history of medicine in Australia because of the problems and pressures currently facing the profession.”

The committee represented almost 20,000 medical specialists then, and today approx. 48,000, as such we remain a powerful voice.

A great deal has happened since this historic day in the Australian health care system.

However, the central purpose of why CPMC was established has not changed with our commitment to representing the interests of specialist areas of medicine when they seek to raise issues of quality of care and standards of education in the profession as well as workforce.

CPMC has always enjoyed a professional alliance with key groups such as those around us today and so please join me to congratulate CPMC on the 110th meeting.

END
COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES

3.1 Department of Health

This item refers to the address by Deputy Secretary Dr Wendy Southern. It is expected that Dr Southern will address her areas of responsibility as listed below and make reference to the 12 May Federal Budget and provisions of interest to CPMC.

Biography

The biography has been sourced from

Dr Wendy Southern joined the Department of Health in February 2015 as Deputy Secretary of the National Programme Delivery Group. She is responsible for the Population Health Division, Indigenous and Rural Health Division and the Health Workforce Division.

From 2010, Wendy was the Deputy Secretary of Policy Group at the Department of Immigration and Border Protection, leading the development and delivery of policy advice and programme management across the department.

Previous to this, Wendy was acting Deputy Secretary, Governance at the Department of Prime Minister and Cabinet (PM&C). She has held many roles within PM&C. Before joining the Australian Public Service, Wendy worked in various research, teaching and consultancy positions at the Australian National University, Monash University and the University of the South Pacific. In 2010, Wendy was awarded the Institute of Chartered Accountants’ inaugural award for outstanding contribution to Australian administration. Wendy has studied at schools in both the UK and Melbourne and has a PhD in geography from the Australian National University.

Portfolio Responsibilities: National Programme Delivery Division comprises nineteen branches as follows:

- Indigenous and Rural Health,
- Indigenous Health Programmes
- System Effectiveness
- Remote and Indigenous Access
- Indigenous Health Reform
- Population Health
- Cancer and Palliative Care
- Tobacco Control
- Drug Strategy Prevention and Treatment
- Chronic Disease and Food Policy
- Principal Medical Adviser
- Health Workforce
- Chief Nurse and Midwifery Officer
- Health Training
Members may wish to note the transition from HWA of all health workforce strategic initiatives. There are a number of cross-overs of functions between Divisions, for example Mr Mark Cormack is another Deputy Secretary responsible for primary and mental health care, GP access, acute care and the Principal Medical Adviser acute care.

Please note the briefing note in relation to the Federal Budget which will have been despatched Tuesday 12th May, following the Treasurers delivery, and sent via email from CPMC Secretariat. Members may wish to raise questions to Dr Southern after her address, and she has been given 45 minutes to meet College Presidents.

**Recommendation**
That members note the information provided.
The Hon. Sussan Ley is the Member for Farrer, New South Wales in the House of Representatives. Ms Ley was born in Nigeria. Ms Ley was elected to the House of Representatives for Farrer, New South Wales in 2001. She has been Minister for Health since 2014.

The most recent announcement from Minister Ley features the reform to Medicare involving the following elements:

1. The Government is establishing a Medicare Benefits Schedule (MBS) Review Taskforce led by Professor Bruce Robinson, Dean of the Sydney Medical School, University of Sydney. Currently, the MBS has more than 5,500 services listed, not all of which reflect contemporary best clinical practice. The MBS Review Taskforce will consider how services can be aligned with contemporary clinical evidence and improve health outcomes for patients.

2. The Government is establishing a Primary Health Care Advisory Group led by former Australian Medical Association President, Dr Steve Hambleton. The Advisory Group will investigate options to provide: better care for people with complex and chronic illness; innovative care and funding models; better recognition and treatment of mental health conditions; and greater connection between primary health care and hospital care.

3. The Government will also work with clinical leaders, medical organisations and patient representatives to develop clearer Medicare compliance rules and benchmarks. The vast majority of medical practitioners provide quality health care, but a small number do not do the right thing in their use of Medicare. Their activities have a significant impact on Medicare and may adversely affect the quality of care for patients.

Ms Ley has said the Government was committed to protecting the cost-effectiveness and sustainability of its investment in Medicare to ensure universal access remained for all Australians long-term.

The Minister has been invited to address College Presidents at 12:30pm and may remain for lunch.
Present:
Professor Michael Hollands  Chair, Committee of Presidents of Medical Colleges
Professor Michael Grigg  President, The Royal Australasian College of Surgeons
Dr Anthony Cross  President, Australasian College for Emergency Medicine
Professor Lucie Walters  President, Australian College of Rural and Remote Medicine
A/Professor Stephen Shumack  President, Australasian College of Dermatologists
Dr Genevieve Goulding  President, Australia and New Zealand College of Anaesthetists
Professor Bala Venkatesh  President, College of Intensive Care Medicine
Dr Frank Jones  President, Royal Australian College of General Practitioners
Dr Lee Gruner  President, Royal Australasian College of Medical Administrators
Dr Murray Patton  President, Royal Australian and New Zealand College of Psychiatrists
Professor Peter Stewart  President, Royal College of Pathologists of Australasia
Professor Michael Permezel  President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists
A/Professor Mark Daniell  Vice President, Royal Australasian College of Ophthalmologists
Professor Chris Milross  President, Royal Australia and New Zealand College of Radiologists
Professor Nick Talley  President, Royal Australasian College of Physicians

CEOs of Medical Colleges:
Ms Alana Killen  CEO, Australasian College for Emergency Medicine
Ms Marita Cowie  CEO, Australian College of Rural and Remote Medicine
Ms Carolyn Handley  Deputy CEO, Australia and New Zealand College of Anaesthetists
Mr Phillip Hart  CEO, College of Intensive Care Medicine of Australia and New Zealand
Dr Zena Burgess  CEO, Royal Australian College of General Practitioners
Dr Karen Owen  CEO, Royal Australasian College of Medical Administrators
Ms Elaine Halley  General Manager, Education & Training Royal Australian and New Zealand College of Psychiatrists
Dr Debra Graves  CEO, Royal College of Pathologists of Australia
Ms Lyn Johnson  Director Education & Training, Royal Australasian and New Zealand College of Obstetricians and Gynaecologists
Dr David Andrews  CEO, Royal Australasian and New Zealand College of Ophthalmologists
Ms Natalia Vukolova  CEO, Royal Australian and New Zealand College of Radiologists
Ms Linda Smith  CEO, Royal Australasian College of Physicians
Allan Chapman  General Manager, NSW Region, Royal Australasian College of Surgeons

CPMC
Ms Angela Magarry  CEO, Committee of Presidents of Medical Colleges
Ms Carolyn Andreae  Minutes, Committee of Presidents of Medical Colleges

Profession Observers
Professor Robin Mortimer  President, Australian Medical Council
9.00am

1. **WELCOME AND INTRODUCTION**

1.1 **Apologies**
Professor Michael Hollands welcomed all attendees to the meeting.

Apologies were received from Dr Tammy Kimpton (AIDA) and Professor Warwick Anderson (NHMRC). The Chair called for any other apologies. Apologies were received from Ms Michelle Thompson (ACSP), Dr Michael Jamieson (ACSP), Dr David Hillis (RACS), Professor Villis Marshall (ACSQH), Dr Brian Owler (AMA) and Professor Simon Wilcox (CPMEC).

1.2 **Conflicts of Interest and Confidentiality**
Members were asked to declare any conflicts of interest, and no declarations were made.

1.3 **Observers**
Dr Derek Sherwood (Chair) and Ms Sue Ineson (CEO) of the Council of the Medical Colleges, New Zealand were welcomed to the meeting.

2. **FORUM REPORTS**

2.1 **Committee of Presidents of Medical Colleges**
Professor Hollands delivered his report, noting that the main piece of work has been on revalidation.

Professor Hollands mentioned he would ask for input later in the meeting in the discussion with the Medical Board of Australia.

Professor Hollands noted that the Rural Health Continuing Education sub-program had been continued with funding until 30 June, 2015 and applications for Funding Round 7 had been received, for completion by December 2015.

Professor Hollands advised the Committee that he and Ms Magarry had attended a stakeholders meeting Chaired by the Secretary of Health, Mr Martin Bowles. He informed the forum that a diverse group of stakeholders were in attendance at the meeting, such as allied health groups (pharmacy, ambulance, dentistry) as well as medical groups, private health care and consumer representatives. All were asked to identify what they saw as significant issues for health care in Australia. Responses included rural health, quality, consumer engagement and workforce. The closing comments of Martin Bowles, was that he saw the meeting as an opportunity for the Department of Health to develop stronger engagement with stakeholders in the health care sector and engage their expertise where appropriate.

Professor Hollands provided a progress update to the forum on the convening of the Indigenous Health Sub-Committee which was held 18 February, co-chaired by AIDA. Ms Magarry will continue to work with AIDA to develop the Indigenous Knowledge Initiative to be held in advance of the May CPMC meeting and a further meeting of the sub-committee is scheduled for September at the AIDA Annual Meeting.
2.2 Australian Medical Council
Professor Robin Mortimer spoke to his report.
The Australian Medical Council re-elected Professor Robin Mortimer as President, and Associate Professor Jill Sewell as Deputy President at the November 2014 Annual General Meeting.

A discussion in relation to the external review began, and its recommendations occurred in the context of implementation of the main findings. The three year review of the NRAS was discussed, confirming the report will be finalised by April. An overview of the work being undertaken by the Prevocational Standards Accreditation Committee was provided, noting the review of standards of internship and assessment.

Professor Mortimer and Mr Frank discussed filling the vacancy on the Council for a Community Member and a member of State and Territory Board of the Medical Board of Australia, seeking assistance of the State Medical Boards in advertising with their Boards and Committees.

Professor Mortimer informed members the next AMC council meeting will be in Toowoomba in June. He informed the Committee that the motivation in having the meeting in Toowoomba is to conduct a review and develop accreditation, standard processes and improvements to the IT and internet systems. He informed members Ms Magarry, CEO of the CPMC is invited to attend the two day meeting as an observer.

Professor Mortimer spoke of the overseas trained specialist and how it has become a College issue regarding their primary source of education.

A discussion regarding the issue of accreditation occurred in the context of a question from Professor Nicholas Talley (RACP) concerning the value of having community members on every committee and it was agreed that while they do bring a difference and add quality to the meetings, it was more important to have the right people involved.

Dr Anthony Cross (ACEM) requested an update on the external review of the AMC and whether the review would be made public. Professor Mortimer informed the forum there were ten recommendations made and two technical reviews, including reports on assessment and accreditation and establishing an ethos with more customer focus systems and an IT upgrade to support AMC assessment and accreditation functions.

2.3 Chief Medical Officer
Professor Chris Baggoley spoke to his report and noted the appointments of the National Health & Medical Research Council (NHMRC) members for the next Triennium 2015-18. He announced the appointment of the Chief Executive Officer of the NHRMC was Ms Anne Kelso to replace Professor Warwick Andersen after he leaves in March 2015.

Professor Chris Baggoley spoke of the National Diabetes Strategy Draft Action Plan, the consultation work occurring on Medicare reform and the development of the National Antimicrobial Resistance Strategy; Primary Health Networks and the Budget Measure concerning rebuilding general practice.

A discussion occurred in relation to overseas trained doctors attempting the IELTS assessment multiple times and what avenues these doctors may have to address their situation.

Professor Nick Talley raised the issue of Primary Health Networks (PHN) in the context of rebuilding general practice and how they would differ from Medicare Locals. Dr Lee Gruner (RACMA) raised an issue of concern in relation to the scope of consultation concerning Medicare reforms and the importance of
broadening the process to a wider range of stakeholders and also about where the process was going. It was suggested that if CPMC wishes to be part of these discussions, to contact the Minister.

Dr Frank Jones (RACGP) raised a matter concerning how to address community expectations in relation to antimicrobials and their use and the discussion included sharing of educational materials already available.

A discussion concerning the latest developments in relation to the Department of Health managing the GP training model occurred.

2.4 National Health and Medical Research Council
Professor Warwick Anderson was an apology for the meeting and his report was noted. The report included the process of recognising Australian centres that excel in research; the outcomes from the Research Translation Faculty held on 12-13 November, 2014; the boost to funding dementia research announced on 8 January 2015 which aims to support fellows to undertake research in this area; the examination of the effectiveness of homeopathy and finalisation of a plain language summary of the assessment. An overview of the NHMRC Grant Application Round Summary was provided in that report.

2.5 Medical Board of Australia & AHPRA update
Dr Joanna Flynn spoke to her report noting the release of the AHPRA Annual Report 2013/14 and the continuing work to develop a clear framework for a Best Practice Guidance document for the assessment of specialist IMGs and Dr Flynn welcomed further College input.

The Board has commissioned an external research group to deliver a report on revalidation and the report provided by CPMC on this matter was acknowledged by Dr Flynn as useful.

Dr Lee Gruner (RACMA) raised the issue of criminal checks in the context of seeking clarification about the MBAs new approach, and a short discussion occurred regarding improving the practitioner experience of notifications.

Dr Flynn spoke about mandatory reporting in the context of a need for clearer and more consistent guidelines due to the fact that despite education and training, there remains some confusion surrounding the issue.

Mr Martin Fletcher (AHPRA) provided an update on AHPRAs monitoring and compliance process regarding health practitioners with limits on their registration, or those suspended or cancelled. AHPRA has established an Expert Advisory Panel on drug and alcohol screening to provide ongoing expert advice on the biological assessment, testing and monitoring processes. This included hair testing. AHPRA advised it has introduced an interim drug screening protocol nationally to guide the monitoring of practitioners with drug-related impairment. Mr Fletcher advised that AHPRA is seeking expressions of interest from pathology providers to provide drug-screening services to AHPRA to support the ongoing monitoring of practitioners know to have drug related impairment.

Dr Bala Venkatesh (CICM) raised a query in relation to the skilled occupation list and acknowledged that while Australian Department of Immigration and Citizenship is currently undergoing a review of the SOL, it appears to have information on it which differs to that available elsewhere regarding demand for certain specialties. Dr Flynn noted that if you have good evidence to support reasons for an occupation or a particular speciality to be withdrawn from the list, any College has the right to review through the DIAC process. Further discussion continued on working visas in the context of skilled migration and whether a similar process to student visas would be applicable to SIMGs and subsequent medical registration.
2.6 Australian Indigenous Doctors’ Association
The report from AIDA was delivered by Dr Kali Hayward, Vice-President. She acknowledged the traditional owners of the land upon which the meeting was convened as the Gadigal People. Dr Hayward also recommended each CPMC meeting start with acknowledgment of the traditional land owners, past and present. Professor Hollands agreed.

Dr Hayward provided the forum with an update on the sub-committee meeting held between AIDA and CPMC, noting the importance of the collaboration. Dr Hayward noted that AIDA is looking forward to working in collaboration with the colleges and launching the Indigenous Health Initiative Mentoring Program.

Dr Hayward congratulated the College of Dermatologists regarding their work with Indigenous Health.

Dr Hayward spoke of the Closing the Gap report and the GP Aboriginal Medical Service report. She informed the forum that in her practice she sees a large number of patients with various chronic diseases and how it impacts their day-to-day lives. She referred to the work conducted by the Indigenous Health Sub-Committee and how it does have an effect of filtering down to the ground level. Dr Hayward therefore recommended the work continue.

Professor Hollands reinforced Dr Hayward’s report and commented on the sub-committee meeting he had co-chaired with AIDA the previous day, noting the importance of the Indigenous programs run by organisations and encouraging diversity.

2.7 Australian Commission on Safety and Quality in Health Care
Professor Villis Marshall was an apology for the meeting and his report was noted. Follow up with the Commission regarding several issues outlined in the report would occur.

2.8 Australian Medical Association
The AMA Secretary-General, Ms Anne Trimmer gave apologies for AMA President Dr Brian Owler.

Ms Trimmer spoke to her report and noted the significance of the consultation process being undertaken by the new Health Minister which included many bilateral discussions. In relation to the government’s negotiations over the Pharmacy Agreements Ms Trimmer noted the submission from the Guild to allow an expanded scope of practice for pharmacists and referred the example of where pharmacies currently deliver vaccination programs and these already exist in two states.

Ms Trimmer spoke about the Medicare co-payment and Medicare rebate debate. She noted that the AMA had been inundated with correspondence from members. Ms Trimmer confirmed the central role of primary care in acting as a gatekeeper in the health care system and noted there was more work to be done, including two more Medicare rebate changes to go through the Senate.

Ms Trimmer referred to the issue of under and over employment of medical practitioners, noting that while only anecdotal figures in relation to workforce demand were available, the AMA was concerned for the information to be mapped for planning purposes.

Ms Trimmer noted the AMA had published a guideline to assist doctors on the proper use of personal mobile devices when taking clinical images. The guide outlines the key ethical and legal issues for doctors to be aware of including transmission of clinical images for the purpose of providing clinical care.

Ms Trimmer mentioned doctors’ health as one of the key platforms of the AMA and concurred with Dr Flynn’s comments in relation to ensuring equity in access to services across the country.
The issue of pre-approval processes with health insurers was mentioned in the context of recent developments in relation to plastic surgeons.

Ms Trimmer mentioned the work being conducted with the College of General Practitioners and College of Rural and Remote on the ownership of the accreditation of GP training.

2.9 Medical Deans Australia and New Zealand
Professor Peter Smith, President MDANZ, spoke to the report noting a new collaboration with the Australian Medical Council (AMC) concerning shared expertise and data in assessment. He spoke of the MSOD dataset and database maintenance, together with the data linkage interface with AHPRA, including system tracking outcomes and the high priority for medical curriculum.

Professor Smith noted a strong relationship exists with AIDA, referring to the success of six Indigenous medical students graduating this year. He also noted that a mentoring system is in place for guidance and support in relation to career destination, including access to scholarships by private sources supporting Indigenous students.

Professor Smith raised the matter relating to the reforms to higher education and likely impact on fee levels, however not at the extent as suggested in the media.

Professor Smith discussed the Medical Research Future Fund in the context of any co-payment scheme.

A discussion concerning the current supply of medical graduates and influence on planning the future medical workforce occurred. Professor Smith stated he attended the National Medical Training Advisory Network (NMTAN) meeting in Melbourne, which reports to the Department of Health. He spoke of the doubling of medical graduate interns and the opportunity for vocational training in rural areas. He noted the issue of forward planning and the forecasted possible shortage in emergency medicine. Professor Smith acknowledged the difficulty of training extra places now for the existing shortage but the risk this may in over-supply in the future, and then what avenues there may be for employment. Professor Smith noted future projections show that doctors will work until they are 75 years of age.

Further discussions were had in relation to the future of GPs and PhD fellows and their future employment. The members discussed future funds and the potential for the funds for medical research.

Dr Murray Patton (RANZCP) raised the issue of training in psychiatry and noted the work occurring by the Federal Government in this area.

Professor Hollands agreed to approach the Chair of NMTAN Professor John Horvath to attend the May meeting of CPMC.

**ACTION:** Professor Hollands to arrange for a brief from the NMTAN Chair at the May CPMC meeting.
CPMC Session (Members-Only)

3. General Business

3.1 COAG Review of Medical Intern Training Reviewers
The Chair welcomed Professor Andrew Wilson and Anne-Marie Feyer as the Co-Reviewers leading the review of Medical Intern Training.

Professor Wilson discussed the purpose of the review which was to examine the current model to assess potential reforms to support medical graduates’ transition into practice and further training. He stated that to ensure the workforce continues medical staff must be well trained, fit for purpose and equipped to meet the changing health needs. Professor Wilson spoke of the challenges in the health system, including aged care, quality and safety for care practices.

Professor Wilson highlighted that the review process would include developing a broad discussion paper to underpin consultation visits throughout the states and territories.

Dr Anne-Marie Feyer noted the two stages of the review process would include developing an options paper with the second stage detailing the implementation process. Professor Wilson confirmed August 2015 as the deadline for making recommendations to Health Ministers.

In discussion, Professor Wilson noted there was limited information or literature available in relation to internship history however shortened hours in EBA’s for interns and the number of interns that do not complete the internships with the term assessment was known. One key and fundamental issue regarding the first year post graduation was that year was viewed as a highly stressful period for the intern, and there were difficulties in adapting to the work environment. He went on to emphasise the importance of an intern getting value out of this process and one possibility worth considering was a two year internship. He noted that other countries offer registration immediately upon graduation however.

Members discussed the issue of internship through to independent practice. Professor Wilson mentioned the value of internship and the importance of focussing on what can be achieved in that time. He spoke of supervision issues in the current model and maintaining a “one size fits all” model. He suggested assessing competencies, and suggested for example that a rural nurse practitioner who entered as a late entry graduate would likely finish with a totally different set of skills. He commented that more flexibility and more diversity in setting outcomes would provide better outcomes.

Members discussed the issue of a growth in the number of interns into the private sector, with Professor Wilson stating that because interns cannot order practical items this is a barrier to what they can currently be able to do. Members noted his comments in relation to managing interns and employment requirements impacting on hours and overtime.

Professor Wilson suggested the discussion paper will go into more depth with additional challenges and ideas for further discussion at the consultation forums.

Discussion continued in relation to the design and scope of vocational training and the notion of streaming from first year. Professor Hollands commented there was evidence of streaming from the United States and in Canada whereas a member queried whether there was sufficient evidence of this in Australia and whether anything could be achieved from doing it.
Members discussed flexible internship training programs, and if early streaming would add value, and how to get the next generation of academics to train. Further discussions began about flexing in and flexing out, if the intern changes their mind.

Associate Professor Lucie Walters raised the benefit of community practice and preparing the next generation by working one year as a doctor in a collective general rural practice. She extended an invitation to Professor Wilson to visit the practice centre at Mt Gambier.

Discussions progressed in relation to interns and their employability generally in a health service with feedback from health service managers questioning the rationale for employing them if they are not providing the service required, and hence why employ them. Committee members discussed the difficulties knowing if interns can do what is required and add value. It was acknowledged that they were employees and not supernumerary but they were closely supervised and received high-level training on the job. A Committee member suggested it may be useful to talk to hospital administration staff who dealt with interns to seek their feedback. The Princeton Internships program was mentioned in this discussion.

Professor Wilson concluded his presentation after adding that he intended to seek consultation with interns themselves and invited submissions by April 10, 2015.

3.2 Revalidation- Dr Joanna Flynn
The Chair welcomed Dr Joanna Flynn, Chair, Medical Board of Australia to discuss the issue of revalidation with reference to the CPMC report and any other activities.

Dr Flynn commenced by stating that Revalidation is a process for doctors to regularly show they are fit to practice medicine, giving patients and the community the assurance that the practitioner is competent. She referred to recent conversations between the MBA and AHPRA concerning quality assurance processes and noted the importance of assuring the public that all doctors in this country remain competent and fit for practice. She commented on the importance of preventing harm across the health system through the establishment of evidence based, and cost effective risk assessment tools.

Dr Flynn spoke of the approach in establishing a Revalidation Model, noting the critical input from the Colleges. The MBA had developed a RFT process which was sent to Revalidation experts in the field. The outcome of this was the engagement of Julian Archer, Director, Collaboration for the Advancement of Medical Education Research and Assessment (CAMERA).

Dr Flynn advised members that she is currently seeking advice regarding Revalidation and developing options to consider, and acknowledged the legislation standards required for CPD. She noted there is a CPD audit process and they are sampling all doctors, not just specialists.

Dr Flynn stated any revalidation system must be built on existing regulatory systems and aim to utilise and link existing data rather than creating a separate new system. This quality assurance system will be a competency based assessment system.

Dr Flynn spoke of focussing on non-fellow candidates in the first instance with regard to the high risk factor, working together to get processes up and running and reporting consistently and coherently. She noted her concerns about people not engaged in College processes and referred to the work on credentialing and undertaking audit meetings for further assessment and measurement.

Dr Flynn noted that this is an opportunity to make a sleek system for consistency purposes. She noted that Australia, Canada, and the United States are in close contact with the New Zealand Council of Medical Colleges, which will help to reduce duplication and repetition.
Professor Hollands commented that there may be challenges with the small geographic population areas. Dr Flynn confirmed that she knew where these people are located based on their registration details.

Professor Hollands proposed for all Colleges to derive a list of definitions for the terms of reference, for discussion at future meetings, to assist with the design of the model. He suggested the task may best fit with the College CEOs. Dr Debra Graves, RCPA and Ms Allana Killen, ACEM offered to steer the discussion at the CEO level and to report back at the May CPMC meeting.

| ACTION: CPMC College CEOs meeting to work up ToRs and report back to May CPMC meeting |
| CEOs |

3.3 Address by The Hon. Catherine King

Professor Michael Hollands welcomed the Honourable Ms Catherine King to address the members on the issues she saw as important to engage on in health policy.

Ms King highlighted the importance of consultation in the sector and on engaging in discussion on health policy not solely with from the perspective of health financing because it limits the process.

Ms King informed members that she has been engaged in health policy at various points for a large part of her career, and referred to her experience at the Commonwealth Department of Health where she gained expertise in public policy, partnership agreements and reform. Ms King highlighted current issues as changes to scope of practice, integration of clinical care and the number of specialists available in the system.

Ms King informed members that she had been travelling the country, talking to various Colleges, visiting specialised areas of the system such as Emergency Departments and this experience has assisted her understanding of current policy issues. Of emerging importance was the government’s reform agenda focussing on Medicare, the Medical Benefits Schedule, introduction of a co-payment system and impact from change on patients. Ms King acknowledged there was a concern held by members in relation to pathway training and funding specialist training.

On the issue of revalidation, a question was raised regarding what the Opposition would like to see in the profession for doctors to demonstrate their competency and trustworthiness as competent practitioners in the community. In response, Ms King supported profession-led revalidation with a focus on transparency as the vital element and suggested there should be some assurance of competency which is tested and assessed on a regular basis.

On the issue of health services and health outcomes in rural and remote areas and differences with their urban neighbours Ms King was asked about Opposition policy including providing some examples. Ms King responded by advising that Mr Steven Jones was the Shadow Assistant Health Minister and Member for Throsby, responsible for Rural and Remote Health. She considered health equality was an issue with regards to prevention, coordination and access to health services for populations who live in urban and remote communities. A national platform for rural and remote health would be released in April 2015 and Ms King indicated all Colleges would receive a copy.

Ms King spoke about her interesting visit to the Lawson Clinic and the work they were undertaking in Psychiatry. She was intrigued about the work they were doing in Tele Medicine in the rural and remote areas. She noted the importance of taking a closer look at access and service provisions in Primary Health Care Networks. Ms King suggested the possibilities of other providers tendering for this work, such as Royal Flying Doctors and Aspen Medical.
On the question of how the Opposition would balance increased price signals, cost savings and increased services in chronic disease management Ms King responded indicating that there are finite government resources, which everyone wants part of. Ms King acknowledged the challenges for managing chronic diseases and the right for medical professionals to set their own fees.

Ms King raised the Opposition’s issues with how the current Government was managing changes to Medicare as a universal system of health coverage referring to inconsistencies in Commonwealth health funding by referring to Commonwealth expenditure on pharmacies worth $15 billion over 5 years. Ms King noted that it was possible to find efficiencies within the health system and considered it was important that all Australians have access to health services, however noted the need to work together to identify the savings and to reinvest in a more structured health system.

Ms King spoke to the challenges in the health system, such as workforce issues and how workforce is distributed. She spoke further about smoking rates and the Community Pharmacy Agreement and producing evidenced based information.

On the question in relation to areas to save and raise revenue with reference to the $15 billion spend on pharmacies and whether that was evidenced based Ms King responded that she was surprised the money raised from tobacco excise does not go to health. In relation to the Community Pharmacy agreement Ms King confirmed it is up for review with negotiations currently underway, noting the Pharmacy Guild was leading the negotiations and the new Health Minister had invited her to the first Roundtable discussion. In this regard, Ms King noted that the role of pharmacists needed to be considered carefully in relation to requests for changes in their scope of practice from the perspective of pharmacists not having access to medical / health records, so if there is prescribing rights afforded, this may cause risk. Ms King considered General Practice was at the core of peoples care, and that by adding another layer this could cause problems to continuity of care. However in remote areas where a pharmacist was the sole health care provider, there may be a necessity, under certain circumstances.

On the matter of ALP health policy, a question in relation to the MBS was asked with Ms King referring to the international evidence that a strong primary care system resulted in better health outcomes. She spoke of the $5 reduction for general practice, the freeze on indexation of all MBS items until 2018 and the tabling of the new MBS schedule. Ms King indicated her interest in regular reviews of the MBS noting that according to the recent Commission of Audit found that of all 6000 MBS items only 3 per cent are reviewed formally for efficiency and their evidence base. Ms King noted that while she understands that the Department of Health is doing their own audit of MBS items, it is however a slow and expensive process to undertake. Further, her understanding was that this section has since amalgamated into the new Health Productivity Commission.

She referred back to international evidence. In Primary Care there is movement in the bundling up of MBS items to allow more flexibility in the way primary care provide services with population based payments in the United Kingdom. She considered that this is possible to do in Australia, however not possible without full active engagement by clinicians who see value in the process.

Ms King spoke of how Primary Care Providers manage complex cases without MBS items. She understands that some Primary Care Providers have employed nurses to carry out these complex functions, although there is no MBS item listed against this service.

On the matter of the Future Fund, Ms King indicated it was ALP policy not to have one. Ms King noted decisions in relation to the construct of a Medical Research Fund appear to have been made in isolation of the medical sector. In her view the important questions to be addressed in health policy
relate to how a government ensures that Commonwealth expenditure on health is used in the most efficient way and how does it take into account the increase in chronic disease and an ageing population as well as what is spent on medical research.

On the general societal issue of asylum seekers/detention centres Ms King stated that all levels of government have a responsibility in this area and she was concerned about children in detention and the importance of governments acting more compassionately and having better policies in place and services for processing people, and getting children into communities as quickly as possible. She encouraged members to read the Human Rights Commission Report to understand some of the “trade off” and on and off shore processing. Ms King sees it as important to still raise issues as the current government have duty of care and is responsible and accountable for unaccompanied minors.

On the issue of the ALP policy on tackling obesity Ms King referred to the risk factors in relation to obesity and concern at the cuts which have been made to the various programmes at the State and Commonwealth levels in the area of preventive health.

4.1 Minutes of the Previous Meeting
The Chair invited comment in relation to the Minutes of the previous meeting held on Thursday 14 November, 2015. There being no comments or amendment confirmation of the Minutes was received from Professor Grigg (RACS) and seconded by Professor Venkatesh (CICM).

4.2 Business Arising
There was no business arising from the Minutes.

5.1 Chair’s Report
Professor Michael Hollands reported that he had attended the CEO stakeholder breakfast forum with the Secretary of the Department of Health, held in Canberra on Monday 16 February comprising approximately twenty eight participants, with two Colleges invited individually and a broad spectrum of invitees, including the AMA, the Pharmacy Guild and Medicines Australia and a representative from the Consumers Health forum. He stated that as a group all participants were asked what were the key issues affecting the health system, with responses including co-payments, training, education, non-medical provider groups keen on registration and the registration of ambulance officers.

Professor Hollands stated that on behalf of CPMC members, the main concerns were excellence in health care, training the next generation of specialists, and Indigenous health issues. Professor Hollands informed members of the Secretary’s conclusion to the meeting was that he would like to use the expertise in the room to help develop health policy and is considering convening quarterly meetings in the future.

Professor Nicholas Talley reported that he had attended a meeting with a select group on Tuesday 17th February hosted by the Federal Health Minister and with representation by general practice, physicians, surgeons, the AMA, pathology, advisers and the Secretary of the Department, Martin Bowles. Professor Talley noted the group were asked their views about the short, medium and long terms challenges to the health system and what they would consider valuable and especially those which would be useful in the short term.

Dr Frank Jones commented on the focus of primary care and stated there was a strong presence of primary care attendees at the meeting. He informed the members that the Minister was looking at short term and long term solutions and whatever may save expensive hospital costs.

A discussion took place concerning ways to enhance interaction with the Australian Commission on Safety and Quality in Healthcare, particularly in relation to the TGA review, the Atlas, and ‘perspective change’
with members agreeing for Professor Hollands to meet with the Commission’s CEO, Professor Picone to discuss and report back to the May CPMC meeting.

**ACTION:** Ms Magarry and Professor Hollands to seek a meeting with the CEO, ACSQHC, Professor Deborah Picone

5.1.2 **CEO Report**

Ms Magarry spoke to her report and noted her main focus on activities since the November meeting had been resolving the funding arrangements for the Rural Health Continuing Education Stream One sub-program (RHCE). She informed the Committee members that Dr Lee Gruner will chair the assessment panel to progress Funding Round 7 which is approximately $700,000 in both individual and College grants.

Ms Magarry informed the Committee that CPMC had engaged with the Mr James McAdam, Senior Adviser to the Federal Health Minister Sussan Ley. Ms Magarry advised that there had been several structural changes to the Department of Health affecting structural reform and workforce and that she expected a different approach to be taken to health workforce. Ms Magarry informed members that the next meeting is at Parliament House, 14 May 2015.

Ms Magarry provided an update about the Indigenous health sub-committee and the agreement to convene another Indigenous Knowledge Initiative prior to the May CPMC meeting, utilising a local Aboriginal Health Service. She advised of further work to occur jointly between the two organisations.

Ms Magarry indicated that much of her work had also involved managing the wind down of the RHCE program following the advice by government in November that programs would likely not be funded, only to then have to follow the wind up process to manage the RHCE Funding Round 7. This had resulted in higher than expected travel and administrative work. Ms Magarry reminded members that there is a charge-back arrangement from the RHCE program management agreement in accordance with her role as National Director. The additional cost had therefore been covered.

Professor Hollands informed members about the Indigenous Initiative to be held at a community health centre and meet with staff to see the work being conducted at the centre.

5.1.3 **Financial Statements 2nd quarter 2014-15**

Ms Magarry spoke to the financial reports to the end of December, Q2 and informed the Committee that the January figures will be in the next financial report on 14 May 2015 or on demand. Ms Magarry was asked about the total equity position which she took on notice.

5.1.4 **Account Authorities**

Ms Magarry spoke to the item in relation to the benefit of having another signatory to the accounts so that should staff be on leave, accounting can proceed without delay. She thanked RANZCO for continuing to undertake the role and requested the Board to approve the addition of Ms Kym Buckley, ACT Regional Manager, ANZCA.

Professor Hollands moved the motion for a third signatory, Ms Kym Buckley. This was agreed by Professor Bala Venkatesh and seconded by Professor Mark Daniell. All Board members were in favour.

A discussion occurred in relation to the need for CPMC to have an authorised Deputy Chair. Professor Hollands indicated there was provision in the Constitution for an Executive and to-date the company had managed by having the Chair to work with the Chair-elect or ask a member of the executive to act on behalf of the Chair. This had worked sufficiently well. Professor Hollands agreed to give consideration to the matter.
5.2 Sub-Committee Reports

5.2.1 Education Sub-Committee
Dr Lee Gruner reported that there had not been any recent business and requested the Board to agree to put the sub-committee into abeyance and this was agreed.

Professor Michael Hollands noted that a key piece of work at the moment is revalidation. He requested members to suggest any other matters worthy of the sub-committee to work on and members agreed the focus should be on revalidation. Dr Gruner agreed to lead that work.

5.2.2 Indigenous Health Sub-Committee
Professor Michael Hollands updated the members on the action item from the recently convened sub-committee as sourcing information in relation to courses offered by the Colleges for Indigenous Doctors in Medicine.

Professor Hollands informed the members he was keen for Committee members to attend the Indigenous Knowledge Initiative with AIDA in May 2015. He stated it would be an important and interesting opportunity for both AIDA and the CPMC Committee members.

5.3 Representative reports

5.3.1 National Medical Training Advisory Network
Professor Hollands was an apology for the 17 February 2015 meeting of the National Medical Training Advisory Network (NMTAN). Ms Magarry informed members that she had asked for the minutes from the meeting to be authorised for broader circulation to ensure all members other than those Colleges on NMTAN could be kept up-to-date on the proceedings.

Professor Hollands initiated discussion concerning medical workforce planning and mentioned that with more specialists having been trained overseas but now working permanently in Australia this was having an impact on managing supply. He suggested the emphasis should be on data collection and will take this to his meeting with the new Federal Health Minister.

A general discussion occurred about the capacity of the Department to manage the transition of work from HWA and that a large priority since August 2014 had been to release previously prepared reports to clear any backlog.

Professor Hollands noted that there was no date scheduled for the next meeting however it was important for CPMC to focus on as this was an area of greatest risk to managing the training of specialist medical personnel. A short discussion occurred in relation to the difficulty in obtaining comparative data from NMTAN and that Colleges had offered to conduct the work to ensure accuracy and consistency.

5.3.2 MBA National Specialist IMG Committee
No report was received.

5.4 Australian Academy of Health and Medical Sciences
Professor Hollands invited Professor Nicholas Talley to report on the Australian Academy of Health and Medical Sciences, noting they are continuing to develop a fellowship and currently working through applications that have come into the Academy. He stated that decisions will be made in the near future and announced an official launch for the Academy in the first quarter of this year. Professor Talley noted that it has been a very challenging experience developing a new Academy from the ground up and it is developing well and will have a place in the research space.

Professor Talley indicated the Academy has a strategy to work closely with the NH&MRC.

Members asked a question in relation to the Academy’s Constitution and whether it was a research facility or a research training facility. Professor Talley stated that the concept was for the Academy to be a supporting and mentoring model for clinical researchers.

### 6.0 Strategy

#### 6.1 Lost in Labyrinth report and moratorium

The President, RANZCP Dr Murray Patton raised the issue of the ten year restriction on Medicare benefits for overseas trained medical practitioners (the ten year moratorium) referring to the 2012 House of Representatives Standing Committee on Health and Ageing report *Lost in the Labyrinth: Report on the inquiry into registration processes and support for overseas trained doctors* which had never been formally responded to by government. This report included recommendations relating to the ten year moratorium and Dr Patton informed members that the Department of Health was considering a ‘return of service’ model as a way forward. Dr Patton spoke about the issues for overseas trained doctors. Professor Venkatesh commented that there he was aware of special approvals having been made. Dr Patton said he had concerns in relation to consistency.

Professor Hollands suggested that RANZCP writes to each individual College encouraging them to write to the Department of Health to seek information about the process for responding to the 2012 report. Members agreed.

<table>
<thead>
<tr>
<th>ACTION</th>
<th>RANZCP to write to the Presidents of the Colleges</th>
<th>Dr Patton</th>
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</table>

#### 6.2 Asylum seeker mental health (RANZCP)

The President, RANZCP Dr Murray Patton raised the issue of asylum seeker mental health in relation to the joint work occurring between the Royal Australian and New Zealand College of Psychiatrists, the Royal Australian College of General Practitioners, and the Royal Australasian College of Physicians on this matter. Dr Patton referred specifically to the health issues faced by asylum seekers and refugees along with the challenges faced by medical practitioners working with asylum seekers in detention. A general discussion occurred in relation to the current work occurring in this area. Professor Talley stated the RACP were happy to work on this document. Committee members collectively agreed the importance of removing children in detention as it was more of a humanitarian issue having minors in detention.

<table>
<thead>
<tr>
<th>ACTION: RACP to circulate correspondence for each individual College to consider.</th>
<th>RACP</th>
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</table>

#### 6.3 AMC Specialist Education Advisory Committee (SEAC)

Two nominations had been received member Colleges to replace Dr John Kolbe on the SEAC. A vote was called for with Mr Ian Civil (RACS) nominated by CPMC as the representative.
6.4 **Intensive Care Workforce Summit**
Professor Bala Venkatesh addressed the report arising from the Workforce Summit which was a one day workshop, where current issues were discussed, such as workforce levels, employment, unemployment and future plans.

Professor Venkatesh referred the Committee to the tabled report as it affects all Colleges, with particular reference to the ratio of the advanced trainee to Fellows. He informed the Committee the table was based on data from the MTRP register. The data shows five trainees to one Fellow position.

A general discussion on trainee selection policy and workforce planning occurred. Strategies were discussed regarding service provision and training posts. Committee members spoke of integrated hospital programs and 4 year accredited rotation program blocks.

6.5 **Trauma Register**
Professor Michael Grigg proposed a state of concern and a request for support of the Australian Trauma Registry to be tabled in this meeting.

Professor Grigg, with Professor Hollands’ permission has proposed for Professor Hollands to send out a supporting letter to the Australian Trauma Registry.

Professor Hollands recommended and a motion was agreed and seconded by Dr Anthony Cross with all in favour.

| ACTION – CPMC to send a letter of concern and request for support of the Australian Trauma Registry | CPMC CEO |

7.1 **Election of CPMC Chair-elect**
Four nominees were lodged to the CPMC Secretariat by the due date. An election occurred and Professor Nicholas Talley was elected as Chair to assume the role after the Annual General Meeting in November 2015.

7.2 **Meeting Evaluation**
No formal evaluation was provided.

8. **Next Meeting**
The 110th meeting of the Committee of Presidents of Medical Colleges will be held at Parliament House on 14th May 2015 in the Private Dining area, level 2.

The meeting was closed by Professor Hollands at 3pm.
### Committee of Presidents of Medical Colleges

109th Meeting held Thursday 19 February 2015

**ACTIONS ARISING**

<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
<th>By Whom</th>
<th>Done</th>
</tr>
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<tbody>
<tr>
<td>2.9</td>
<td>Professor Hollands to arrange for a brief from the NMTAN Chair at the May CPMC meeting.</td>
<td>CPMC</td>
<td>?</td>
</tr>
<tr>
<td>3.2</td>
<td>CPMC College CEOs meeting to work up ToRs and report back to May CPMC meeting</td>
<td>CEOs group- Alana Killen and Debra Graves</td>
<td>In-train</td>
</tr>
<tr>
<td>5.1</td>
<td>Prof Hollands to seek a meeting with the CEO, ACSQHC, Professor Deborah Picone</td>
<td>CPMC</td>
<td>(suitable dates clash)</td>
</tr>
<tr>
<td>5.1.2</td>
<td>Ms Magarry to respond to the question regarding total equity.</td>
<td>CPMC CEO</td>
<td>yes</td>
</tr>
<tr>
<td>6.1</td>
<td>RANZCP to write to the Presidents of the Colleges</td>
<td>Dr Patton</td>
<td>?</td>
</tr>
<tr>
<td>6.2</td>
<td>RACP to circulate correspondence for each individual College to consider.</td>
<td>RACP</td>
<td>draft</td>
</tr>
<tr>
<td>6.5</td>
<td>CPMC to send a letter of concern and request for support of the Australian Trauma Registry</td>
<td>CPMC CEO</td>
<td>draft</td>
</tr>
</tbody>
</table>
Committee of Presidents of Medical Colleges

Item 5.1 Chair’s Report
The Chair will update members on various matters verbally. This paper sets out the draft Terms of Reference prepared by the Secretariat as a result of discussion at the February 2015 meeting. The ToRs are for approval at this meeting.

Draft Terms of Reference for the CPMC Chair

PURPOSE
The Chair is director of the CPMC, who chairs CPMC meetings, and who acts as the chief point of liaison between the CPMC and the chief executive officer (CEO), member organisations and the wider community.

TERMS OF REFERENCE
The Chair’s roles are to:
1. Contribute to the work of the CPMC Council as a director.
2. Chair CPMC and CPMC Executive meetings.
3. Undertake other duties of the chair of the board of directors, including
   a. Chairing the annual general meeting (AGM) and any general meetings.
   b. Review and sign the statutory accounts of the CPMC.
   c. Review and sign other documents required for the conduct of the CPMC’s business.
4. Serve as a member of any CPMC, sub-committee or working groups, in an ex-officio capacity.
5. Report on the activities of the CPMC, by means of verbal and written reports
6. Manage the CEO on behalf of the directors and, in particular, to:
   a. Lead recruitment and appointment of a CEO (as applicable).
   b. Liaise with the CEO in the day-to-day running of the CPMC.
   c. Approve unbudgeted expenditure by the CPMC, in line with the CEO’s delegation, or present requests to the Executive or CPMC
   d. Develop and revise the CEO key performance indicators, in collaboration with the CEO and directors
   e. Conduct annual performance appraisal of the CEO based on feedback from directors and others as appropriate.
   f. Conduct an annual review of the CEO’s remuneration package.
   g. Renegotiate the CEO’s contract at the end of each term of office, subject to the advice of the directors.
   h. Lead performance management of the CEO, including termination of the CEO’s contract (if applicable).
7. Undertake the following additional functions on behalf of the directors
   a. Respond to or delegate responsibility for correspondence received by the Chair or directors.
   b. Represent CPMC on the Australian Medical Council; Rural Health Continuing Education program and National Medical Training Advisory Network.
   c. Represent or delegate responsibility for attendance at general meetings.
   d. Develop commentary for communications purposes – print and radio media as required.
   e. Performance manage directors with significant roles in the CPMC as required.
   f. Act as conduit for feedback from member organisations to the CEO regarding if required.
   g. Oversee the development and revision of CPMC policies and procedures.
   h. Thank member organisations, staff and others for their contributions to CPMC activities.

The roles of the chair do NOT include:
1. Making substantive decisions on behalf of the CPMC
DELEGATIONS
The following are delegated roles from the directors:
1. All of the above.

The following require approval of the directors:
1. Changes to CPMC policy.
2. Unbudgeted expenditure with a significant impact on the CPMC current or future financial position.
3. Substantive appointments to outside organisations.

COORDINATION/COMMUNICATION
The important groups/roles for co-ordination/communication for the Chair are the:
1. CPMC (governance).
2. Executive (governance).
3. Member organisations (communication and feedback).
4. Other CPMC sub-committees and working groups (communication and feedback).
5. CPMC deputy chair (communication and feedback).
6. CPMC CEO (management and liaison regarding business of the CPMC).

The Chair undertakes their work in accordance with relevant CPMC policies. Bullying, discrimination and harassment will be managed, as relevant, in accordance with the CPMC Policy on Bullying, Discrimination and Harassment and other policies (available by contacting the CEO at ceo@cpmc.edu.au).

Questions arising in the course of the work of the Chair should be raised with the deputy chair, CEO or the CPMC’s legal counsel, as relevant.

APPOINTMENT
The election of the CPMC Chair is by the directors for two years.

REAPPOINTMENT
The Chair may not be re-elected.

REPORTING
The Chair provides regular reports of activities to the directors, the Executive, member organisations and the wider community. The chair receives regular reports from the CEO and informally as required.

ADMINISTRATIVE RELATIONSHIPS
Administrative support for the Chair will be from a member College in support of the CEO.
COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES

Item 5.1.2 Chief Executive’s Report - 14 May 2015 meeting

Reporting against Performance Plan

1. Strategy

1.1 Understands the medical, educational, operational, regulatory and political milieu in which CPMC operates
   • Develops advocacy, policy and government relations (APGR) plan 2013-15
   • Develops and conducts a government relations day in 2014 building upon regular CPMC meetings.

Status - met
   • The APGR plan was agreed in-principle at the August 2013 CPMC meeting to facilitate engagement and targeted advocacy with Departmental Secretaries, officials and parliamentarians. Regular contact is kept with peak bodies.
   • A mini government relations day occurred on 30 October with FAS from Strategic Liaison section of the Health Department. Further similar expected in 2015 at CPMC offices.
   • Change over in Health Ministers acknowledged via twitter and contact made with key Ministerial staff (some major changes expected).
   • Change of Health Secretary and restructure occurred in February 2015.
   • Liaison with the Office of Catherine King, Opposition Health has occurred concerning general CPMC business and RHCE and she addressed members at the February meeting.
   • Communication occurred with the Health Minister and Assistant Health Minister concerning RHCE continuity. There was a joint letter by CPMC and NRHA as well.
   • This meeting at Parliament House is unique with the opportunity for members to meet Parliamentarians, receive Budget briefings and do their own separate meetings if so desired.

1.2 Develop and lead strategic planning based on this milieu that includes appropriate new or revised initiatives
   • Develops revised UNITE and consolidates input for UNITE version2
   • Develops implementation plan with resources and data points

Status - met
   • The 2011-13 plan was discussed over several meetings.
   • The Mission Statement has been developed, consulted and available for inclusion with the discussion on the future strategic plan.
   • The discussion to support a 2015 -17 plan occurred at the November meeting. As a result further work occurred to develop a firmer role for the Chair with ToRs presented for approval at this meeting; and a draft plan reflecting strategic goals and areas of special interest in the context of resources for practical implementation has been developed and presented to this meeting at item 6.2

1.3 Build and maintain the necessary infrastructure to facilitate achievement of these strategic goals.
   • Reports against the UNITE, APGR and government relations day activities in CEO report to CPMC
   • Establishes CPMC Canberra as hub of government relations for CPMC members

Status - met
   • UNITE was subject of November discussion and minutes highlight outcome.
   • CEOs represented at the post MT session to allow for greater involvement in strategic discussion.
   • Completed the AHMAC supported project: Accreditation of Specialist Medical Training Sites
   • Re-appointed to the DHS Stakeholder Reference Group
   • Convened the Revalidation workshop, with associated report and discussion with Dr Flynn (MBA) concerning next steps- this is a standing item for members to determine approach.
   • Re-appointed as alternate on the NMTAN - update from Prof Horvarth this meeting.
   • Issues such as STP, DOH restructure and engagement, Medicare reform & strategy this meeting agenda.
   • Engagement with stakeholders continues, eg New Zealand colleagues.
2. Operations

2.1 Ensure the smooth operation of the Committee’s activities including meetings, representations and the provision of advice to colleges, government, the media and other organisations.

- Key dates and meetings occur with CPMC, government key stakeholders and MPs/Senators, advisers.
- Establishes media/communications platform for CPMC member information and broader stakeholder awareness.
- Establishes contact with health reporters and college newsletters, >3 pieces per annum

Status - continuing to meet

- Supported the Academy of Health and Medical Sciences nomination process and attended the launch.
- Supported the nomination to the NHMRC Council.
- I undertake all event logistics including securing venues, developing catering, paying all accounts, managing the various logistics for CPMC quarterly meetings, subcommittees and ad hoc events such as the Indigenous Knowledge Initiative.
- Contact established with key health reporters, engaged with them after announcement of Medicare reform.
- CPMC Twitter site going well.
- Written pieces for some College newsletters on RHCE and with a link to CPMC.

2.2 Ensure provision of high quality programs and services that meet the contracts that CPMC has with governments and other organisations, within agreed budgets and timeframes.

- Existing contracts managed to acquittal and final report.
- Develops new contracts or renewal of contracts consistent with strategic plan and within capacity.

Status

Rural Health Continuing Education Sub-Program Stream One (RHCE)

On 17 December 2014, the Department of Health met with the RHCE Program Management Committee (PMC) and advised that it would fund the RHCE program until December 2015. It also advised that the function of the RHCE Program would then be transferred from CPMC to Primary Health Networks, and that CPMC would need to be involved in the transition process. At that meeting, a seventh funding round of RHCE was negotiated with the Department with projects to span an eight month period, which was the maximum the Department and the PMC could agree to due to application, contract and acquittal process requirements. Similarly, it was agreed that individual grants for rural specialists would cover CPD activities undertaken within those eight months. Accordingly, in January/February 2015, a dual project and individual grants funding round was undertaken. An assessment panel comprising six members from the RHCE PMC was given a week to assess the project and individual grants, before meeting on 20 February to agree on the successful grant applicants. Projects were assessed against five scoring categories, covering value and feasibility, quality of CPD, need and sustainability, reach and collaborative nature of the project, and rurality. Individual grants were considered against rurality of the practitioner, the stated need, the quality and practicality of the activities, and value for money. The results were as follows:

- 14 CPD projects worth $962,833 (GST exc) funded across nine Colleges (from 20 applications); and
- 50 CPD support grants worth $219,030 (GST exc) provided to rural medical specialists out of 61 applications.

All contracts governing the 64 successful grants have been executed and work is underway. Projects will reach completion by 15 November. CPMC will continue to manage the transition to PHNs. CPMC CEO will continue to provide support as National Director and cover for leave arrangements for the Project Manager.

Indigenous Health Subcommittee & link to completed NATSIM Project - recommendations were enveloped into the agenda to support the subcommittee. There is ongoing work via the Collaboration Agreement, the sub-committee and general engagement with AIDA.

AHMAC Accreditation of Specialist Medical Training Facilities Project has been lead by CPMC in conjunction with the AMC & NSW Health and is to be presented to the AHMAC meeting in June.
2.3 Lead effective management of CPMC’s financial resources by building and maintaining appropriate budgeting, investing procedures and controls.

- Financial management moves effectively to Canberra with controls in place
- CPMC Budget 2013-14 established to revenue raise and build reserves, and operating manual developed in conjunction with accounting and book keeping services to assist in the audit and control.
- Sub-lease at ANZCA ACT Office in place until January 2015.

Status- continuing to be met
- For the year ending 30 June, 2014 CPMC was in surplus as audit papers showed.
- CPMC is within budget and any variances are accounted for as outlined in 5.1.3
- CPMC will incur some extra travel costs associated with the Chair’s travel and attendance at Canada’s IAMRA conference in October 2015.
- CPMC has had a 100 per cent turn around in financial position since 2013.
- CEO has worked to the financial strategy as approved by the Board in 2013-14 to stabilise the company and develop reserves to support the management of any risk. CPMC will report a surplus for 2014-15 and will contribute to reserves.
- The 2015-16 budget has been prepared which aims to continue as per 2014-15 strategy and this is outlined in 5.1.4.
- At the request of some College members a review of the subscription fees occurred with modelling to support a change in fee structure with the aim of greater equity in sharing the costs of running CPMC. CEOs discussed this paper on 7 May and a verbal update will be provided on this matter.
- MOU in place awaiting further 4 years signature which will result in a small rise by CPI.

2.4 Ensure that CPMC operates within an appropriate risk environment through diligent monitoring, reporting and management of risks and their mitigation.

- Develop a risk management plan for internal membership information and awareness (e.g. finance and audit controls)
- Ensure insurances in place at correct coverage.
- Ensure that quarterly risk reporting occurs

Status- risks managed
- The issues associated with IT compliance have been addressed. Uberglobal provides cloud hosting and David Newman and Associates provides web server support + IT changes.
- Insurances & WCI have been renewed and are in place.
- The risk register has been developed, nothing to report this quarter.
- Developing up administrative assistance with regards to logistics, consistent administrative support for the meetings and general support underway is dependent upon the budget.

3. Relationships

3.1 Support CPMC by making available all necessary advice, reports and resources required for the prudent governance of CPMC and the promotion of its mission.

- Information and advice made available through Communique and establishes newsletter on-line
- Members are governance aware through orientation pack to CPMC

Status- continuing to be met
- The members guide was revised for 2015 and sent to all new members.
- CPMC website was completely overhauled and all Communiques on the CPMC website updated. Building add-ons for the website is still under development.
- Email alerts and or Information Bulletins out to members on critical issues of interest.
- Governance information piece developed. Changes made to the ASIC register as they occur.
3.2 Establish and build productive relationships with member colleges and engage then in the CPMC’s strategic vision

- Identifies 3-5 core issues from each college CEO which builds an issues brief for the APGR agenda.
- Develops submissions to government where appropriate in conjunction with the presidents and CEOs of the member colleges (>3 per year)

**Status – continuing to be met**

CPMC strategic business planning process has included reference to the range of issues raised with me by the College CEOs. In order to implement the plan if approved, at item 6.2, resources will be required. I regularly meet with the Chair of the CEOs group and value the interactions with all College CEOs. Issues are mostly College specific but on matters of common interest such as relevant information, submission development, and government liaison issues I send out communication and requests for information.

CEOs lunch forum established to ensure policy development by government includes input from consulting with the Colleges as the experts in the field. More work is anticipated for 2015 given the new Health Minister. Will provide a presentation to the May meeting on key strategic issues to inform the draft plan.

3.3 Provide innovative leadership and effective management of CPMC’s staff, where applicable, conforming with all authorised personnel policies, regulations and laws.

- Divided management function of RHCE staff with RACP managed effectively through appropriate support and strategic management oversight of the project.
- An orientation manual to be developed for any potential new staff

**Status**

- Projects require strategic direction and interaction which occurs via the 0.1FTE as National Director, RHCE however this is generally daily either on the program management, evaluation or payment of funding agreement scheduled payments. Approximately 10 hours per week.
- Regular interaction with ANZCA (ACT) Regional Manager – this individual works 20 hours per week.

3.4 Contribute to the protection and promotion of CPMC and specialist medical colleges as a whole by liaising with and influencing clients, consumers, the media, government and other health-related organisations

- meet and greet occurs via CPMC meetings for member benefit, same for immediate stakeholders
- draft up articles for op-eds, establish Twitter and use it, initiate media contact and interest and drive that through the APGR plan.

**Status**

- Significant liaison has occurred with other peak bodies regarding the Federal Budget, MBS Review, RHCE and move to PHNs, and in preparation for the May CPMC meeting where a celebratory morning tea will occur for the 110th CPMC meeting. All MPs and Senators will an interest or responsibility for health or education were invited. Attendees will be from Departments of Health and Finance, opposition and independent members, including some peak bodies. It is expected that CPMC’s profile will be raised further through holding the event in Parliament House as this is communicated on the message boards throughout all offices.
- Submission to AHMAC Review of Medical Intern Training completed and lodged.
- Submission to DFAT regarding the Trans-Pacific Partnership Agreement negotiations.
- Correspondence to the Minister regarding MBS Review and Taskforce
- Update on Twitter where appropriate.
- Interaction with AIDA on Indigenous issues and the NATSIM project.

3.5 In addition to these accountabilities, the CEO as a range of working relationships, including with CPMC and its sub-committees, specialist medical colleges and their members, direct staff reports, Governments, other health-related or regulatory organisations, the media, patients and the community.

- feature in college updates promoting the broader CPMC member views - twice per annum
- attend forums and meetings, Medicare meetings, government stakeholder meetings (including Estimates) and contribute to the broader health policy reform debate through professional membership.
- Maintain Parliamentary Pass for lobbyists (APH Pass) to engage with advisers and ensure CPMC members gain access to this decision-making level.

**Status**

- Monitoring the transition of HWA into the Department of Health
• Featured in several College magazines in relation to RHCE.
• I have a Parliamentary Pass.
• Attended Estimates
• 20 February: Project Management Steering Committee for RHCE to undertake the assessment panel work for College and individual grants.
• 5 March 2015 Council of Medical Colleges New Zealand meeting on 5 March on behalf of Chair.
• 19 March Department of Human Services personnel regarding the MBS review
• 23rd March meeting with Minister for Health, Parliament House
• 25th March Academy of Health & Medical Sciences launch and Fellowship awards, Canberra.
• 31st March IHPA SCG, teleconference
• 1st April AMA Roundtable forum, Canberra
• 15 April meeting of the AHPRA Professions Reference Group, teleconference
• 28th April AMC Progress Reports Working Party, Canberra
• 29th April DHS Strategic Directions meeting, Canberra
• 29 April, 2015 Deputy Secretary DHS, on Medicare reform taskforce
• 4th May Northern Clinical Training Network Steering Committee
• 5th May met with Department of Health Workforce Director regarding NMTAN
• Upcoming NMTAN meeting 19th May to attend on behalf of Chair
• In addition several College CEOs meetings and met with some of the policy advisers in Ministerial Offices, as well as in Colleges.

END
COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES

5.1.3 Financial Statements
This item reflects the financial statements as at the end of Q3 in 2014-15 financial year comprising the Profit and Loss and Balance Sheet. This report also provides information on projected end of year position. CPMC is solvent and has sufficient funds to cover all known expenses.

Balance Sheet
At the February meeting a question in relation to total equity was made which related to deferred grant revenue showing as a liability and this has been resolved in the accounts. Total current assets now reflect the accounts while total current liabilities reflect the provisions for leave and creditors. CPMC has a total equity of $1.52M (operational and RHCE income)

Income
Income is generated from subscriptions, bank interest and project management fees. The variances are in the areas of non-member generated income, with the Department of Human Services no longer paying any sitting fees for CEO quarterly representation on Medicare, and the RHCE charge-back for the full year has not been finalised but is expected by EOFY. The inclusion of $2.044M RHCE grant funds into the CPMC MYOB file has been necessary to properly reflect the management of funds by CPMC, however this amount is grant funding and will be expended according to the RHCE grant funding agreement.

Expenses
CPMC has tracked well in Quarter 3 with variances accruing in areas relating to travel and engagement by the Chair & CEO, as well as CPMC meeting expenses.

It should be noted that CPMC has held more events than in past years such as the AHMAC Specialist Accreditation workshop, a Strategic Liaison Forum with the Department of Health, the Revalidation workshop, the Indigenous Knowledge Initiatives and RHCE planning forums. When added to the usual quarterly meeting costs a small variance against budget has occurred.

CPMC has increased its engagement with agencies and CMC New Zealand which has resulted in some additional charges for the Chair and CEO.

CPMC receives income to subsidise the CEO undertaking the RHCE management and liaison and this also covers some travel expenses.

End of Year Projections
CPMC budgeted for income of $287,147 and expenses of $270,562 thereby making provision for a small surplus to add to building reserves. Approximately $20,000 is expected in surplus at EOFY.

It should be noted that there is a paper on the subscription fees for 2015-16 which is starting the discussion about greater equity in the spread of fees across the membership but the result will not alter the ability of CPMC to cover known expenses to run the company, and provide for the reserves as well as any contingencies. The Chair will also introduce the matter regarding the CEO’s FTE in the discussion concerning subscription fees and budget 2015-16 (item 5.1.4).

Recommendation
That members note the financial position of the company.
COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES

5.1.4 CPMC Subscriptions and Budget 2015-16

This item refers to the traditional discussion concerning the annual budget, subscription fees and any other financial issue the Directors may wish to discuss.

2014-15 budget result
It is anticipated that CPMC will deliver a surplus against budget of approximately $20K. In keeping with the decision made on 25 June 2013 to increase subscription fees to manage the company’s solvency and build reserves, at the end of the financial year CPMC will deliver a surplus and contribute to managed reserves. It should be noted that there has been a 100 per cent turn around in company position since the CEO was appointed in July 2013. The company will undergo an interim audit in late May to provide for the audited statements to be made available for the August 2015 meeting and ratified at the November AGM.

Fees Review – proceeding
At the request of some of the larger Colleges the CEO was asked to fast-track the fee review with the aim of establishing greater equity in the spread of fees across the Colleges. This exercise was complex and involved research, consultation with peak body colleagues, modelling and options. The first cut of the approach was discussed with the CEOs group on 7 May, 2015. It was considered more appropriate for the company directors to determine the Strategic Plan (Towards 2017) rather than focus firstly on fees. The CEOs agreed that it would be more useful to strike the strategic plan then work up some principles for establishing a fee structure and to consider what the Medical Deans have done, then discuss it all between now and August 2015.

2015-16 Proposed budget
CPMC relies on subscription fees for around ninety per cent of company operating budget. This is because as a small entity with a lean infrastructure there is minimal capacity to undertake additional project work. RHCE will transition into Primary Health Networks and that income stream will cease. In 2015-16 CPMC is expected to continue to grow in its relevance with stakeholders and potentially involve more engagement with associated costs but the draft CPMC budget takes these matters into consideration.

Recommendation
That members note the information provided and approve the CPMC budget for 2015-16 as shown in draft at this meeting.
### Committee of Presidents of Medical Colleges

**Item 5.1.4 Draft 2015-16 budget**

<table>
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<th>Item</th>
<th>2013-14</th>
<th>2014-15</th>
<th>2015-16</th>
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<td>2,500</td>
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<tr>
<td>Superannuation</td>
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<td>13000</td>
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<td>Teleconference expenses</td>
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<td>Workcover</td>
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<td>1,600</td>
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<td>Accommodation (9)</td>
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<td>10,000</td>
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<td>1,200</td>
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<td><strong>Total expense</strong></td>
<td>222,530</td>
<td>271938</td>
<td>264300</td>
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</table>

**Net surplus/loss**

See notes

CPMC item 5.1.4 subscription fees and budget
NOTES

1. CF is an estimate only
2. RHCE funding agreement ceases 2014-15.
3. Challenge to find suitably skilled and willing admin assistance, in 2015-16 some negotiation will occur related to the terms of reference of the Chair which identify support for the Chair and CEO via College MOUs similar to the CMC New Zealand model.
4. Provision for capital equipment in case the existing computing equipment needs upgrading.
5. CPMC meeting costs have risen due to local venue charges, the difficulty in finding private rooms for College President dinners – most charge a fee of $5K for the space- and catering fees at the venues have risen. CPMC has also convened additional separate meeting/conference vents, and government relations activities. All expected to rise in 2015-16 hence provision has been made for this.
6. CEOs professional development expenses while only related to College forums, are in the CEO contract and are expected to be better utilised in 2015-16.
7. Rent is low compared to the market and a further 4 years lease has been signed.
8. Chair will introduce in his item 5.1 the benefit of increasing CEO time to 0.7FTE to better reflect the actual workload undertaken and the expected changes in 2015-16. If this is approved the budget will alter as the contract will need amending.
9. Travel related expenses have risen because of the additional meetings attended and the RHCE wind down/windup process. It is expected that the Chair will travel & engage further in 2015-16 year so provision has been made for that.
Balance Sheet
As of March 2015

This report includes Year-End Adjustments.

<table>
<thead>
<tr>
<th>Assets</th>
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<tbody>
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<td><strong>Current Assets</strong></td>
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<tr>
<td>Bank Accounts</td>
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<td>COP: Westpac Cheque 42-3262</td>
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<tr>
<td>COP: Westpac Maxi 42-3588</td>
<td>$134,426.69</td>
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<td>Indigenous Health AC 649819</td>
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<td>RHCE AC 688025</td>
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<td>Clearing Accounts</td>
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<td><strong>Total Clearing Accounts</strong></td>
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<td><strong>Total Current Assets</strong></td>
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<tr>
<td><strong>Total Assets</strong></td>
<td>$1,589,169.47</td>
</tr>
</tbody>
</table>

| Liabilities                                 |       |
| Current Liabilities                         |       |
| GST Liabilities                             |       |
| GST Collected                               | -$0.10 |
| GST Paid                                    | $0.33  |
| **Total GST Liabilities**                   | $0.23  |
| Other Current Liabilities                   |       |
| Trade Creditors                             | $49,058.74 |
| Provision for Holiday Pay                   | $15,454.35 |
| Provision for Long Service Leave            | $2,521.72 |
| **Total Other Current Liabilities**         | $67,034.81 |
| **Total Current Liabilities**               | $67,035.04 |
| **Total Liabilities**                       | $67,035.04 |
| **Net Assets**                              | $1,522,134.43 |

| Equity                                      |       |
| Retained Earnings                           | $91,801.06 |
| Current Year Earnings                       | $1,486,860.51 |
| Adjustment to reconcile                     | -$74,993.92 |
| Historical Balancing                        | $18,466.78 |
| **Total Equity**                            | $1,522,134.43 |
## Profit & Loss [Budget Analysis]

### July 2014 To June 2015

<table>
<thead>
<tr>
<th>Selected Period</th>
<th>Budgeted</th>
<th>$ Difference</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Subscription fees</td>
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<td>Project Mgmt from RHCE</td>
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<td>RHCE Grant Funds</td>
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<td>$2,044,752.55</td>
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<td>Indigenous Health Project</td>
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<td>$46,773.00</td>
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<tr>
<td>Interest Received</td>
<td>$16,885.07</td>
<td>$2,000.00</td>
<td>$14,885.07</td>
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<tr>
<td><strong>Total Income</strong></td>
<td>$2,381,604.30</td>
<td>$287,147.00</td>
<td>$2,094,457.30</td>
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</tbody>
</table>

| **Gross Profit** | $2,381,604.30 | $287,147.00 | $2,094,457.30 | 729.4%        |

| **Expenses**     |          |              |              |
| Committee of Presidents |          |              |              |
| SUSPENSE ACCOUNT | $46,773.00 | $0.00 | $46,773.00 | NA |
| Accounting fees | $3,956.50 | $7,200.00 | -$3,243.50 | (45.0)%       |
| Administrative Assistance | $0.00 | $40,000.00 | -$40,000.00 | (100.0)%      |
| ASIC fees | $0.00 | $240.00 | -$240.00 | (100.0)%      |
| Audit Fees | $5,000.00 | $5,500.00 | -$500.00 | (9.1)%        |
| Bank fees | $104.35 | $252.00 | -$147.65 | (58.6)%       |
| Computer Expenses | $0.00 | $3,000.00 | -$3,000.00 | (100.0)%      |
| Couriers & Freight | $0.00 | $120.00 | -$120.00 | (100.0)%      |
| Internet | $9,071.59 | $1,200.00 | $7,871.59 | 656.0%        |
| Website Platform Design and De | $0.00 | $120.00 | -$120.00 | (100.0)%      |
| Legal Fees | $0.00 | $2,520.00 | -$2,520.00 | (100.0)%      |
| Licences and fees | $0.00 | $10.00 | -$10.00 | (100.0)%      |
| Meeting Expenses | $15,436.14 | $15,000.00 | $436.14 | 2.9%          |
| Office Supplies | $375.37 | $500.00 | -$124.63 | (24.9)%       |
| Postage | $17.36 | $200.00 | -$182.64 | (91.3)%       |
| Professional Development | $0.00 | $4,500.00 | -$4,500.00 | (100.0)%      |
| Rent | $3,470.61 | $10,200.00 | -$6,729.39 | (66.0)%       |
| Salaries | $98,691.03 | $131,592.00 | -$32,900.97 | (25.0)%       |
| Stationery | $476.53 | $60.00 | $416.53 | 694.2%        |
| Registration/Subscriptions | $2,300.00 | $600.00 | $1,700.00 | 283.3%        |
| Sundry Expenses | $209.27 | $2,500.00 | -$2,290.73 | (91.7)%       |
| Superannuation | $9,375.66 | $12,996.00 | -$3,620.34 | (27.9)%       |
| Teleconference Expenses | $43.45 | $1,992.00 | -$1,948.55 | (97.8)%       |
| Telephone | $1,695.01 | $1,992.00 | -$296.99 | (14.9)%       |
| Workcover | $1,662.80 | $1,608.00 | $54.80 | 3.4%          |
| Travel |          |              |              |
| Accommodation | $9,698.26 | $6,000.00 | $3,698.26 | 61.6%          |
| Airfares | $13,960.00 | $12,000.00 | $1,960.00 | 16.3%          |
| Parking | $420.04 | $600.00 | -$179.96 | (30.0)%       |
| Taxis | $729.52 | $2,520.00 | -$1,790.48 | (71.1)%       |
| Other Travel Expenses | $2,753.90 | $1,200.00 | $1,553.90 | 129.5%        |
| **Total Travel** | $27,561.72 | $22,320.00 | $5,241.72 | 23.5%          |

| Insurance Expenses |          |              |              |
| Business Insurance | $0.00 | $1,440.00 | -$1,440.00 | (100.0)%      |
| Pro Indemnity Insurance | $0.00 | $1,440.00 | -$1,440.00 | (100.0)%      |
| Public Liability Insurance | $0.00 | $1,440.00 | -$1,440.00 | (100.0)%      |

| **Total Insurance Expenses** | $0.00 | $4,320.00 | -$4,320.00 | (100.0)%      |

| **Total Committee of Presidents** | $226,220.39 | $270,562.00 | -$44,341.61 | (16.4)%       |
# Profit & Loss [Budget Analysis]

## July 2014 To June 2015

<table>
<thead>
<tr>
<th>Description</th>
<th>Selected Period</th>
<th>Budgeted</th>
<th>$ Difference</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding and Management Fees</td>
<td>$649,674.90</td>
<td>$980,000.00</td>
<td>-$330,325.10</td>
<td>(33.7)%</td>
</tr>
<tr>
<td>PMU Extension</td>
<td>$18,848.50</td>
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<tr>
<td>Total Expenses</td>
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<td>-$355,818.21</td>
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<tr>
<td>Operating Profit</td>
<td>$1,486,860.51</td>
<td>-$963,415.00</td>
<td>$2,450,275.51</td>
<td>254.3%</td>
</tr>
<tr>
<td>Total Other Income</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>NA</td>
</tr>
<tr>
<td>Total Other Expenses</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>NA</td>
</tr>
<tr>
<td>Net Profit/(Loss)</td>
<td>$1,486,860.51</td>
<td>-$963,415.00</td>
<td>$2,450,275.51</td>
<td>254.3%</td>
</tr>
</tbody>
</table>
**Committee of Presidents of Medical Colleges**

**Item 5.1.5 Governance Issues- changes in Directors**

The following changes in Directors have occurred since the August 2014 meeting of the Committee:

<table>
<thead>
<tr>
<th>Name</th>
<th>College</th>
<th>Nature of Change</th>
<th>Date</th>
<th>ASIC Notified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof Michael Grigg</td>
<td>RACS</td>
<td>Ceased</td>
<td>1/5/15</td>
<td>8/5/15</td>
</tr>
<tr>
<td>Prof David Watters</td>
<td>RACS</td>
<td>Appointed</td>
<td>1/5/15</td>
<td>8/5/15</td>
</tr>
<tr>
<td>Dr Murray Patton</td>
<td>RANZCP</td>
<td>Ceased</td>
<td>1/5/15</td>
<td>8/5/15</td>
</tr>
<tr>
<td>Prof Malcolm Hopwood</td>
<td>RANZCP</td>
<td>Appointed</td>
<td>1/5/15</td>
<td>8/5/15</td>
</tr>
</tbody>
</table>
Minutes
AIDA-CPMC Indigenous Health Sub-Committee Meeting
13:15 – 16:00, Sydney, 18 February 2015

Attendees

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Professor Michael Hollands</td>
<td>CPMC co-Chair</td>
</tr>
<tr>
<td>Dr Kali Hayward</td>
<td>A/AIDA co-Chair</td>
</tr>
<tr>
<td>Dr Ian McCrossin</td>
<td>Australasian College of Dermatologists</td>
</tr>
<tr>
<td>Dr Elizabeth Mowatt</td>
<td>The Australasian College of Emergency Medicine</td>
</tr>
<tr>
<td>Dr Shrina Begg</td>
<td>Australian and New Zealand College of Anaesthetists</td>
</tr>
<tr>
<td>Associate Professor Bradley Murphy</td>
<td>The Royal Australian College of General Practitioners</td>
</tr>
<tr>
<td>Ms Angela Magarry</td>
<td>CEO CPMC</td>
</tr>
<tr>
<td>Ms Kate Thomann</td>
<td>CEO AIDA</td>
</tr>
<tr>
<td>Mr Brenton Rodgers</td>
<td>Department of Health</td>
</tr>
<tr>
<td>AIDA Secretariat Support</td>
<td></td>
</tr>
<tr>
<td>Ms Sam Crossman</td>
<td>AIDA Policy and Programs Manager</td>
</tr>
</tbody>
</table>

Apologies

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Tammy Kimpton</td>
<td>AIDA co-Chair</td>
</tr>
<tr>
<td>Associate Professor Noel Hayman</td>
<td>Royal Australasian College of Physicians</td>
</tr>
<tr>
<td>Dr Tony Austin</td>
<td>Royal Australasian College of Medical Administrators</td>
</tr>
<tr>
<td>Associate Professor Kelvin Kong</td>
<td>Royal Australasian College of Surgeons</td>
</tr>
</tbody>
</table>

Agenda Item 1 - Welcome and introductions

Dr Kali Hayward provided an Acknowledgement of Country at the start of the meeting acknowledging the Gadigal people on whose land the meeting is taking place. Dr Hayward and Associate Professor Michael Hollands welcomed participants to the meeting and noted apologies. Meeting participants introduced themselves to other participants.

Agenda Item 2 - Acceptance of previous minutes/update on actions arising

It was noted that meeting minutes from the last meeting of the CPMC IHSC, held on 22 November 2013, had been circulated. Meeting participants were asked if there were any issues with these minutes. No issues with regards to the minutes were raised.

A summary of the Actions Arising, and progress against these Actions, from the 22 November CPMC IHSC was provided to meeting participants. Some Actions Arising had been completed and others were dealt with under subsequent meeting agenda items.
Agenda Item 3 - Review Subcommittee Terms of Reference (ToR)

Reflecting on the AIDA-CPMC Collaboration Agreement and the outcomes from the National Aboriginal and Torres Strait Islander Medical Specialist Framework, the 2012 CPMC IHS ToR were revised by the Secretariats of AIDA and CPMC for CPMC IHSC member’s consideration.

After discussion it was agreed that:

- the term of the group would be for two years;
- the name group would be changed to the AIDA-CPMC Indigenous Health Subcommittee (AIDA-CPMC IHSC) reflecting that the group is the vehicle through which activities under the Collaboration Agreement are progressed;
- the Presidents of CPMC and AIDA would continue to co-Chair this activity;
- the group would report to both the CPMC and the AIDA Board;
- AIDA would consider how many representatives to have on this group;
- each College would be eligible to have representation of the AIDA-CPMC IHSC;
- it would be welcomed if the Department of Health continued to be a member on this group; and
- the inclusion of Medical Deans Australia and New Zealand was a historical legacy (due to Professor Judy Searle’s previous position) and the inclusion of the Confederation of Presidents of Medical Education Councils was no longer appropriate.

There was discussion around the Indigenous Knowledge Initiative (IKI) to determine if the way that the IKI had been envisaged in the ToR was the best use of resources and this opportunity. Attendance at the IKI was added under the meetings heading to underline the importance of AIDA-CPMC IHSC members attending this event. There was some preliminary discussion of the 2015 IKI and more information on final outcome is outlined at agenda item 8.

ACTION 3.1.: CPMC to confirm with the National Aboriginal Community Controlled Health Organisation if they would like to continue to be involved with this group.
ACTION 3.2: CPMC to confirm if the AMC would be interested in becoming a member.
ACTION 3.3: AIDA to update revised ToR in line with discussion at the meeting.
ACTION 3.4: AIDA to provide further advice on representation on this group.

Agenda Item 4 - National Aboriginal and Torres Strait Islander Medical Specialist Framework (NATSIMSF) Project Update

Meeting participants were reminded that the NATSIMSF Project was lodged in April 2014 and that one key activity that was not completed was an Aboriginal and Torres Strait Islander health curriculum. Meeting participants discussed the best way forward to address this. It was agreed that an overarching principles based framework would be the best approach and that a Working Group of the AIDA-CPMC IHSC could be established to facilitate this. This framework would be an overarching document providing a starting point and ideally each College could develop their own specialty focused curriculum (it was noted that some Colleges are already doing this). Finally, it was agreed that all trainees (and Fellows), should be reminded that Aboriginal and Torres Strait Islander health is part of their job.
ACTION 4.1: Associate Professor Hollands to ascertain with College Presidents their interest in pursuing a principles-based curriculum.

ACTION 4.2: If agreed, establish a Working Group of the AIDA-CPMC IHSC to progress this activity.

Agenda Item 5 - Update against the Collaboration Agreement
Meeting participants noted the update on key achievements of the AIDA-CPMC Collaboration Agreement 2013-2015 against Priority Outputs for 2013-2015 that were specified in the Collaboration Agreement.

Agenda Item 6 - Proposed extension to the current Collaboration Agreement
Meeting participants discussed the issue of a proposed extension to the current Collaboration Agreement. Noting that there are some activities under the current Collaboration Agreement that are still outstanding, meeting participants agreed that it should be proposed to the CPMC and AIDA Boards that the current Collaboration should be extended for one year.

ACTION 6.1: CMPC and AIDA Boards to consider extending the AIDA-CPMC Collaboration agreement for a further 12 months.

Agenda Item 7 - Implementation and resourcing of the Collaboration Agreement
As outlined at agenda item 4, the AIDA and CPMC Secretariats have developed a draft work plan. This work plan is intended to progress efforts to increase the number of Aboriginal and Torres Strait Islander specialists and content of Aboriginal and Torres Strait Islander in Medical Colleges. It was agreed that AIDA and CPMC would write jointly to the Department of Health to seek funding for implementation.

ACTION 7.1: AIDA and CMPC Secretariats to draft a letter to the Minister for Health to seek funding for a project officer to drive the implementation of the Collaboration Agreement. The Commonwealth has previously funded implementation through a Medical College and the resource was an effective and efficient mechanism for progressing the work. It was acknowledged that without such a resource, progress has stalled.

Agenda Item 8 - Indigenous Knowledge Initiative (IKI)
Ms Thomann briefed meeting participants on the Indigenous Knowledge Initiative (IKI) including a draft program that had been developed for consideration. Ms Thomann noted that the IKI had been tentatively scheduled on 13 May 2015 before the next meeting of the CPMC. Meeting participants discussed the background to the activity, a draft program, potential participants and agreed that both College Presidents and CEOs should be invited to attend the IKI.

ACTION 8.1: AIDA and CMPC Secretariats to work together to run the IKI for College Presidents, CEOs and AIDA-CPMC IHSC representatives on 13 May 2015.
Agenda Item 9 - Australian Medical Council
Meeting participants discussed the Australian Medical Council’s (AMC) engagement in Aboriginal and Torres Strait Islander medical workforce development and health since the November 2013 meeting. In particular, the group noted the External Review Australian Medical Council 2013 – Summary and Recommendations from the Report of the International Panel. It was noted that recommendations seven and ten of the review are particularly relevant to Indigenous health. These recommendations were:

- to raise the quality and responsiveness of the AMC’s leadership in Indigenous health and the need of its practitioners (seven); and
- create an effective set of partnerships to ensure that all doctors practising in remote and rural settings are qualified and competent (ten).

In the context of these recommendations, meeting participants were pleased to note the 2014 announcement of an AMC’s Indigenous Planning Advisory Group (IPAG). It was agreed that letters of congratulation (drafted in anticipation) from the co-Chairs should be sent to the AMC CEO, Mr Ian Frank, and the IPAG co-Chairs Associate Professor Noel Hayman and Mr Greg Phillips.

ACTION 9.1 AIDA Secretariat to send signed letters to Mr Frank, Associate Professor Hayman and Mr Phillips.

Agenda Item 10 - Data Modelling Project
AIDA CEO, Ms Kate Thomann, briefed meeting participants on a data modelling project that AIDA is currently undertaking. This project may map out Aboriginal and Torres Strait Islander medical workforce requirements, including within the specialist medical colleges, to 2030.

Agenda Item 11 – Next meeting, summary and close
Participants agreed that the next meeting of the AIDA-CPMC IHSC would be held within the confines of the AIDA Conference on 17 September 2015 in Adelaide after the Growing our Fellows Workshop. Meeting participants also agreed that the next IKI should be held in Canberra on 13 May 2015 to coincide with the 14 May CPMC Meeting.

No other business was raised.
National Medical Training Advisory Network Executive Committee
6th Meeting - Minutes
11:00 – 15.00 pm Tuesday 17 February 2015

Attendees:
Prof John Horvath (Chair) Commonwealth Department of Health
Dr Tammy Kimpton Australian Indigenous Doctors’ Association Limited
Dr Stephen Parnis Australian Medical Association
Dr Danika Thiemt Australian Medical Association Council of Doctors-in-Training
Prof Kate Leslie Australian Medical Council (proxy for Prof Robin Mortimer)
Mr Brian Fernandes Australian Medical Students Association
Dr Peter Satterthwaite Central Adelaide Local Health Network (via teleconference)
Dr Jagdishwar Singh Confederation of Postgraduate Medical Education Councils
( proxy for A/Prof Terry Brown)
Emeritus Prof Louis Landau Department of Health WA
Mr Dan Jefferson Department of Health Victoria
Prof Peter Procopis Medical Board of Australia
Prof Peter Smith Medical Deans Australia and New Zealand
Dr Tim Kelly National Rural Health Alliance
Ms Robyn Burley New South Wales Ministry of Health
Prof Frank Jones Royal Australian College of General Practitioners
Dr Draginja Kasap Royal Australasian College of Medical Administrators
Ms Penny Shakespeare Commonwealth Department of Health

Apologies:
Prof Robin Mortimer Australian Medical Council
Mr Gavin O’Meara Australian Private Hospitals Association
A/Prof Michael Hollands Committee of Presidents of Medical Colleges
A/Prof Terry Brown Confederation of Postgraduate Medical Education Councils
Prof Richard Doherty Royal Australasian College of Physicians
Dr Ian Kamerman Rural Doctors Association of Australia

Secretariat:
Ms Tarja Saastamoinen Commonwealth Department of Health
Ms Maureen McCarty Commonwealth Department of Health
Ms Marjo Roshier-Taks Commonwealth Department of Health
Ms Kate Fraser Commonwealth Department of Health
Item 1.1: Welcome and apologies

Discussion points:

- The Chair welcomed committee members, noted apologies and membership changes.
- A new high level structure for the Department has been implemented.
- The new National Programme Delivery Group is led by Ms Wendy Southern and comprises Indigenous and Rural Health, Population Health and Workforce Divisions.

Action items: Nil

Item 1.2: Minutes and business arising from previous meeting

Discussion points:

- Minutes from the previous meeting were endorsed by the committee, with the correction of the organisation name from Australian to Australasian College of Medical Administrators.
- Actions arising from 3 December 2014 meeting were summarised.

Action items: Nil

Item 2.1: Member Guidelines including revised terms of reference for NMTAN

Discussion points:

- The management of the development of an annual report on medical education and training is anticipated to transfer to the NMTAN; the Department is currently working on the repeal of the Medical Training Review Panel (MTRP).
- The MTRP Data Sub-committee will continue to provide advice on the report on medical education and training and on other data projects.
- Where appropriate, specific medical colleges will be invited to NMTAN meetings to participate in relevant policy related discussions.
- The NMTAN is now covered under the guidelines of the Remuneration Tribunal Determination 014/03. The Tribunal has recently reduced the sitting fees for a range of committees, including the NMTAN.
- In line with the requirements of the Department, NMTAN members are requested to travel economy class, however for long distance travel (e.g. from Western Australia), this may be negotiable.
- Members agreed to a number of wording changes under 4.Composition of the committee:
  - 3 x representatives of State and Territory Governments nominated by HWPC.
  - 5 x Medical educators nominated by CPMC.
  - The AMA Council of Doctors in Training to be moved from medical student associations to professional medical associations sector.
Action items:

- Secretariat to update the NMTAN Member Guidelines.
- Secretariat to circulate Terms of Reference for MTRP Data Sub-committee.

**Item 3.1: Changing clinical work with projected changing burden of chronic disease**

Discussion points:

- As Dr Annette Pantle and Dr Liz Marles are no longer members of the NMTAN, only Dr Tammy Kimpton remains on the sub-committee.
- The Chair asked for nominations for the sub-committee.
- Nominations were received at the meeting from:
  - Prof Frank Jones
  - Dr Draginja Kasap
  - Ms Robyn Burley
- Mr Dan Jefferson offered to provide information on the current work in Victoria on chronic disease activity in the acute care setting.
- Members suggested focusing broadly on chronic disease, rather than diabetes specifically.
- It was noted that the Department is currently undertaking a number of chronic disease management/prevention activities that can further inform the scope of the NMTAN project.
- The timeframe of the workforce projections would need to be at least 15 years.

Action items:

- Secretariat to gather information on chronic disease related work undertaken within the Department.
- Sub-committee meeting to be held and chair to be nominated by the end of March.
- Sub-committee work plan to be presented at the next NMTAN meeting (19 May 2015).

**Item 4.1: Update on the psychiatry modelling project**

Discussion points:

- Updated supply and demand analysis shows a shortage of psychiatrists, although the gap between supply and demand is less than previously reported in HW2025 Volume 3.
- A number of issues have been encountered during analysis:
  - As a result of the new training program there will be variable numbers of trainees in each stage of training; therefore transition rates will not be able to be determined until 2017.
  - The data provided by the Royal Australian New Zealand College of Psychiatrists (RANZCP) need further clarification; for example, on the structure of the advanced training program.
The current demand projection is based on Medicare Benefits Scheme (MBS) and inpatient data, but outpatient data is not fed into the modelling.

There are a significant number of people obtaining fellowship who do not take up consultant positions.

Suggestions from NMTAN members:
- Include geographical data analysis to highlight the gap in training in regional areas.
- Need to identify gaps that slow efficiency of the training program.
- Need to review the Specialist Training Programme (STP) funding allocation and prioritise areas of shortage.

The Chair requested nominations for a member of the committee to attend discussions with the RANZCP on the training program and data provided by the RANZCP.

Action items:
- The Secretariat will identify a NMTAN member to assist Maureen McCarty with discussions with the RANZCP.
- Dr Danika Thiemt to provide contact details of a doctor in training to provide advice to the sub-committee.
- Sub-committee to request the RANZCP to nominate a representative to assist with forming policy options for the project and invite them to the next NMTAN meeting.

Item 4.2: Project scope and methodology for general practice and anaesthetics

GP discussion points:
- The data analysis team will utilise GP allocation data now transferred to the Department from GPET.
- Data collection and analysis needs to be carried out on the current trainee numbers, migration patterns and the amount of time GPs spend training.

Action items:
- Maureen McCarty to meet with the RACGP and ACCRM to review all data available to inform the modelling.

Anaesthetics discussion points:
- The methodology for anaesthetics is similar to that of general practice.
- HW2015 Volume 3 suggested that there would be a future oversupply of anaesthetists. It is anticipated that this modelling project will confirm an oversupply.

Action items:
- The Capacity Building Sub-committee to meet with ANZCA to discuss the training program and the data requirements for the training plan.
• Sub-committee to approach the State and Territory health departments to obtain data on STP positions, to feed into capacity modelling.

**Item 5.1: Employment patterns and intentions of prevocational doctors - update**

Discussion points:

• No further meetings have been held by the sub-committee.
• The importance of access to workforce data on the number and distribution of specialists to inform career choices of junior doctors and medical students was highlighted.

Action items: Nil

**Item 5.2: Discussion and feedback on report: A snapshot of the existing pre-vocational doctor workforce in Australia – Hospital non-specialist and specialist-in-training.**

Discussion points:

• Members agreed that it is important to make this information available to students, graduates and doctors in training, however more context/information is needed to accompany the data to ensure appropriate interpretation.
• It was acknowledged that for some of the specialities modelled in oversupply, geographical distribution is an issue.
• The need for some specialties may not match the funding to be able to employ the required numbers.
• The report is for information to the NMTAN only at this stage, and not for further distribution.

Action items:

• Secretariat to develop fact sheets on individual specialities, based on data in the Pre-vocational report combined with available information on geographical distribution, and other relevant information.
• Fact sheets to be considered by the NMTAN for wider distribution.

**Item 6.1: Review of Medical Intern Training**

Discussion points:

• A discussion paper will be available and circulated shortly with written submissions accepted until 10 April.
• The consultation process will occur in May and June, including the release of an options paper.
• The final report will be drafted by August to be tabled at the September AHMAC meeting, before being presented to the COAG Health Council.
Action items:

- Secretariat to circulate discussion paper to committee members once received from reviewers.
- NMTAN members to participate in the consultation process where appropriate.

**Item 7.1: Next steps and key messages**

Discussion points:

- Chair summarised outcomes from the meeting

Action items: Nil

**Item 7.2: NMTAN meeting dates for 2015**

Discussion points:

- The next NMTAN Executive Committee meeting is scheduled for 19 May 2015 at the Parkroyal Hotel, Melbourne Airport, from 11am to 3pm AEST.

- Meeting dates for the remainder of the year are 22 September 2015 and 1 December 2015. Meeting venues to be confirmed.

Action items:

- Secretariat to send invites, confirm attendance and provide meeting papers to NMTAN Executive Committee members for the 19 May 2015 meeting.
Stakeholder Advisory Committee (SAC) Meeting Minutes
Meeting 1, 2015
Date: Tuesday 31 March 2015
Time: 2.00pm – 4.00pm AEDT
Location: Video conference
Chair: Mr James Downie

Members in attendance
- James Downie (IHPA)
- Prema Thavaneswaran – Proxy (MTAA)
- Judy Searle – Proxy (Medical Deans Aust. & New Zealand)
- Troy Delbridge – Proxy (Private Healthcare Australia)
- Patrick Tobin – Proxy (Catholic Healthcare Australia)
- Brian Hanning (Australian Health Services Alliance)
- Dr Simon Towler (Consumer Health Forum)
- Patrick Tobin – Proxy (Catholic Healthcare Australia)
- Brian Hanning (Australian Health Services Alliance)
- Dr Simon Towler (Consumer Health Forum)
- Mr Martin Mullane (AMA)

Attendees
- Chereta Daylight (IHPA)
- Adam Bannon (IHPA)
- Alice Jetson (IHPA)
- Juliet Pisani-Forde (IHPA)
- Jo Root (Consumer Health Forum)
- Louise O’Donnell (Mental Health Australia)

Apologies
- Dr John O’Donnell (Catholic Healthcare Australia)
- Prof Peter Smith (Medical Deans)
- Ms Tina Karanastasis (FECCA)
- Mr Frank Quinlan (Mental Health Australia)
- Mr Andrew McAuliffe (AHHA)
- Ms Angela Magarry (CPMC)
- Tony Sherbon (IHPA)
## Agenda Item 1: Welcome and Apologies

<table>
<thead>
<tr>
<th>Number</th>
<th>Recommendations</th>
<th>Decisions</th>
<th>Actions</th>
</tr>
</thead>
</table>
| 1.     | That members NOTE apologies received from SAC members for this meeting. | The following SAC member apologies were noted:  
- Dr John O'Donnell (Catholic Healthcare Australia)  
- Prof Peter Smith (Medical Deans)  
- Ms Tina Karanastasis (FECCA)  
- Mr Frank Quinlan (MHA)  
- Mr Andrew McAuliffe (AHHA)  
- Ms Angela Magarry (CPMC)  
- Dr Tony Sherbon (IHPA) | Nil |

## Agenda Item 2: Declaration of Conflict of Interest

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<thead>
<tr>
<th>Number</th>
<th>Recommendations</th>
<th>Decisions</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>That members declare any perceived or actual conflicts of interest with regard to the meeting agenda.</td>
<td>Nil conflicts declared</td>
<td>Nil</td>
</tr>
</tbody>
</table>

## Agenda Item 3: Minutes and Actions

### Agenda Item 3:1: Minutes and Actions of the 18 November 2014 SAC meeting

<table>
<thead>
<tr>
<th>Number</th>
<th>Recommendations</th>
<th>Decisions</th>
<th>Actions</th>
</tr>
</thead>
</table>
| 1.     | That the minutes for SAC meeting on the 18 November 2014 are ENDORSED as correct. | ENDORSED  
IHPA noted that the Round 17 NHCDC Private Sector Report went to the Pricing Authority in February 2015 and is | Chair to sign copy of the endorsed minutes and circulate to members out-of-session. |
IHPA noted that the Round 17 NHCDC Public Sector report is being presented to the Pricing Authority in April with the intention to publish the report in June 2015.

It was further noted that the NHCDC Round 18 is currently underway with the Public Sector in the collection phase and IHPA anticipates earlier publication than Round 17. The Round 18 NHCDC Private Sector is currently in a data acquisition phase. IHPA noted that NHCDC Round 18 will be published in AR-DRG version 7.

### Agenda Item 3: Minutes and Actions of the 9 February 2015 CAC meeting

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</tbody>
</table>

1. **NOTE** that the draft minutes of the 9 February 2015 Clinical Advisory Committee (CAC) Meeting.

   **NOTED**

2. **NOTE** that whilst the draft minutes of the 9 February 2015 meeting have been circulated to the CAC, the minutes remain draft and are provided to the Stakeholder Advisory Committee for information purposes only.

   **NOTED**

   Nil
### Agenda Item 4.0: National Efficient Price Determination 2015-16

<table>
<thead>
<tr>
<th>Number</th>
<th>Recommendations</th>
<th>Decisions</th>
<th>Actions</th>
</tr>
</thead>
</table>
| 1.     | NOTE that the Pricing Authority approved the *National Efficient Price Determination 2015-16* (NEP15 Determination – Attachment A) at its 19 February 2015 meeting. | NOTED IHPA noted that similar to previous year’s most jurisdictions with the exception of Tas and Vic have implemented the IHPA NWAU model. IHPA identified the following highlights from the NEP Determination 2015-16:  
- Bundled Pricing for home delivered services including TPN/HEN/HDD/HDV  
- Multidisciplinary clinic adjustment where more than three clinicians from different specialities are providing a service – based on the 2013/14 Non-admitted and Subacute Costing Study undertaken by EY.  
- Commenced pricing the patient end of a non-admitted telehealth service. | IHPA to update indexation working paper, and provide to SAC members. |
| 2.     | NOTE that the NEP15 Determination was published on IHPA’s website on 25 February 2015. | NOTED | Nil |

### Agenda Item 5.0: National Efficient Cost Determination 2015-16

<table>
<thead>
<tr>
<th>Number</th>
<th>Recommendations</th>
<th>Decisions</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>NOTE that the Pricing Authority approved</td>
<td>NOTED</td>
<td>Nil</td>
</tr>
</tbody>
</table>
IHPA noted that 16 hospitals, most of which hosted large emergency departments, that were previously block funded were moved into the ABF model in 2015-16.

IHPA noted that it also collapsed the regional classification which has resulted in a more stable model.

IHPA indicated that there is likely to be minimal changes in the NEC model in 2016-17.

2. **NOTE** that the NEC15 Determination was published on IHPA’s website on 25 February 2015

---

### Agenda Item 6.0: IHPA Work Program 2015-16

<table>
<thead>
<tr>
<th>User</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>IHPA noted that under existing legislation it is required to produce a Work Program annually.</td>
<td>Nil</td>
</tr>
<tr>
<td>1.</td>
<td><strong>DISCUSS</strong> the draft IHPA Work Program 2015-16 (draft Work Program) setting out the work program from 1 July 2015 to 30 June 2016 (Attachment A)</td>
<td>NOTED</td>
<td>Nil</td>
</tr>
<tr>
<td>2.</td>
<td>that the draft Work Program was released to health ministers for comment in late-February 2015.</td>
<td>NOTED</td>
<td>Nil</td>
</tr>
<tr>
<td></td>
<td>that IHPA will seek public comment on the draft Work Program in late-April 2015 prior to final endorsement</td>
<td>NOTED</td>
<td>SAC member organisations to provide comments on the IHPA Work Program either out of session or during the public meeting</td>
</tr>
</tbody>
</table>
### Agenda Item 7.0: Development of the Australian Mental Health Care Classification Version 1.0

<table>
<thead>
<tr>
<th>Number</th>
<th>Recommendations</th>
<th>Decisions</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>NOTE the progress to date of the Australian Mental Health Care Classification Development Project.</td>
<td>NOTED</td>
<td>Nil</td>
</tr>
<tr>
<td>2.</td>
<td>NOTE that a public consultation paper was released on 5 January 2015 and closed on 13 February 2015.</td>
<td>NOTED</td>
<td>Nil</td>
</tr>
<tr>
<td>3.</td>
<td>NOTE 29 responses were received, listed at Attachment A.</td>
<td>NOTED</td>
<td>Nil</td>
</tr>
<tr>
<td>4.</td>
<td>NOTE the key issues identified and the responses from IHPA, summary at Attachment B.</td>
<td>NOTED</td>
<td>Nil</td>
</tr>
<tr>
<td>5.</td>
<td>NOTE the next steps and future consultation processes.</td>
<td>NOTED</td>
<td>Nil</td>
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</table>

### Agenda Item 8.0: ABF Evaluation – Progress Update

<table>
<thead>
<tr>
<th>Number</th>
<th>Recommendations</th>
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<th>Actions</th>
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<tbody>
<tr>
<td>1.</td>
<td>NOTE the progress of the Evaluating the impact of the implementation of national activity based funding (ABF) for public hospital services (the ABF Evaluation) project.</td>
<td>NOTED</td>
<td>Nil</td>
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</tbody>
</table>
### Agenda Item 9.0: IHPA ABF Conference

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<tr>
<th>Number</th>
<th>Recommendations</th>
<th>Decisions</th>
<th>Actions</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>NOTE the Activity Based Funding Conference 2015 program at Attachment A.</td>
<td>NOTED</td>
<td>Nil</td>
</tr>
<tr>
<td>2.</td>
<td>NOTE that the conference has secured Prof. Keith Willett and Dr Sule Calikoglu as international speakers.</td>
<td>NOTED</td>
<td>Nil</td>
</tr>
<tr>
<td>3.</td>
<td>NOTE that abstract submissions have been extended until Wednesday 1 April 2015</td>
<td>NOTED</td>
<td>Nil</td>
</tr>
<tr>
<td>4.</td>
<td>NOTE that registrations are open on the conference website</td>
<td>NOTED</td>
<td>Nil</td>
</tr>
<tr>
<td>5.</td>
<td>NOTE that IHPA can offer members resources to promote the event to their staff and stakeholders</td>
<td>NOTED</td>
<td>Nil</td>
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</table>

### Agenda Item 10.0: SAC Meeting Schedule 2015

<table>
<thead>
<tr>
<th>Number</th>
<th>Recommendations</th>
<th>Decisions</th>
<th>Actions</th>
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<tbody>
<tr>
<td>1.</td>
<td>NOTE the 2015 SAC meeting schedule</td>
<td>NOTED</td>
<td>Nil</td>
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</table>

Evaluation is likely to be put out for tender in late 2015.
SAC Meeting minutes 31 March 2015

<table>
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<td></td>
<td></td>
<td></td>
<td>follows:</td>
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<td></td>
<td></td>
<td></td>
<td>• Wednesday 3 June 2015</td>
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<td></td>
<td></td>
<td></td>
<td>• Wednesday 5 August 2015</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Wednesday 7 October 2015</td>
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</table>

Meeting closed: 3:00pm AEDT

Next meeting: Wednesday 3 June 2015 2:00pm – 4:00pm AEST (video conference)

Minutes approved by Chair (Mr James Downie) ___________________________ Date ___________________________
Item 6.2 Strategic Plan 2015-17 ‘Towards 2017’

At the 6 November 2014 CPMC meeting members discussed the strategic plan supported by a background paper which stimulated discussion. Further discussion occurred briefly at the February 2015 meeting which agreed on developing terms of reference for the Chair (at item 5.1).

This item provides members with a summary of the November agreed points and attached draft business plan for the period 2015-17 for approval.

Background – Summary of November meeting comments

All Colleges agreed that CPMC:

- Needs to collaborate on issues and continue to work in the policy space and identify the top 3 to 5 areas to focus on. This will enable the best use of resources as well as enable traction;
- Had access to a very influential group of decision-makers through the Profession Observers and with political connections into the Ministerial offices where required;
- Functions to enable discussion between the groups which levels the playing field to exchange views and information and this allow Colleges to get across the broader health sector issues; and
- Provides value for money as it is the unifying non biased clinical voice in health policy in Australia.

With the above in mind, all agreed that to be an effective alternative voice to the AMA it was important for CPMC to:

- remain focussed on a vision for Australia’s health and to not divide on smaller issues or deal with contentious issues;
- more closely engage with CMC New Zealand;
- enable greater cohesion between the CEOs group; and,
- identify areas of common ground with the AMA.

Key threats to CPMC included the Academy of Health and Medical Sciences with the potential for medical bodies to look to it for expert opinion rather than CPMC; universities treading on the training space; and the tone used by NMTAN and workforce officials regarding what they consider to be acceptable minimum clinical experience and therefore reduced training exposure to save on costs of training.

In the next three years it was agreed that strong representation on committees was vital to influence systems for what is best for the Australian community. Although CPMC’s core business was educating specialists it should also advocate for areas of practice that involve Fellows thereby having an interest in both the public and private sectors.
Strategic business activities in 2015-17

In 2015-17 CPMC will continue to convene the quarterly forums comprising health sector leaders and organisations. It will increase its influence by the Chair/Executive/members attending other sector committees and hold special forums on sector issues of interest to members which will also facilitate inter-collegiate discussion. To this end some of the emerging issues to focus on include leading the discussion on the reform to Medicare; regulation (revalidation); access to training and the training process with a focus on supervision; genomic and genetics in the future; the PCEHR and quality and safety.

Some of the issues raised by individual College Presidents since February have included the need for CPMC to become the strong voice of specialist medicine in Australia where there is merit in CPMC learning from sister Colleges overseas such as Canada.

In addressing the challenges of developing Australia’s future health workforce, it is critical for CPMC to take the lead in advising on issues of workforce needs versus distribution, and also on models of training and the cost of provision. It is also vital to participate in any discussions concerning changes in professional scopes of practice because of the connection to models of care and flexible workforce development in the national policy space.

Workforce challenges include the rising number of medical graduates by 2016 and the costs of training them by universities and hospitals. While it may result in only the eminent graduates gaining access to training schemes where there are delays for certain specialties of up to five years, this may in fact bolster the general medical workforce at PGY2-5 years in the system and hence improve quality.

Key to determining the business plan is setting the strategic goals which reflect attention to what the public wants from the specialist medical system which is the best, safest, most cost-effective and quality health system for all Australians.

The following Objectives are aligned with the previous Strategic Plan and are relevant to maintain for 2015-17:

Objective 1: CPMC will provide a Morning Forum for discussion with the membership on issues and with external organisations who wish to liaise with the Colleges.

Objective 2: CPMC will consolidate its influence by meeting with sector and political leaders and through representation at other meetings.

Objective 3: CPMC will respond to sector issues and members’ requests according to CPMC’s goals and resources.

Each of these objectives contains a series of activities for focus.

Recommendation

Members note the Strategic Business Plan for CPMC 2015-17 and endorse it.
## COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES STRATEGIC GOALS TOWARDS 2017

### PURPOSE

The Committee of Presidents of Medical Colleges will be the recognised and authoritative voice for the specialist Medical Colleges of Australia, acting to promote the highest quality of medical care and supporting the provision of well-trained and safe medical workforce serving the best interests of the Australian community by coordinated and collective advocacy and collaboration.

### VISION

- **Operate with high standards of professionalism**
- **Act with integrity and be guided by ethical principles**
- **Ensure collegiality through collaboration**

### STRATEGIC GOALS

- **CPMC will be an effective collective voice for the Medical Colleges**
- **CPMC will add value to the individual Member Colleges’ work**
- **CPMC will promote well trained and safe medical workforce serving the interests of the Australian community.**
In 2015-17 CPMC will work towards achieving the Strategic Goals Towards 2017 according to the following objectives and actions. This plan builds upon the 2011-13 CPM Strategic Plan, and in particular that CPMC was a forum for dissemination of information and exchange of ideas among presidents and colleges, and between colleges and jurisdictional representatives.

**Objective 1:** CPMC will provide a Morning Forum for discussion with the membership on issues and with external organisations who wish to liaise with the Colleges.

<table>
<thead>
<tr>
<th>Actions</th>
<th>Performance Measures</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Maintain standing invitation to key health sector leaders and organisations to participate at CPMC meetings</td>
<td>Invitees will include: Secretary Department of Health Representatives of: • Australian Medical Council • National Health &amp; Medical Research Council • Medical Board of Australia • Australian Indigenous Doctors’ Association • Australian Commission on Safety &amp; Quality in Healthcare • Australian Medical Association • Medical Deans of Australia and New Zealand An may include: • Other representatives • Private Health organisations • Public Health organisations</td>
<td>(e.g: addition to forum for private health etc)</td>
</tr>
<tr>
<td>1.2 CPMC will organise forums on sector issues of interest to members and intercollege discussions</td>
<td>Forums and discussion sessions organised as required (up to 2 per yr) Possible topics include: • Workforce issues and innovative models of care. • Regulatory policy and accreditation including Medicare and PBS</td>
<td></td>
</tr>
<tr>
<td>1.3 Opportunity for members to share information and network with ‘Profession Observers’.</td>
<td>Sufficient time for members to raise topics, develop papers and ask questions to be scheduled for each meeting.</td>
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</tbody>
</table>
**Objective 2:** CPMC will consolidate its influence by meeting with sector and political leaders and through representation at other meetings.

<table>
<thead>
<tr>
<th>Actions</th>
<th>Performance Measures</th>
<th>Action taken</th>
</tr>
</thead>
</table>
| 2.1 Advocate on CPMC issues to political leaders | • Minister for Health to attend one CPMC meeting per annum  
• Chair & CEO to attend Ministerial Roundtable events  
• Chair / Executive to meet with Ministers once every quarter as part of a government relations day with meetings to be including:  
  • Minister Health  
  • Opposition Health spokesperson  
  • Education Minister  
  • Opposition Education/VET  
  • Foreign Minister  
  • Others as required |  |
| 2.2 Develop and maintain strong relationships with key sector agencies in medicine, and develop new contacts | • Participate in the regular Secretary’s meetings  
• Conducts a strategic planning forum with key senior officials to steer workforce and other medicine issues  
• Departments of Health in the areas of strategic policy, workforce, rural and population health  
• Colleges CEOS forum & communications |  |
| 2.3 Chair or delegate to attend key health sector meetings including  
  • NMTANs  
  • DHS Stakeholder Reference Group  
  • Medicare  
  • Safety and Quality Forums | • Attend all meetings as required and report to the quarterly CPMC meetings. |  |
**Objective 3:** CPMC will respond to sector issues and members’ requests according to CPMC’s goals and resources.

<table>
<thead>
<tr>
<th>Actions</th>
<th>Performance Measures</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 CPMC Secretariat to build support from sector College</td>
<td>• CPMC has access to member Colleges for support to cover event logistics and coordination similar to CMC, NZ.</td>
<td></td>
</tr>
</tbody>
</table>
| 3.2 Responds proactively to issues                                     | • CPMC conducts annual planning forum which determines principles of response to enable policy development  
• Responds within 7 days to internal requests and 10 days to external requests  
• CPMC develops quality submissions on issues of commonality delivered in a timely manner  
• CPMC participates in coordination of submissions on issues of commonality but where lead may be from member  
• Information provided to stakeholders via the communiqué after each quarterly meeting.  
• Twitter monitoring to enable topics of interest to be sent to members |              |
| 3.3 Advocate for College issues within the sector                      | • Newsletters  
• College publications  
• CPMC website (load up some data)                                         |              |
| 3.4 Establish inter-collegiate knowledge through dialogue at CPMC meetings or in separate forums | • Maintenance of strategic issues session at CPMC meetings for Members  
• Establish the specialist trainee inter-collegiate forum  
• Maintain the CPMC strategic liaison lunch |              |
| 3.5 Research and forward projects                                      | • Complete the Indigenous cultural competency curriculum project  
• Compete for special project work to build capabilities |              |
RACGP position statement on homeopathy

Position

[The RACGP/Committee of Presidents of Medical Colleges or CPMC] supports the use of evidence-based medicine, in which current research information is used as the basis for clinical decision-making.

In light of strong evidence to confirm that homeopathy has no effect beyond that of placebo as a treatment for various clinical conditions, the position of [the RACGP/CPMC] is:

1. Medical practitioners should not practice homeopathy, refer patients to homeopathic practitioners, or recommend homeopathic products to their patients.
2. Pharmacists should not sell, recommend, or support the use of homeopathic products.
3. Homeopathic alternatives should not be used in place of conventional immunisation.
4. Private health insurers should not supply rebates for or otherwise support homeopathic services or products.

Background

The contention that homeopathy is an effective treatment is not supported by evidence from systematic literature reviews. The National Health and Medical Research Council (NHMRC) analysed the scientific evidence for the effectiveness of homeopathy in treating a range of clinical conditions and released a position statement\(^1\) in March 2015. The NHMRC’s review concluded ‘homeopathy does not produce health benefits over and above that of placebo, or equivalent to that of another treatment.\(^2\) Crucially, the report states that there are “no health conditions for which there is reliable evidence that homeopathy is effective” as a treatment.

While not covered in the NHMRC’s review, it is also the case that homeopathic alternatives to conventional vaccination do not prevent communicable diseases or increase protective antibodies to disease. The National Centre for Immunisation Research and Surveillance has advised that there are no studies of sufficient quality to demonstrate the safety or effectiveness of ‘homeopathic vaccines’ for protection against disease.\(^3\) Indeed, there is no plausible biological mechanism of action by which these products could prevent infection.\(^4\)

Harms associated with homeopathy

Homeopathic products are sometimes considered harmless as they are generally administered at a high dilution. Some may not even contain a single molecule of the original source material. However, there are a number of risks associated with the use of homeopathy.

Delaying or avoiding conventional medical care

When the use of homeopathy causes a person to delay or avoid consultation with a registered medical practitioner or reject conventional medical approaches, serious and sometimes fatal consequences can occur. As evidenced by recent Australian court findings, spurious claims made by homeopathic practitioners\(^5\) and retailers\(^6\) can mislead individuals about the effectiveness of conventional medicine.

When homeopathic vaccines are used as an alternative to conventional immunisation, both the individual and the community are left exposed to preventable diseases.
Problems associated with unregulated products

Although homeopathic products manufactured in Australia are regulated as medicines under the *Therapeutic Goods Act 1989*, products sold on international websites may not meet Australian quality and safety standards. These products may be of particular concern when materials from problematic sources are employed in the preparation (e.g., pathogenic organs or tissues; causative agents such as bacteria, fungi, parasites, ova, yeast, and virus particles; disease products; excretions or secretions; heavy metals and toxins such as aconitum, kerosene and thallium). Impurities of source material and contamination associated with poor manufacturing processes also present threats to the quality and safety of these products.7

Direct adverse effects

Various direct harms associated with the use of homeopathic products have been noted in the literature, including allergic reaction, drug interactions, and complications related to the ingestion of toxic substances.8

The importance of patient-centred practice

[The RACGP/CPMC] supports the concept of patient-centred practice, in which the values, preferences, and personal healthcare philosophy of the patient are respected and individuals play an important role in their own healthcare. An estimated six per cent of Australians use homeopathy over the course of a year.9 It is important that these patients feel comfortable in discussing their use of complementary and alternative medicines with all members of their treatment team.

It is good practice for medical practitioners to initiate conversations with patients about their use of or intention to use homeopathy, and assist patients to think critically about the efficacy and safety of homeopathy so that they may make informed healthcare decisions.

Private health insurance and homeopathy

Many private health insurers provide ancillary (extras) cover that subsidises homeopathic treatment, and the individual's costs in taking out this cover are subsidised under the Australian Government's private health insurance rebate. [The RACGP/CPMC] is concerned that health insurance premiums continue to rise as funds disburse significant sums for the use of homeopathy and other natural therapies lacking rigorous evidentiary support. In the 2013-14 financial year, health insurers paid out $164 million in benefits for natural therapies, up by almost 60 per cent from 2010-11.10

[The RACGP/CPMC] also notes that offering subsidies for the use of homeopathy sends a confusing message to consumers. Listing homeopathic treatments alongside evidence-based modalities in a list of member benefits lends legitimacy to a practice that is not supported by scientific data.

References

5. Coronial inquest into the death of Penelope Dingle. State Coroner of Western Australia, 2010.
Item 6.4 Discussion with Chair, NMTANs Professor John Horvarth

PROFESSOR JOHN S HORVATH AO, MB, BS (SYD), FRACP

Professor John Horvath was the Australian Government Chief Medical Officer from 2003 to 2009. He is currently continuing to advise the Department of Health and the School of Medicine, University of Sydney, and holds the position of Honorary Professor of Medicine.

Professor Horvath is a Fellow of the Royal Australasian College of Physicians and is a distinguished practitioner, researcher and teacher. Professor Horvath sits on the Board of the Garvan Research Foundation, the Centenary Institute of Medical Research and Health Workforce Australia. He is a member of the Advisory Board to the World Health Organisation Influenza Collaborating Centre, a member of the Advisory Council to the Australian Organ and Tissue Donation Agency and a member of the Finance and Administration Committee of the School of Medicine at the University of Sydney.

Professor Horvath was previously Clinical Professor of Medicine at University of Sydney. He is also known as a leader in a range of medical training and workforce organisations. He is also a former President of the Australian Medical Council and the NSW Medical Board.

Professor Horvarth has been invited to speak to the group about the National Medical Training Advisory Network and will have accompanying him Ms Tarja Saastamoinen, from the Department in attendance.
<table>
<thead>
<tr>
<th>EVALUATION CATEGORY</th>
<th>CIRCLE ONE CATEGORY</th>
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<tbody>
<tr>
<td>1 The materials provided were</td>
<td>Too late for review ……Timely for review</td>
</tr>
<tr>
<td></td>
<td>1 2 3 4 5</td>
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<tr>
<td>2 The materials provided were</td>
<td>Confusing …………………Informative</td>
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<tr>
<td>3 The broad focus of the meeting was</td>
<td>Operational………. Strategic</td>
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<td>1 2 3 4 5</td>
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<tr>
<td>4 The meeting structure allowed</td>
<td>Limited participation …Full participation</td>
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<td>1 2 3 4 5</td>
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<tr>
<td>5 The discussion was</td>
<td>Unfocused………. Focused</td>
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<td></td>
<td>1 2 3 4 5</td>
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<tr>
<td>6 The issues covered were</td>
<td>Not very important …… Very important</td>
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<td>1 2 3 4 5</td>
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<tr>
<td>7 The time given to all agenda items was</td>
<td>Inadequate………. Adequate</td>
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<td>1 2 3 4 5</td>
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<tr>
<td>8 Inclusion of CEOs in the post Morning Forum was</td>
<td>Operational………. Strategic</td>
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<td>1 2 3 4 5</td>
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</table>

Reflecting on the above:

9 Were the event logistics satisfactory?

10 What was most helpful for you at this board meeting?

11 What was least helpful for you?

12 What would you suggest for next meeting?

THANK YOU