# Agenda

**111th Committee of Presidents of Medical Colleges**

**Thursday 6th August 2015**

**Auditorium, Australia and New Zealand College of Anaesthetists**

**630 St Kilda Road, Melbourne**

<table>
<thead>
<tr>
<th>Item #</th>
<th>Time</th>
<th>Agenda Item</th>
<th>Presented by</th>
<th>Paper</th>
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<tbody>
<tr>
<td>08:45</td>
<td>08:45</td>
<td>Tea – coffee on arrival</td>
<td>ANZCA</td>
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<tr>
<td>1</td>
<td>9.00am</td>
<td><strong>Meeting formalities</strong></td>
<td>Chair</td>
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<tr>
<td>1.1</td>
<td>9:00am</td>
<td>Attendance and Apologies</td>
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<td>1.2</td>
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<td>Conflicts of Interest and Confidentiality</td>
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<td>Other issues- welcome Professor</td>
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<td>Christopher Baker, ACD President</td>
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<td>2</td>
<td>9:00am</td>
<td><strong>Forum Reports</strong></td>
<td>Chair</td>
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<tr>
<td>2.1</td>
<td>9:00am</td>
<td>Committee of Presidents of Medical Colleges</td>
<td>Prof. M Hollands</td>
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<td>2.2</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>2.3</td>
<td>9:20am</td>
<td>Commonwealth Chief Medical Officer</td>
<td>Prof. C. Baggoley</td>
<td>✓</td>
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<td>2.4</td>
<td>9:30am</td>
<td>National Health &amp; Medical Research Council</td>
<td>Prof. Anne Kelso</td>
<td>✓</td>
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<td>2.5</td>
<td>9:40am</td>
<td>Medical Board of Australia</td>
<td>Dr J. Flynn</td>
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<td>CEO M. Fletcher</td>
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<td>2.6</td>
<td>10am</td>
<td>Australian Indigenous Doctors’ Association</td>
<td>Dr Kali Hayward</td>
<td>✓</td>
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<td>2.7</td>
<td>10:10am</td>
<td>Australian Commission on Safety &amp; Quality in Healthcare</td>
<td>Prof. Villis Marshall</td>
<td>✓</td>
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<td>2.8</td>
<td>10:20am</td>
<td>The Australian Medical Association</td>
<td>Dr Brian Owler</td>
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<td>CEO Anne Trimmer</td>
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<td>2.9</td>
<td>10:30am</td>
<td>Medical Deans of Australia &amp; New Zealand</td>
<td>Prof Glasgow</td>
<td>✓</td>
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<td>2.10</td>
<td>10:40am</td>
<td>Confederation of Postgraduate Medical Education Councils</td>
<td>Prof Terry Brown</td>
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**11.00 – 11.45am - Morning Tea**
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<tr>
<td>3</td>
<td></td>
<td>Minutes for Confirmation</td>
<td>Chair</td>
<td>✓</td>
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<tr>
<td>3.1</td>
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<td>Minutes of previous meeting held 14 May 2015</td>
<td>Chair</td>
<td>✓</td>
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<tr>
<td>3.2</td>
<td></td>
<td>Business Arising from Minutes</td>
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<td>3.3</td>
<td></td>
<td>Chair’s Report</td>
<td>Chair</td>
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<td>3.4</td>
<td></td>
<td>Chief Executive Officer’s Report</td>
<td>CEO</td>
<td>✓</td>
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<td>3.5</td>
<td></td>
<td>Financial Statements and report</td>
<td>CEO</td>
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<td>3.6</td>
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<td>Changes in Directors</td>
<td>For noting</td>
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<td>3.7</td>
<td></td>
<td>Other Governance Matters</td>
<td>Chair</td>
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<td>4</td>
<td></td>
<td>Sub-Committee Reports</td>
<td>L.Gruner</td>
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<td>4.1</td>
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<td>Education subcommittee (in abeyance)</td>
<td>M.Hollands</td>
<td>✓</td>
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<td>4.2</td>
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<td>Indigenous Health subcommittee</td>
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<td>Representatives reports for Noting</td>
<td>Chair</td>
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<td>5.1</td>
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<td>National Medical Training Advisory Network</td>
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<td>5.2</td>
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<td>IHPA Stakeholder Advisory Committee</td>
<td>note</td>
<td>✓</td>
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<td>6</td>
<td></td>
<td>Strategy</td>
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<td>6.1</td>
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<td>Update on College systems to address bullying and sexual harassment</td>
<td>Chair</td>
<td>✓</td>
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<td>6.2</td>
<td></td>
<td>Revalidation – regulation policy</td>
<td>Chair</td>
<td>✓</td>
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<td>6.3</td>
<td></td>
<td>Government Relations Update</td>
<td>Chair</td>
<td>✓</td>
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<tr>
<td>6.4</td>
<td></td>
<td>Credentialing and extended scope of practice</td>
<td>Prof D. Watters</td>
<td>✓</td>
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<tr>
<td>6.5</td>
<td>1pm</td>
<td>Briefing from Dr Penny Browne, Senior Medical Officer Avant Mutual Group Limited (presentation)</td>
<td>Chair</td>
<td>✓</td>
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<td>7</td>
<td></td>
<td>Other Business</td>
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<td>7.1</td>
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<td>Meeting Evaluation</td>
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<td>8</td>
<td></td>
<td>Next Meeting: ANZCA Melbourne 12 November 2015</td>
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**College Presidents dinner: CECONIS at 7pm**

61 linders a ne
Mel our ne
ictoria 3000

estaurant tel: 03 8663 0 00
fa : 03 8663 0 66
_____ceconis.com
Committee of Presidents of Medical Colleges

Item 1.1 Meeting Formalities

Apologies Received:

- A/Professor Lucie Walters, ACRRM
  - Dr Mike Beckoff Deputy Chair ACRRM to attend
- Professor Malcolm Hopwood RANZCP
  - Dr Kym Jenkins RANZCP President-elect to attend
- Professor Judy Searle, MDANZ CEO
1. Directors and Council

1.1 General meeting of the Australian Medical Council Limited

The mid-year general meeting of Council was held on Thursday 25 and Friday 26 June in the regional city of Toowoomba, Queensland.

On Thursday 25 June, the Council attendees formed small groups to visit health services and education providers in and around Toowoomba, and on Friday morning the small groups provided feedback to the Council on the various site visits.

A number of areas were identified for exploration through the program of site visits, and discussions including:

- Recruitment, retention and appropriate distribution of the health workforce;
- Models of generalist medical practice and of multidisciplinary health teams, and education and training pathways in rural and regional areas for Indigenous students;
- The health and health care of Aboriginal and Torres Strait Islander people;
- Demography, health outcomes and health care priorities for rural and regional communities; 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 meetings in Toowoomba were seen as a unique opportunity to engage with 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, Chief Executive Officer of the CPMC, attended the two day general meeting as an observer.

1.2 Joint Meeting between Australian Medical Council and Medical Board of Australia

The AMC Directors, the Medical Board of Australia and AHPRA held their annual joint meeting on 29 July 2015.
2. National Registration and Accreditation Scheme

The AMC understands that the report and recommendations of the review of NRAS conducted by Mr Kim Snowball will be considered by the Health Ministers at their August meeting. A number of the recommendations if adopted are likely to have implications for accreditation processes. The AMC is continuing to monitor the progress of the review report.

3. Accreditation

3.1 Specialist Education Accreditation Committee

The AMC Specialist Education Accreditation Committee last met on 21 May 2015 and considered a range of matters regarding the accreditation of specialist medical programs, as outlined below.

3.1.1 Accreditation decisions

AMC Directors granted an extension of accreditation to the training programs and continuing professional development program of the Australasian College of Emergency Medicine (ACEM) to 31 March 2018. The Directors approved the extension of accreditation of the Fellowship program in Emergency Medicine and the continuing professional development program of ACEM by two years, to 31 March 2018.

The Directors also noted the progress of the following education providers and their programs of study in meeting conditions on their accreditation and the accreditation of their programs of study:

- Australian and New Zealand College of Anaesthetists (ANZCA)
- Royal Australian and New Zealand College of Radiologists (RANZCR)
- Royal Australasian College of Medical Administrators (RACMA)

3.1.2 College of Intensive Care Medicine of Australia and New Zealand (CICM) 2015 Follow-up Assessment

The 2015 follow-up assessment of the programs of the College of Intensive Care Medicine of Australia and New Zealand is currently underway. The team observed the College’s examination activities and met with trainees, supervisors and fellows at the College’s Annual Scientific Meeting in Darwin on 29 May 2015. The team’s meeting with College committees and office bearers took place from 29 to 31 July 2015.

3.1.3 Assessments in planning

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

In 2016, the AMC will undertake a reaccreditation assessment of the programs of the Royal Australian and New Zealand College of Ophthalmologists (RANZCO).

On the Committee’s recommendation, the March 2015 meeting of Directors appointed Professor Kate Leslie as chair the 2016 review team. The AMC and College have agreed to undertake this assessment from 16 to 26 May 2016.
Royal Australasian College of Dental Surgeons (RACDS) 2016 Reaccreditation Assessment

In 2016, the AMC accreditation of the Oral and Maxillofacial Surgery program of the Royal Australasian College of Dental Surgeons (RACDS) ends and reaccreditation is due. The AMC has conducted both previous assessments of this College as a joint accreditation with the Australian Dental Council, and a joint assessment is again planned.

The RACDS’ Oral and Maxillofacial Surgery program is accredited by four accreditation councils: the Australian and New Zealand Medical Councils, and Australian and New Zealand Dental Councils. As the accreditation period granted by the two Dental Councils does not align, there is currently discussion about aligning these, which may result in the AMC deferring its accreditation assessment to 2017 so it remains aligned with the ADC accreditation period.

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

In 2016, the AMC will undertake a reaccreditation assessment of the programs of the Royal College of Pathologists of Australasia (RCPA).

3.1.4 Review of accreditation standards for specialist training programs

The AMC is conducting a review of the accreditation standards for specialist medical programs and continuing professional development programs. The AMC undertakes a full review of the approved accreditation standards every five years. It completes these reviews through a consultative process.

The revised standards were released for initial stakeholder consultation from March to May 2015. The revised standards were sent to key stakeholders including; specialist colleges, health departments, regulatory bodies, junior doctor groups, consumer groups and a number of professional organisations. The AMC also met with a number of key stakeholder groups.

The AMC received 33 responses to the initial consultation on the draft revised standards. The Working Party considered the stakeholder feedback and has developed a new draft set of revised standards for a second round of consultation. The feedback:

- Generally supported the revised standards, but suggested terms be clarified, or standards/notes rewritten for clarity. In response the glossary has been expanded;
- Proposed 15 additional standards. The AMC has added one new standard, which relates to enhanced training opportunities for Maori and Aboriginal and Torres Strait Islander trainees; and
- Supported a separate standard on assessment of specialist international medical graduates. This was not supported by all colleges, but was supported by both the Medical Board of Australia and the Medical Council of New Zealand. A separate standard is included in the revisions
Also in the revised draft standards:

- There has been further streamlining of standards, with explanations moved to notes (where the explanation relates to the specific standard) or the glossary (where it is a general definition);
- Reference is made to AMC work on the topic of generalism and interprofessional education; and
- The standard of reconsideration, review and appeals has been moved from the standards relating to trainees, to the governance section of the standards.

The AMC is now conducting a second round of consultation on the final set of revised standards.

Once it has considered the feedback from this round of consultation, the AMC is holding a workshop for the colleges undergoing any form of accreditation in 2016 to discuss the changes (September 2015). The AMC has indicated that it does not expect colleges to demonstrate that they meet the new standards in 2016, but will wish to see how the college is planning to address the standards. The workshop will provide an opportunity to discuss the presentation of material for accreditation in 2016. The AMC plans to hold a second workshop for the remaining colleges within a few months of this first workshop.

The expected completion date of the standards review is September 2015, with implementation of the revised standards from 2016.

3.2 **Prevocational Standards Accreditation Committee**

The AMC Prevocational Standards Accreditation Committee 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.

The AMC conducts the assessment of intern accreditation authorities according to the *Procedures for Assessment and Accreditation of Intern Training Accreditation Authorities by the Australian Medical Council* (2013).

3.2.1 **Canberra Region Medical Education Council (CRMEC) 2014 Accreditation Assessment**

AMC Directors granted the Canberra Region Medical Education Council accreditation as an intern training accreditation authority for three years to 31 March 2018, subject to conditions on accreditation as outlined in the accreditation report and the submission of satisfactory progress reports to the AMC.

This is a new Council, which operated as an interim committee in 2014. Previously the NSW Health Education and Training Institute accredited posts in the ACT.
3.2.2 Postgraduate Medical Council of Victoria (PMCV) 2015 Accreditation Assessment

The 2015 accreditation assessment of the Postgraduate Medical Council of Victoria is currently underway. As part of this assessment, an AMC assessment team observed a range of PMCV’s accreditation activities including accreditation visits to the Royal Children’s Hospital and Monash Health in Melbourne, and PMCV’s Accreditation Sub-Committee meeting. The assessment team met with PMCV staff in Melbourne from 22 to 23 July.

3.2.3 Postgraduate Medical Council of Western Australia (PMCWA) 2015 Accreditation Assessment

The 2015 accreditation assessment of the Postgraduate Medical Council of Western Australia is currently underway, with meetings between the AMC assessment team and PMCWA staff occurring from 12 to 13 August in Perth. Members of an AMC assessment team observed PMCWA’s Accreditation Sub-Committee meeting on 27 July, and will observe PMCWA’s accreditation visit to the Fiona Stanley Hospital in Perth on 11 August.

4. Assessment and Examinations

The AMC currently administers the Primary Source Verification process which verifies the medical qualifications of all International Medical Graduates, including overseas trained specialists. Under this process IMGs submit their qualifications to the AMC, where they are checked, scanned and sent to the Educational Commission for Foreign Medical Graduates (ECFMG) in the United States. Following an initial vetting by the ECFMG, the qualifications are then sent to the original awarding institution for verification. Once verified, a report is provided to the AMC and placed on a secure portal which may be accessed by staff of the specialist colleges and AHPRA.

Under this process IMGs must apply for verification through a designated authority that is recognised by ECFMG, such as the AMC, to process and receive verifications. The ECFMG has introduced a new process - the Electronic Portfolio of International Qualifications (EPIC). This new process will allow individual IMGs to apply directly to ECFMG for verification of their qualifications (removing the necessity of lodging qualifications through a designated authority). Once verified, the details of the qualifications and the verification are held on a secure site by the ECFMG. When the applicant applies for assessment through the AMC or the specialist college, the details of the verification are downloaded to the AMC portal.

This new process is expected to reduce the time for processing the verification of qualifications and will allow the applicant to deal directly with the ECFMG rather than working through a third party, such as a specialist college or the AMC. The process is now being phased in and will be fully operational by the end of this year. The AMC will continue to work with the specialist colleges to ensure the smooth implementation of the new verification procedures.
5. Indigenous Planning Advisory Group

In 2014, AMC Directors agreed to prioritise Recommendation 7 of the 2013 external review of the AMC, which recommended 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.

Associate Professor Brad Murphy represents CPMC on the Advisory Group. The group has met three times in 2015; 19 March, 12 May and 30 July.

The group provides communiques to its stakeholders following each meeting. See ATTACHMENT 1 for the second communiqué from the AMC.

6. AMC Generalism Workshop

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. 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 2013, the Australian Health Practitioner Regulation Agency advised that in delivering accreditation functions the AMC would be required to consider the objectives and guiding principles of the National Law, and the following:

1. Opportunities to increase cross-profession collaboration and innovation and maximise efficiencies;
2. Opportunities to facilitate and support inter-professional learning; and
3. Opportunities to encourage use of simulated learning environments where appropriate.

AHPRA placed the same requirement on all the accreditation authorities operating under the National Law.

On 9 June 2015, the AMC, in collaboration with the Australian Nursing and Midwifery Accreditation Council, the Australian Pharmacy Council and the Council on Chiropractic Education Australasia, ran a workshop on Interprofessional Learning for Interprofessional Practice followed by a half day meeting on 10 June of accreditation council and national board representatives to discuss the impact of workshop outcomes on accreditation processes.
The workshop considered the health service drivers of interprofessional practice, examples of interprofessional education, and the role of accreditation standards and processes in enabling good interprofessional education.

The workshop was attended by about 110 participants drawn from the regulated health professions, education providers and health jurisdictions. Professor Maree O'Keefe, Associate Dean, Learning and Teaching in the Faculty of Health Sciences at the University of Adelaide, presented the outcomes of her work undertaken in a National Teaching Fellowship, *Collaborating across boundaries: A framework for an integrated interprofessional curriculum*, including:

- Commonly used interprofessional education models;
- Evaluation of interprofessional learning models;
- Interprofessional learning competencies.

While the detailed report of the meeting is yet to be completed, a statement of outcomes is available at ATTACHMENT 2.

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 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. The following working group members have been chosen to act as chairs of each theme area:

**Admission and Assessment and Supervision**: Professor David Ellwood and Associate Professor Christine Jorm

**Continuum of Medical Education / Role of Employers (Health Sector)**: Dr Susan O’Dwyer

**Curriculum and Definition of Professionalism**: Associate Professor Eleanor Milligan

**Legal Issues including sharing of Information (including MBA and employers)**: Dr Kim Rooney

The AMC gathered information on professionalism and fitness to practise from medical schools and other stakeholders, national and international accreditation authorities and AMC accreditation reports. The working group’s initial meeting was held on 1 May 2015. The group explored the above theme areas and discussed potential outcomes of the working group. The theme chairs met by teleconference on 13 May 2015 to discuss the outcomes of the 1 May meeting and determine the next steps for the project. A summary document outlining the issues and possible actions for these issues was presented for discussion to the Council on 26 June 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. On 14 May 2015, the judge made orders dismissing ACCS’ application and ordering it to pay costs.
This is the second communique from the Australian Medical Council's Indigenous Planning Advisory Group. The Advisory Group has been set up to assist the Australian Medical Council (AMC) develop a more effective and visible strategy for engagement with Indigenous health organisations, students and medical practitioners. This supports the AMC’s purpose across its accreditation, standard setting, and policy and assessment functions.

The Advisory Group is co-chaired by Dr Noel Hayman, Director of Inala Indigenous Health Service, and Dr Gregory Philips, Executive Director of ABSTARR Consulting.

Members of the Indigenous Planning Advisory Group are drawn from Indigenous stakeholder organisations including the Australian Indigenous Doctors Association (AIDA), Maori Medical Practitioners Association (Te Ora), Leaders in Indigenous Medical Education (the LIME Network), members of the Australian Medical Council, and peak bodies such as the Medical Board of Australia, Medical Deans Australia and New Zealand, Committee of Presidents of Medical Colleges (CPMC), Health Professions Accreditation Councils Forum that are stakeholders in the AMC major accreditation and assessment functions.

At the second meeting on 12 May 2015 the Advisory Group commenced its review of the existing relevant work of the AMC, the impact of accreditation, and the way the AMC builds successful relationships, partnerships and strategies to support its national and international assessment and accreditation processes.

The meeting considered the key elements of the accreditation process and the structure and purpose of AMC accreditation reports. The group identified opportunities to build on AMC training of accreditation assessors, and support for Indigenous assessors. The strategies include working with current and previous Indigenous assessors to identify strengths and resources to support all teams to apply the Indigenous health accreditation standards consistently and appropriately. The working group noted the strong focus by AMC teams and the AMC’s public accreditation reports on the assessment of the program against the approved accreditation standards, and consequently the need for accreditation standards to be clear, appropriate and capable of being met. The group contributed its views on the AMC’s draft revisions to the Standards for Assessment and Accreditation of Specialist Medical Education Programs and Professional Development Programs by the Australian Medical Council. The group’s suggestions for change will be referred to the AMC working group managing the review of these standards.

The 12 May meeting was held in the AMC’s National Test Centre, which is a purpose built facility to conduct the AMC clinical examination for international medical graduates seeking to practise in Australia and to enable the AMC to improve the quality, efficiency and transparency of its clinical assessments. The numbers of international medical graduates assessed by the AMC were discussed (some 1200 through the first stage multiple choice exam and some 960 through the second stage clinical exam). Members of the working group were shown the Test Centre facilities, and asked for further information on the AMC assessment approaches. These processes will be discussed again at the next working group meeting.
The Advisory Group considered the AMC’s contributions to national cross-profession accreditation and assessment processes and international links in accreditation of medical programs and assessment of international medical graduates. The capacity to build on those links to advance Indigenous health was also discussed.

The next meeting of the Advisory Group will take place on Thursday 30 July 2015.

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

Collaborating for patient care – Interprofessional Learning for Interprofessional Practice

Workshop

Melbourne June 9, 2015

The following outline represents the key outcomes generated through the workshop “Collaborating for patient care – Interprofessional Learning for Interprofessional Practice” held in Melbourne on June 9, 2015.

Over 100 senior participants from the higher education sector, health services, State and national governments, national boards and accreditation authorities attended the workshop.

The key outcomes from the workshop were discussed the following day at a joint meeting attended by the national boards, accreditation authorities and the Australian Health Practitioner Regulation Agency (AHPRA). The joint meeting considered those matters that were within the brief and purview of the National Registration and Accreditation Scheme.

The Facilitator for the workshop, Mr Kim Snowball, reported to the joint meeting that the workshop had reached a significant degree of consensus on the issue of collaboration for patient care through application of interprofessional education and practice in the Australian health system. The workshop also had identified some key opportunities and barriers for its wider application in the health and education sectors.

Key workshop outcomes

1. The workshop acknowledged that health care delivery had historically operated in very strong professional and service silos and this was reflected in health professional education.
2. The participants acknowledged the central role of effective interprofessional practice in improved patient treatment and care in almost all contemporary health service delivery settings.
3. It is this collaborative feature of many existing and emerging models of clinical practice that is driving the need to educate and train future health professionals to work more collaboratively across professions at the earliest stage in the interest of better patient safety and care.
4. There was broad and general consensus supporting a move towards a more planned and organised approach to interprofessional education as a basic principle underpinning the design and delivery of health professional education and training programs in Australia.
5. There was support for the World Health Organization definition of interprofessional education as a starting point.
6. The eight competencies presented by Professor Maree O'Keefe, Associate Dean, Learning and Teaching, Faculty of Health Sciences, University of Adelaide to reflect the content of interprofessional education were supported, while assessment of the competencies would require some further work.

7. There was a view expressed at the workshop for a closer relationship to be developed between the education and health sectors in both undergraduate and post graduate programs. In particular the importance of communicating interprofessional practice into the design and delivery of education programs so students were better equipped to perform in an interprofessional practice environment.

Given this set of outcomes from the workshop the Facilitator also explained that the workshop had considered barriers to the future development of interprofessional education and what actions might need to be taken by the various agencies involved.

Clearly, universities, national boards, accreditation authorities, health departments and the professions all have a role to play. The following action points describe those more immediate and those medium term actions that would assist the continued development of interprofessional education in Australia.

**Key suggested actions for regulators**

1. There was strong support for the focus on learning outcomes announced at the workshop by the accreditation authorities and away from detailed process standards, such as prescriptive contact hours and time in specific modes of education delivery, especially the restriction on simulated learning which were seen as a barrier to innovation and opportunities for interprofessional education.

2. There was a strong view that a clear and unambiguous signal from the national boards and accreditation authorities describing their support for interprofessional education would be of major benefit. In doing so it would give permission and support for innovation, while maintaining an accreditation standard for interprofessional education.

3. Some specific actions proposed included providing the regulatory means for cross professional supervision in appropriate circumstances and ensuring that early adopters and champions were recognised.

4. Investigate suggestions made at the workshop for a one week shadowing across professions.

5. Examine whether national boards’ continual professional development requirements might be used as a useful mechanism to drive interprofessional practice and education.

6. Investigate opportunities for cross-profession accreditation and/or for one accreditation authority to recognise the quality assurance and accreditation activities of other accreditation authorities.

In addition to these specific actions and issues it was apparent from the workshop that significant gaps in understanding of the respective roles and responsibilities existed.

All parties saw benefit in closer dialogue, particularly between the accreditation authorities and the higher education sector, in order to understand and address the barriers and opportunities to better organise and plan the delivery of interprofessional education in Australia.

The participants in the workshop were seen as a useful means of communicating developments and actions associated with interprofessional education.
CHIEF MEDICAL OFFICER’S REPORT

COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES

6 August 2015
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AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH - NEW ORGANISATIONAL STRUCTURE

Please see attached official structure chart, as of 1 July 2015.
SPECIALIST TRAINING PROGRAMME (STP)

The Minister for Health and Minister for Sport, the Hon Sussan Ley MP, announced that the Department would commence a consultation process with specialist colleges and other key stakeholders about reforms to the programme from 2017. The consultation will focus on in-depth workforce planning to better match investments in training with identified specialties of potential shortage and areas that may be oversubscribed into the future.

The Department has now commenced work on this review, which will be conducted in two strands:

(1) operational aspects of the programme; and

(2) data modelling to develop potential methodologies for the allocation of training posts to the colleges from 2017.

A discussion paper, prepared by the department as a platform for consultation on the operational aspects of the STP will be distributed shortly. Colleges and jurisdictions will be invited to provide comment on the paper. Following receipt of those comments the Department intends to meet with each specialist college involved in the STP to discuss their feedback.

In regard to the data modelling the Department will be leading this work, as its core business includes medical workforce planning and projections and health workforce distribution policy and programme design. Stakeholders will be closely involved in the redesign, including specialist medical colleges and training settings. The National Medical Training Advisory Network (NMTAN) will also be asked to assist.
NATIONAL MEDICAL TRAINING ADVISORY NETWORK (NMTAN)

Background

The National Medical Training Advisory Network (NMTAN) was established in February 2014. Membership of the NMTAN consists of representatives of national medical accreditation and registration agencies, medical associations, medical schools, rural health organisations, medical student bodies, the specialist colleges, states and territories, the private sector and the Australian Indigenous Doctor Association.

The NMTAN currently has three subcommittees considering different aspects of medical training to inform future workforce planning.

The ‘Changing clinical work with projected changing burden of chronic disease’ subcommittee is examining the implications of the increasing incidence of chronic disease and increased delivery of chronic disease management in the primary care setting. At the NMTAN Executive Committee meeting on 19 May 2015, the committee endorsed the scoping paper for the project.

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 initial focus is 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. Workforce projections for psychiatry have been updated. The Capacity Analysis Tool has also been developed and will assist in the next stage of the psychiatry modelling project and future modelling of the other medical specialties.

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 is being used to develop a series of fact sheets on each of the medical specialties. The first two fact sheets, on anaesthesia and psychiatry, are in the process of being finalised.

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). A NMTAN Data Subcommittee has been established to provide advice on the annual report and other data projects.

The NMTAN website has been established and can be accessed via http://www.health.gov.au/internet/main/publishing.nsf/Content/nmtan. The website information will be updated as work progresses.
NATIONAL IMMUNISATION PROGRAM

Background
The National Immunisation Program (NIP) is a joint Commonwealth and state and territory initiative which provides free vaccination programs to reduce the incidence of vaccine preventable diseases in Australia by increasing immunisation coverage rates. Currently, national immunisation coverage rates for children at one, two and five years of age are high, which are at or above 90 per cent.

1. Budget measures
The 2015-16 Budget included a number of measures relating to immunisation. These included:

1.1 New addition to NIP – 18 month dose of pertussis-containing (whooping cough) vaccine
Following positive recommendations from the Pharmaceutical Benefits Advisory Committee (PBAC), the Australian Government approved funding to list an additional dose of pertussis-containing vaccine for infants on the NIP. This booster dose complements pertussis vaccinations currently provided on the NIP for infants at two, four and six months of age and as a booster to children and adolescents at four and 10-15 years.

As part of this program, the Australian Childhood Immunisation Register (ACIR) will be modified to enable these vaccinations to be reported and enable targeted and enhanced surveillance of adverse events. A communication campaign will also be developed to encourage uptake of this vaccine. The Commonwealth will continue to work with states and territories to implement this Program which will commence in October 2015, subject to vaccine supply.

1.2 Improving Immunisation Coverage Rates
Activities under this measure will improve immunisation coverage rates in Australia with:

- Broader and better immunisation data capture by expanding the National Human Papillomavirus (HPV) Vaccination Register to become the Australian Schools Vaccination Register. This Register will provide tools, such as recall and reminder systems, to improve adolescent vaccination rates.
- Activities to improve the community’s understanding and awareness of the National Immunisation Program, and tools to assist immunisation providers’ discussions with vaccine hesitant parents.
- An incentive to immunisation providers to complete catch up vaccinations.
  From 1 January 2016, an incentive payment will be available for immunisation providers, including general practices, who identify, call in and vaccinate children in their practice up to seven years of age who are more than two months overdue for vaccination, and then record the catch up on the ACIR. Providers will receive a $6 payment for each NIP Schedule point caught up.

1.3 Strengthen Immunisation Requirements – No Jab No Pay
The Australian Government, through the Department of Social Services, will strengthen the immunisation requirements that apply to Child Care Benefit (CCB), Child Care Rebate (CCR) and Family Tax Benefit Part A Supplement (FBT-A Supplement). Parents’ eligibility to receive these family assistance payments is linked to their child’s immunisation status. Currently,
parents who do not vaccinate their children can still receive these payments if they submit a conscientious objector form, have an approved religious or medical exemption, or are participating in an approved research study. Under the No Jab No Pay measure, from 1 January 2016, only families who fully immunise their children, are on a recognised immunisation catch up schedule, have an approved medical exemption or are participating in an approved research study will be acceptable to continue to receive these family payments if a child is not fully vaccinated.

The ACIR currently captures data for children up to seven years of age. As part of the Department of Social Services No Jab No Pay policy, the ACIR will be expanded to capture immunisation data for children up to 19 years of age. This will link family assistance payments to the immunisation status of all children (not just the very young).

1.4 National Shingles (herpes zoster) Vaccination Program – whole of life register
Following a positive PBAC recommendation in November 2014, the Australian Government will implement the National Shingles Vaccination Program to provide shingles vaccination (Zostavax®) to 70 year olds, with a five-year catch-up program for 71-79 year olds. Funding for this Program also includes the expansion of the ACIR to capture all vaccines given from birth to death through GPs and community clinics. This, in conjunction with the register expansions outlined above, will result in an Australian Immunisation Register (AIR). The Programme will commence in November 2016, subject to vaccine supply, with the AIR being operational by September 2016, prior to the Program commencement.

2. Administration of bioCSL Fluvax to children under five years old
bioCSL’s Fluvax is not approved for use in children under five and is not recommended for children under 10 due to adverse events (febrile convulsions) in children. There are a number of measures in place to mitigate its use in this age group, and all reports of bioCSL’s Fluvax given to a child under five years are followed up by state and territory governments.

In response to the unexpectedly high number of confirmed cases of the administration of bioCSL Fluvax to children under five (29 cases as at 26 June 2015), the Chief Medical Officer has contacted key stakeholders, to stress the importance of reinforcing appropriate influenza vaccine use in children. Total confirmed cases represent approximately 0.1% of total seasonal influenza vaccinations given to children in this age group. The Department is continuing to work with jurisdictions to monitor this situation.
RELEASE AND IMPLEMENTATION OF AUSTRALIA’S FIRST NATIONAL ANTIMICROBIAL RESISTANCE STRATEGY


AMR is a significant global health priority, largely driven by the misuse of antibiotics in human health, agriculture and animal health. The Strategy is a blueprint for coordinated action by governments, health professionals, non-government organisations, industry and consumers to work in partnership. It focuses activity on antibiotic resistance and identifies broad areas for action in relation to: antimicrobial stewardship; surveillance; infection prevention and control; communication and education; research and development; international partnerships; and governance.

The Strategy’s goal and objectives and the actions needed to achieve them have been informed by a review of national and international literature, expert advice and consultation with sector stakeholders. The Strategy aligns with the World Health Organization’s Global Action Plan on Antimicrobial Resistance which was endorsed at the World Health Assembly in May 2015.

Of particular interest to CPMC members is Objective One – Increase awareness and understanding of antimicrobial resistance, its implications and actions to combat it, through effective communication, education and training. This Objective notes the importance of communication and education initiatives which focus on antimicrobial resistance, antimicrobial stewardship and infection prevention and control through all stages of health professionals’ formal training and workplace based orientation.

Implementation of the Strategy is a shared responsibility which relies on the commitment of time, resources and funding from stakeholders across all sectors and levels of government. Efforts will now be focussed on the development of a detailed Implementation Plan which will identify concrete, measurable actions in response to antimicrobial resistance in Australia, as well as stakeholder responsibilities for implementation and associated timeframes. The Implementation Plan will be developed in consultation with sector stakeholders over the coming months. A National Forum will also be held on 17 November, during Antibiotic Awareness Week 2015 (November 16-20).
UPDATE ON THE GOVERNMENT’S RESPONSE TO THE REVIEW OF THE PERSONALLY CONTROLLED ELECTRONIC HEALTH RECORD

Through the 2015/16 Budget, the Australian Government has allocated $485.1 million for the redevelopment and continued operation of the Personally Controlled Electronic Health Record (PCEHR) system.

This funding will enable improvements to be made to the system’s usability and clinical utility. In addition to improvements, the PCEHR system will also be renamed to My Health Record.

The Government recognises that the benefit of an electronic health record for the Australian community depends on its use by health care providers as part of regular clinical practice.

As such, the Government has announced that a number of trials will be undertaken in 2016, with varying consumer participation arrangements.

This includes opt-out trials in at least two different regions in Australia as well as opt-in trial sites which will include other innovative approaches to increasing participation. By increasing the number of participants, it is expected that the My Health Record will be better utilised, be more credible and considered more meaningful.

The trials will be supported by localised information campaigns, education and training opportunities for a broad range of health care providers and incentives for general practice.

By increasing the uptake of the My Health Record system by both patients and healthcare professionals the benefits of an integrated eHealth system will be fully realised. The information and evidence base gathered from the trials will be used to inform the Government on future strategies for increasing uptake and meaningful use of the My Health Record.

The Government is currently undertaking user consultations to gain insight into the current use of the PCEHR by consumers and healthcare providers and to identify opportunities to improve the user experience through increased usability and utility.

The department has also released a public consultation paper intended to provide a plain English description of the proposed changes to the legislative framework for the personally controlled electronic health record (PCEHR) system and Healthcare Identifiers Service (HI Service), and many provider organisation have provided submissions.

As of 25 June 2015 there were over 2.2 million individual records and 7,769 healthcare organisations registered in the PCEHR system. Over 50,600 shared health summaries, 158,800 hospital discharge summaries and over 12,000 event summaries have been uploaded.
REBUILDING GENERAL PRACTICE EDUCATION AND TRAINING BUDGET MEASURE

REPORT

The 2014-15 ‘Rebuilding General Practice Education and Training to deliver more GPs’ Budget measure committed the Government to conducting an open competitive approach to market (ATM), to secure the services of a smaller number of organisations with the capacity to coordinate training across Australia, from 1 January 2016. The ATM for the Australian General Practice Training (AGPT) programme opened on 29 May 2015 and closed on 10 July 2015 at 2pm AEST.

The Department is currently undertaking the assessment phase of tender applications submitted to administer the AGPT and Overseas Trained Doctor National Education and Training programmes. To ensure probity and integrity the Department is unable to comment further on the ATM process.

Where necessary, a three month transition period will commence from 1 October 2015 to ensure a smooth transition to new providers on 1 January 2016.

The Department is continuing to consult with key GP stakeholders regarding the implementation of the Budget measure.

The application process for registrars seeking a placement on the AGPT programme (commencing in 2016) closed on 8 May 2015. The number of applications received was 2,360. Phase 2 of the application process for 1,500 new places on the AGPT programme from 2016 has commenced.

Background

The ‘Rebuilding General Practice Education and Training to deliver more GPs’ Budget measure included expanding the AGPT programme by 300 training places, from 1,200 to 1,500 commencing places per year, from 2015.

On 9 April 2015, Minister Ley announced the new training regions and governance arrangements for the future delivery of GP specialist training. Geographical boundaries for 11 training regions were developed by the government in consultation with GP stakeholders (including the Royal Australian College of General Practitioners, the Australian College of Rural and Remote Medicine, General Practice Supervisors Australia, General Practice Registrars Australia, the Australian Medical Association and the Rural Doctors Association of Australia). The boundaries were established in line with the preferred option identified with those groups. The new training regions form the basis for organisations to submit applications to administer the AGPT programme through the ATM process.

The Minister also announced 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 the Royal Australian College of General Practitioners (RACGP), the Australian College of Rural and Remote Medicine (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 Department, the ACRRM and the RACGP are working together on the draft Terms of Reference for the Advisory Committee. It is anticipated that the GP Training Advisory Committee will commence in 2015.

**AGPT Selection comparison numbers:**

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<th>Cohort</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
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<tr>
<td>Training places</td>
<td>1,192</td>
<td>1,500</td>
<td>1,500</td>
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<tr>
<td>No. of eligible applications</td>
<td>2,026</td>
<td>2,301</td>
<td>2,321*</td>
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*Preliminary figure – there are a small number of applications which require additional assessment before eligibility can be confirmed.

The assessment and selection process is progressing as per the stipulated timetable:

- Stage 1 (13 April – 8 May 2015) is the application phase and a total of 2,360 applications were received of which 2,321 were deemed eligible.
- Stage 2, is where the 2,321 applicants undertake the on line Situational Judgement Test (15 June – 6 July 2015) and the Multiple Mini Interview process (26 June – 19 July 2015) at exam and assessment centres around Australia. This is currently in process.
- Applicants will receive their national scores and be advised of their national ranking on 10 August 2015.

The AGPT programme continues to be popular; despite changes in the governance of GP training the Department has received more applicants in 2015 than in 2014.
REVIEW OF AFTER HOURS PRIMARY HEALTH CARE SERVICES

Background
The Review of After Hours Primary Health Care Services (the Review) was undertaken by the Government in response to recommendations from the Review of Medicare Locals. The Review, led by Professor Claire Jackson, commenced on 19 August 2014. It provided an opportunity to reflect on the current after hours delivery arrangements to determine the most appropriate and effective delivery mechanisms to support ongoing after hours primary health care services nationally. The Review report made 13 recommendations to Government on 31 October 2014.

On 26 March 2015, the Government gave priority to the most time critical recommendations (numbers 1, 2, 3 and 12) which involved the development of a new funding model for after hours primary health care, commencing from 1 July 2015 and consisting of:

- a new Practice Incentives Programme (PIP) after hours incentive payment available to eligible accredited general practices registered for the PIP;
- funding to Primary Health Networks (PHNs) to support locally tailored after hours services; and
- a new after hours GP advice and support line.

As requested by the Prime Minister in his correspondence of 27 May 2015, a response to the remaining recommendations from the Review will be provided to Government shortly.

Current Status
- The new funding model for after hours primary health care commenced on 1 July 2015.
- The PIP after hours incentive provides payments to accredited general practices that ensure their patients have access to quality after hours care. The PIP after hours incentive simplifies the funding process to encourage practices to provide after hours services. It builds on existing infrastructure and provides general practices with a more streamlined, less administratively burdensome way to receive funding for delivering after hours services.
- PHNs will receive Commonwealth funding to work with key local stakeholders to plan, coordinate and support after hours health services. PHNs provide an opportunity to improve access to after hours services that are tailored to the specific needs of different communities. PHNs will focus on addressing gaps in after hours service provision, ‘at risk’ populations and improved service integration.
- The new after hours GP advice and support line commenced transition on 1 July 2015. It is operated by Healthdirect Australia and replaces the previous after hours GP helpline. The new after hours GP advice and support line better targets Australians, both in metropolitan and rural and remote areas, who do not have access to face-to-face medical services in the after hours period.
- A response is being prepared to outline the proposed approach to addressing the remaining recommendations from the Review.
PRACTICE INCENTIVES PROGRAMME (PIP) TEACHING PAYMENT

As part of the 2014-15 Budget, $238.4 million was allocated over five years (2013-14 to 2017-18) to double the PIP teaching payment from $100 per session to $200 for each three hour teaching session.

The increased payment applied to teaching sessions completed from 1 January 2015.

Increasing the PIP teaching payment is expected to better compensate general practices for the time invested in teaching, which will encourage general practices to provide more teaching opportunities for students. This will allow a greater number of students to experience general practice which should lead to a greater number of students pursuing a future career in general practice.

Background
The PIP provides financial incentives to support general practice activities that encourage continuing improvements and quality care, enhance capacity and improve access and health outcomes for patients.

- The PIP teaching payment was introduced in 1999 and is aimed at encouraging general practices to provide teaching sessions to university medical students.

- The PIP teaching payment was designed to compensate practices for the reduced number of consultations as a result of teaching students. It was never intended to fully offset these or other costs that practices will incur when teaching students.

- For each three hour teaching session, practices can get a maximum payment of $200. Practices can claim a maximum of two sessions per GP and student, per calendar day.
REVIEW OF MENTAL HEALTH PROGRAMS AND SERVICES

Background

- The Australian Government engaged the National Mental Health Commission to undertake a Review of Mental Health Programmes and Services (the Review).
- The Final Report from the Review, Contributing lives, thriving communities, was released on 16 April 2015.
- The Review presents an ambitious plan for long term reform of the mental health system, across nine strategic directions and 25 recommendations (the full report of the Review can be accessed via the Commission’s website: www.mentalhealthcommission.gov.au)
- The Minister for Health and Minister for Sport, the Hon Sussan Ley MP indicated that partnerships with states and territories were critical to develop a national approach in the delivery of an efficient and effective mental health system.
- On 17 April 2015, the COAG Health Council (CHC) agreed to work collaboratively with the Australian Government to respond to the Review recommendations.

Key Points

- To ensure a consultative and collaborative approach to progress the Government’s long term response to the review, Minister Ley sought establishment of a time-limited Mental Health Expert Reference Group (MHERG) to provide advice to the Government on key mental health system issues identified by the Review.
- Targeted stakeholder workshops will inform considerations of the MHERG.

MHERG

- This group, chaired by Ms Kate Carnell, brings together twelve experts in mental health with extensive experience in key areas identified for reform, including primary care, youth mental health and service integration.
- The first meeting of the MHERG occurred on 18 June 2015 and focussed on:
  - systems issues of support to Primary Health Networks (PHNs) for primary mental health care;
  - system reform through regional service integration; and
  - supporting the shift to early intervention through stepped care.
- A further three meetings of the MHERG are scheduled in July and August 2015.

Mental Health Stakeholder Workshops

- The MHERG will also be supported by targeted stakeholder workshops to ensure that frontline mental health services and organisations have direct input in the development of policies towards a national approach to mental health reform.
- The first stakeholder workshop is scheduled on 6 August 2015 with a further Workshop planned for late August 2015.
Other mental health reform activity: 5th National Mental Health Plan Working Group

- A number of recommendations from the Review made reference to the development of a new national mental health and suicide prevention plan to refocus national directions and priorities for better integrated and delivered mental health services.
- On 29 May 2015, the Mental Health Drug and Alcohol Principal Committee (MHDAPC) agreed to the establishment of a 5th Plan Working Group within its structure to progress development of the 5th Plan.
PRINCIPAL HEALTH CARE ADVISORY GROUP

Background

- Australia’s primary health care system works well for most people. However, there is increasing evidence that it is not as effective for people with more complex needs, such as those with multiple chronic conditions. Within the current system, services are not as well aligned as they need to be to effectively support ongoing integrated care and to avoid unnecessary hospitalisations, and existing payment models may not be appropriately designed to support service improvements.

- On 22 April 2015, the Minister for Health, the Hon Sussan Ley, announced the Government’s plan to deliver a Healthier Medicare, including the establishment of a Primary Health Care Advisory Group.

- The intent of the Primary Health Care Advisory Group is to guide a necessary shift from a fragmented system based on individual transactions, to a more integrated system that considers the whole of a person’s health care needs.

- The Advisory Group will investigate options to provide: better care for people with complex and chronic conditions; innovative care and funding models; better recognition and treatment of mental health conditions; and greater connection between primary health care and hospital care.

Current Status

- The Primary Health Care Advisory Group (PHCAG) is Chaired by Dr Steve Hambleton, immediate past President of the Australian Medical Association.

- The membership of the group, announced on 4 June 2015, includes individuals with a wide range of experience and expertise in primary health care services, including GPs, nurses, allied health, the private health insurance industry, pharmacy and representative consumer groups. Members have been appointed as individual experts, however they will also be expected to encourage involvement and disseminate information within their relevant professions and organisations.

- To inform its deliberations, the Advisory Group will be undertaking a consultation process in the coming months and all stakeholders are encouraged to engage in this process and where appropriate to promote this opportunity through their organisations and memberships. In addition, as part of this process, members of the Advisory Group will undertake face to face consultations with peak professional organisations.

- The department’s website (www.health.gov.au) is being regularly updated with further information on the role and work of the Healthier Medicare groups, including information about opportunities for the public and health sector to engage in the Advisory Group’s consultation process.

- The Advisory Group is expected to report to Government with key priority areas for action in late 2015.
ESTABLISHMENT AND COMMENCEMENT OF PRIMARY HEALTH NETWORKS

Background

- A total of 31 Primary Health Networks (PHNs) commenced on 1 July 2015 to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care to ensure patients receive the right care in the right place at the right time.

- PHNs will achieve these objectives by working directly with general practitioners, other primary health care providers, secondary care providers and hospitals to ensure improved outcomes for patients. PHNs are independent organisations governed by skills-based Boards.

- PHNs will be expected to understand the health needs of their communities. With support from GP-led Clinical Councils and Community Advisory Committees, PHNs will seek to develop local strategies to improve the operation of the health care system for patients and facilitate effective primary health care provision, to reduce avoidable emergency department presentations and hospital admissions within the PHN catchment area.

- PHNs will also have a local purchasing or commissioning role, by identifying and funding innovative local arrangements for the effective delivery of services.

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

- 2015-16 will be a year of transition as the new PHNs move towards their new commissioning roles while minimising disruption to patients and health care providers.
**NHMRC Report to CPMC**

*May 2015 – July 2015*

**Appointments to NHMRC Council for the 2015-18 triennium**

An announcement of the membership for other NHMRC Principal Committees is expected shortly and details about the functions of these committees can be found at [http://www.nhmrc.gov.au/about/nhmrc-committees](http://www.nhmrc.gov.au/about/nhmrc-committees).

**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 need to come more powerfully from collaboration of researchers, health practitioners and administrators, working together in the interests of patients.

Following the announcement on 28 March 2015 of the first four NHMRC Advanced Health Research and Translation Centres, NHMRC has continued to work with health policy makers nationally to build and expand this concept. The Office is currently planning a workshop with stakeholders for the end of 2015 to share experiences with the scheme. More detail will follow once confirmed.

**Targeted Call for Research into Preparing Australia for the Genomics Revolution in Health Care**
Applications for this Targeted Call for Research (TCR) closed on 13 May 2015 and are currently under review. Research supported through this TCR will investigate how genomic medicine may improve the prevention, diagnosis and treatment of one or more diseases and assess the economic and policy impacts of this technology on the provision of healthcare.

Through this call NHMRC intends to support a single, multidisciplinary, nationally focussed grant of up to $25 million over five years.
NHMRC National Institute for Dementia Research
As part of the 2014 Budget, the Australian Government announced an additional $200 million over five years to boost Australia’s dementia research capacity. Included in this announcement was the establishment of a new NHMRC National Institute for Dementia Research to boost dementia research in Australia and provide the pathway to rapidly translate evidence into policy and practice. The Institute will ensure integration with international research and draw on the expertise of researchers, consumers, health professionals, industry and policy makers to improve dementia prevention, treatment and care outcomes.

At the end of 2014, NHMRC called for tenders to establish and run the NHMRC National Institute of Dementia Research. The Office is currently completing assessment of the tender, with the Minister expected to announce the successful bid in the coming quarter.

Public consultations

Draft Principles and guidelines for the care and use of non-human primates for scientific purposes
Closed 8 May 2015

Proposed changes to NHMRC’s 2012 Infant Feeding Guidelines
Closed 15 May 2015

Clinical Trials Ready – Concept and Criteria
Closed 26 June 2015

Current and Emerging Issues for NHMRC Fellowship Schemes
Closed on 30 June 2015

Ethical guidelines on the use of assisted reproductive technology in clinical practice and research
Closing 17 September 2015

Open grant schemes

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<th>Scheme</th>
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<td>Targeted Call for Research (TCR) into Wind Farms and Human Health</td>
<td>6 May 2015</td>
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<td>Targeted Call for Research (TCR) into Preparing Australia for the Genomics Revolution in Health Care</td>
<td>13 May 2015</td>
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<td>Program Grants</td>
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<td>Partnership Projects – Peer Review Cycle 2</td>
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<td>Targeted Call for Research into Engaging and Retaining</td>
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<td>Young Adults in Interventions to Improve Eating</td>
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<td>Behaviours and Health Outcomes (Preventing Obesity in</td>
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<td>18-24 year olds TCR)</td>
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**Funding outcomes announced**

NIL

**Policy positions, administrative documents and reports released**

- **NHMRC-ARC streamlining progress update**
  04 May 2015

- **NHMRC early advice: Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative**
  29 May 2015

- **Amendments to the Australian Immunisation Handbook (10th Edition) and the Clinical Practice Guidelines: Antenatal Care Module II**
  06 July 2015

**Media releases, speeches, presentations**

- **$15.4 million to support tropical research under Northern Australia growth plan**
  From the Minister for Trade and Investment, The Hon. Andrew Robb AO MP
  10 May 2015

- **2015-16 Budget Update**
  14 May 2015

- **NHMRC releases Statement and Information Paper on impacts of lead on human health**
  19 May 2015

- **Australian-first website to connect more patients with clinical trials**
20 May 2015

**Boost for mental health researcher in the development of online tool**

05 June 2015

**Appointments to key health and medical research body**

23 July 2015

**Feedback sought on draft revisions to ethical guidelines for assisted reproductive technology**

23 July 2015

**Meetings and external engagements**

<table>
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<tr>
<th>Date</th>
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<tr>
<td>May 2015</td>
<td>• 4 - Department of Foreign Affairs and Trade (DFAT) meeting on the WHO reform dialogue process</td>
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<td>• 6 - Meeting with Professor Helen Christensen, Black Dog Institute</td>
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<td>• 7 - Meeting with Dr Michael Armitage, Private Healthcare Australia</td>
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<td>• 12 - Strengthened Export Controls Steering Group meeting</td>
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<td>• 14 - Health portfolio, budget breakfast</td>
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<td>• 14 - NHMRC Research Committee (RC) meeting</td>
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<td>• 19 - NHMRC Principal Committee Indigenous Caucus (PCIC) meeting</td>
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<td>• 19 - CSIRO Boardroom Dinner</td>
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<td>• 21 - Prevention and Community Health Committee (PCHC) meeting</td>
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<td>• 26 - Excellence in Innovation Awards Dinner</td>
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<td>• 27 - Teleconference with Global Alliance for Chronic Diseases (GACD) Secretariat</td>
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<td>• 28 - Human Genetics Advisory Committee (HGAC) meeting</td>
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<td>June 2015</td>
<td>• 2 - Senate Budget Estimates hearing</td>
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<td>• 3&amp;4 - NHMRC Council meeting</td>
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<td></td>
<td>• 4 - Australian Society for Medical Research, Health Minister’s Award dinner</td>
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<td>• 5 - Meeting with Professor James Angus and Dr Erin Lalor, Stroke Foundation</td>
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<td>• 11 - National Science, Technology and Research Committee (NSTRC) meeting</td>
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<td>• 11 - Presentation to ANU Early Career Academic Network (NECTAR)</td>
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<td>• 11 - Meeting with Group of Eight DVCs-R</td>
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<td>• 12 - Australian Research Council (ARC) and NHMRC meeting</td>
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<td>• 12 - NHMRC Embryo Research Licensing Committee (LC) meeting</td>
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<td>• 15 - Meeting with Professor Brendan Crabb, Burnet Institute</td>
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<td>17</td>
<td>Meeting with Dr Carl Magnus-Larsson, CEO Australian Radiation Protection and Nuclear Safety Agency (ARPANSA)</td>
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<td>Meeting with Dr Matthew Miles, MS Research Australia</td>
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<td>18</td>
<td>Australian Academy of Science, National Committee for Data Science roundtable</td>
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<td>18</td>
<td>Epworth Research Institute dinner</td>
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<td>23</td>
<td>Presentation to the Medical Deans of Australia and New Zealand (MDANZ) annual Standing Committee meeting</td>
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<td>23</td>
<td>Meeting with representatives from the Innovative Research Universities (IRU)</td>
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<td>26</td>
<td>Meeting with Dr Merran Smith and Professor Brendon Kearney, Population Health Research Network (PHRN)</td>
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<td>29</td>
<td>Meeting with Professor Archie Clements, Research School of Population Health ANU</td>
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<td>30</td>
<td>Commemoration of Independence, Embassy of the United States of America in Australia</td>
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<tr>
<td>July 2015</td>
<td>1 - Meeting with Professors Christina Mitchell, Steve Wesselingh, Stephen Smith and Bruce Robinson re Advanced Health, Research and Translation Centres</td>
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<td>July 2015</td>
<td>3 - Meeting with Professor Sally Green, Co-director, Australasian Cochrane Centre and Steve McDonald</td>
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<td>8 - Meeting with Dr Stewart Hay, Therapeutic Innovation Australia</td>
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<td>9 - Meeting with ARC on Whole of Government services</td>
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<td>July 2015</td>
<td>13 - Opening remarks at U.S.A.-Australia Biomedical Cooperation conference</td>
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<td>July 2015</td>
<td>22 - Meeting with Dr Antonio Penna, NSW Office for Health and Medical Research</td>
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<td>July 2015</td>
<td>23 - Presentation at the Committee for Economic Development of Australia monthly boardroom lunch</td>
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<td>July 2015</td>
<td>27 - Official welcome to Project Grants peer review panel members - week one</td>
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<td>July 2015</td>
<td>29 - Plenary presentation at the Primary Health Care Research Conference</td>
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<td>July 2015</td>
<td>29 - Round-table discussion at Centre for Cancer Biology, Adelaide</td>
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<tr>
<td>July 2015</td>
<td>31 - Meeting with Heather Nancarrow, CEO Australia’s National Research Organisation for Women’s Safety (ANROWS)</td>
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Report

Medical Board of Australia and AHPRA report to the meeting of the CPMC on 6 August 2015

Revalidation research

Earlier this year the Medical Board of Australia (the Board) commissioned a team of researchers, the Collaboration for the Advancement of Medical Education, Research and Assessment (CAMERA) at Plymouth University Peninsula Schools of Medicine and Dentistry (UK), to undertake research into revalidation.

CAMERA was commissioned to look at the evidence for revalidation, how other jurisdictions structure revalidation processes and to identify a range of options specifically for the Australian context.

The Board will now take time to consider the outcomes of the research and CAMERA’s report and will publish the report in the upcoming months.

The Board will establish an expert group to provide it with advice on revalidation. The expert group will include independent members of the profession and community representatives.

We will seek the views of stakeholders, including the profession through consultation, as this important work continues.

The Board will also be undertaking social research into what the community expects medical practitioners should do to demonstrate ongoing fitness and competence to practise.

The Board looks forward to CPMC’s input into the ongoing work on revalidation.

External health programs for medical practitioners and students

The Board has previously committed to funding external health programs to ensure medical practitioners and students in all states and territories have access to a nationally consistent set of services. Health programs will provide a suite of core services which will include advice and referral, education and awareness and general advocacy.

The governance model provides for the distribution of the Board’s funds to external health programs through a separate entity. The Australian Medical Association has taken on the role of establishing a subsidiary company, Doctors’ Health Services Pty Ltd, which will sub-contract state-based health programs. This enables consistent delivery and monitoring of services in each jurisdiction. Importantly, the structure has been designed so services will be at arm’s length from the Board.

The Doctors’ Health Services has a Board and an Expert Advisory Council which also provides a forum for providers.
The AMA is working with existing health programs to ensure services continue during the transition to implementation of consistent services in each state and territory as part of the nationally agreed model.

**Information sheet - Specialist medical college assessment processes for Australian and New Zealand medical graduates with overseas specialist qualifications**

In response to requests from some colleges, the Board has provided guidance on how to manage applications for specialist recognition from Australian or New Zealand medical graduates who have obtained specialist qualifications overseas.

Australian and New Zealand medical graduates are not eligible to apply for assessment under the specialist pathway as this is a pathway for international medical graduates. They are also not eligible for limited registration under the provisions of the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law). Rather, they are qualified for general registration.

The Board consulted with colleges on the guidance. The Information sheet, which has been finalised and sent to colleges and published on the Board’s website, provides information to assist colleges and applicants. However, it does not introduce significant changes to current college processes and there should be minimal impact on colleges from the release of this information sheet.

**Specialist college data reporting**

Following the changes to the specialist pathway for international medical graduates (IMGs) which came into effect on 1 July 2014, the Board requested that specialist medical colleges report their pathway data directly to the Board.

The Board determined a range of metrics for the colleges to report against. These were based on the data for the specialist pathway that was previously collected by the AMC.

The Board has received the first reports from colleges, covering the first six month period. It includes the number of applications, the IMG’s country of training and the outcome of the college assessment (not comparable, partially comparable or substantially comparable).

The Board will consider the reports and work with the colleges to standardise the reports. It also intends to publish the data.

The Board appreciates the colleges’ input as this reporting process is refined.

**Review of registration standards**

The Board will soon be seeking feedback from the colleges as part of its review and preliminary consultation on the registration standard for specialist registration. The registration standard outlines the Board’s requirements for specialist registration.

The proposed changes are mostly cosmetic with reformatting and re-wording to make the standard clearer. There are no new requirements proposed. The two key changes are:

- additional content in relation to Australian and New Zealand medical graduates with overseas specialist qualifications in line with the Board’s Information sheet
- changes to the section that sets out the documentary evidence required for applicants, that streamlines the application process.

Concurrently, the Board has also reviewed and will undertake preliminary consultation on the registration standard for granting general registration to medical practitioners in the standard pathway who hold an AMC certificate.

The Board will send the confidential consultation paper directly to colleges and looks forward to receiving the feedback.
Revised English language and criminal history registration standards

The Board’s revised registration standards for criminal history and English language skills took effect on 1 July 2015.

Criminal history

The criminal history registration standard has had only minor amendments and the changes have minimal impact on practitioners.

When a practitioner first applies for registration, the Board requires the applicant to declare their criminal history in all countries, including Australia. All registered medical practitioners must inform the Board if they are:

- charged with an offence punishable by 12 months imprisonment or more, or
- convicted or found guilty of an offence punishable by imprisonment in Australia and/or overseas.

When practitioners renew their registration they must disclose any changes to their criminal history.

The registration standard is available on the [Board’s website](#).

English language skills

The new registration standard for English language skills applies to all applicants for initial registration, regardless of whether they qualified in Australia or overseas.

The new standard introduces additional pathways for applicants to demonstrate evidence of their English language skills.

The new standard was developed after a review of the existing standard and public consultation on the proposed changes. The English language skills standards are now largely common across all professions (except Aboriginal and Torres Strait Islander health practitioners).

The registration standard and FAQs are available on the [Board’s website](#).

Public consultation on cosmetic surgery

The Board received a large response to the recent public consultation on cosmetic medical and surgical procedures with more than 550 submissions.

The consultation asked for feedback on four options, including draft *Guidelines for registered medical practitioners who provide cosmetic medical or surgical procedures*.

Submissions came from a wide range of stakeholders including medical colleges, professional associations, medical insurers, clinic groups, medical practitioners, nurses who also work in the cosmetic field and patients.

The consultation has now closed and the Board is analysing the submissions – this will take some time because of the large number of submissions. The submissions will be published on the Board’s website. Before the Board can make a decision about the preferred option, it must liaise with the Office of Best Practice Regulation to ensure that it satisfies the requirements of the *COAG Principles of best practice regulation*.

The Board appreciates the time taken by the colleges and the professional societies to provide their considered feedback.

Dr Joanna Flynn AM
24 July 2015
The Australian Indigenous Doctors’ Association Report to the Committee of Presidents of Medical Colleges (CPMC) Meeting
6 August 2015

The Australian Indigenous Doctors’ Association (AIDA) is dedicated to the pursuit of leadership, partnership and scholarship in Aboriginal and Torres Strait Islander health, education and workforce, and is committed to achieving positive outcomes for Aboriginal and Torres Strait Islander medical students and doctors across the medical education and training continuum.

1. AIDA’s activity with Medical Colleges

AIDA values the continuing high level of engagement it has with the CPMC and individual Medical Colleges. This year a number of initiatives are continuing to progress between staff within respective organisations, including: scholarships to Medical College annual conferences; training posts; information sharing; and promoting the need to provide trainees with access to mentoring. Since our last report, highlights are summarised below.

**Australasian College for Emergency Medicine (ACEM)**
- The AIDA board endorsed the ACEM Aboriginal and Torres Strait Islander Module for the Emergency Medicine Diploma.
- AIDA is working with ACEM and RANZCP on a joint workshop for AIDA 2015.

**Australian College of Rural and Remote Medicine (ACRRM)**
- AIDA is working with ACRRM on a skills workshop for AIDA 2015.

**Australian and New Zealand College of Anaesthetists (ANZCA)**
- AIDA worked with ANZCA on promoting a bursary program to support AIDA members to attend the ANZCA Annual Conference in May 2015.
- AIDA is working with ANZCA on a skills workshop for AIDA 2015.

**Royal Australian College of General Practitioners (RACGP)**
- The AIDA and RACGP mentoring program was formally launched on 18 March 2015.
- AIDA provided a submission to the RACGP on the governance review and review of Practice Based Assessment.

**Royal Australasian College of Surgeons (RACS)**
- AIDA is a key partner with RACS on Phase 3 of the Niche Portal project that will develop new appropriate content, enhance user experiences and learning outcomes, promote the Portal to the target audience via a variety of approaches and capitalise on the benefits of new technologies and social media applications.
- AIDA is in discussions with RACS re developing tutorials for their Simulation Bus and J Doc presentation at AIDA 2015.

**Royal Australian and New Zealand College of Psychiatrists (RANZCP)**
- Dr Tammy Kimpton and Dr Kali Hayward, AIDA’s President and Vice President respectively, gave a 90 minute presentation at the RANZCP Annual Scientific Congress in Brisbane. This presentation “The arts are a powerful tool working inter-culturally” was well attended and received by the delegates at the Congress.
- AIDA is working with RANZCP on a joint presentation at the sixth biennial LIME Connection to be held in Townsville from 11-13 August 2015. AIDA and the Medical Deans of Australia and New Zealand (Medical Deans) co-auspice this event under our joint collaboration agreement.
- AIDA is working with RANZCP and ACEM on a joint ICE management workshop for AIDA 2015.
Other Engagement

2. **Rural Doctors Association of Australia (RDAA)**
   - AIDA is working with the Rural Doctors Association of Australia (RDAA) on the 2015 Rural Health Bursary that is being provided by MDA National as part of its sponsorship arrangement with RDAA.

3. **Medical Deans of Australia and New Zealand (Medical Deans)**
   - AIDA published a joint MJA editorial with the Medical Deans in July on the Collaboration Agreement as part of our 10 year celebrations.
   - AIDA will be further acknowledging and celebrating ten years since the inaugural Collaboration Agreement with the Medical Deans, by launching the new Collaboration Agreement at the LIME Connection VI to be held in Townsville this August.

4. **Australian Medical Council (AMC)**
   - AIDA is represented on the newly established AMC- Indigenous Planning Advisory Group (IPAG) and has participated in and contributed to all IPAG meetings held this year.
   - Provided a submission to the AMC's review of the education, training and professional development provided by the College of Intensive Care Medicine of Australia and New Zealand.
   - Provided a submission to the consultation process being undertaken by the AMC of their accreditation standards for Specialist Medical Colleges.

5. **Australian Medical Students’ Association (AMSA)**
   - AIDA is working with AMSA to review and endorse their policies relating to Aboriginal and Torres Strait Islander health and Aboriginal and Torres Strait Islander Medical Student Recruitment and Retention.

6. **AIDA 2015**

   AIDA’s signature professional networking event (AIDA 2015) will be held this year in South Australia on 16 - 19 September 2015. The theme for AIDA 2015 is *Collaborate, Communicate and Celebrate*, which reflects the importance of collaboration and partnership in the work we do, and within the Aboriginal and Torres Strait Islander health sector more broadly.

   We hope AIDA 2015 will connect and inspire our members and key stakeholders to maintain the momentum and grow more Aboriginal and Torres Strait Islander doctors. Along with the overall program AIDA warmly welcomes and encourages all Medical Colleges to attend the following activities:

   - **Growing our Fellows Workshop**
     The aim of this workshop is for each representative to provide a College overview and participate in a facilitated discussion with delegates. To support this session, we ask colleges to provide a brief handout incorporating a College overview, pathway to fellowship, support systems, membership benefits and career opportunities, as well as any specific initiatives or programs that target Aboriginal and Torres Strait Islander trainees. This handout is a valuable resource to AIDA members who may not be able to attend the event.

   - **AIDA - CPMC IHSC Working Dinner**
     AIDA 2015 provides the opportunity to convene the CPMC-IHS meeting face to face, as it is anticipated that many IHS members will be present for the GOF Workshop. As always, we look forward to working with all Medical Colleges on this event. A letter of invitation was distributed in May 2015 and registration has recently opened.
**Australian atlas of healthcare variation**

Variation in healthcare use and medical practice has been observed for decades around the world. Variation not related to patient need or preference, termed ‘unwarranted variation’, raises serious questions about quality and appropriateness of care, as well as equity, efficiency and value.

The Commission is undertaking a program of work, partly funded through its core work program and partly funded as a specific project by the Commonwealth, to investigate and analyse healthcare variation in areas of interest to all Australian governments.

This work is being conducted over three years and will result in production of an *Australian atlas of healthcare variation* (in both printed and web based formats). Importantly, it will be accompanied by strategies and resources aimed at improving appropriateness of care and reducing unwarranted clinical variation. The first edition atlas will be a catalyst for generating questions and deliberation by health services, consumer groups, Colleges and government, and for ongoing work (such as a second edition of the atlas and action on priority areas).

The first edition atlas will contain 37 data items distributed across seven chapters:
- Antimicrobial dispensing (sample data spread at Attachment 1 - D15-13371)
- Chronic disease
- Mental health and psychotropic medicines
- Care of older people
- Surgical interventions
- Pathology and diagnostics
- Pain management.

In addition to the data spreads and clinical commentary in these chapters, the atlas will comprise an introduction, discussion, priority next steps, plain language guidance for the reader in interpreting the data as it is presented in the maps and graphs, and an accompanying technical supplement.

Consultation with Colleges and relevant specialist groups will occur both through the formal College nominees on the Atlas Advisory Group, and through direct contact and briefings on the analyses with relevant College Presidents and Chairs of specialist groups between July and September 2015. Data spreads are being sent to Colleges to enable such discussions. The report recommendations will also consider synergies between the atlas and related activities, such as *Choosing wisely* and RACP’s *Evaluating evidence, enhancing efficiencies* (EVOLVE) program. Dr Matt
Anstey is a member of the NPS Choosing Wisely Advisory Group as well as the Atlas Advisory group.

The timelines now mean that formal endorsement by Colleges of the paper-based version of the atlas is not possible. However, the Commission will seek these endorsements for the interactive web-based version for release in May 2016.

Publication of the atlas is now planned to occur in mid-October, with an official launch provisionally planned in early-mid November 2015. The Commission anticipates significant interest and has a media strategy and communications plan in development to promote engagement with the Colleges, professional bodies, consumer groups, senior clinicians, and states and territories leading into and upon release of the atlas.

The Commission is considering a range of options for implementation, based on the data presented in the atlas. In some instances, further data analysis will be required to provide a better understanding of the issues (e.g. public/private splits for data about interventional procedures). In other instances, local investigation and follow up will be necessary where there are clear outliers in the data. The Commission anticipates that in some areas there will be advantages in a national approach.

Information on health service accreditation assessments reported to the Commission by accrediting agencies for January to April 2015 has been collated.

184 accreditation assessments took place in the period January to April 2015, all of which were assessments of individual health service organisations. To date 83% of the 1,440 services to undergo assessment during 2013 to 2016 have been assessed.

- In the period January to April 2015, 85% of health service organisations (and 84% of health service clusters) met all core actions at initial assessment.
- 15% of health service organisations (and 16% of health service clusters) had core actions that needed to be re-assessed within 90 days.

The January to April 2015 results represent a 21% improvement on the same period last year for both individual health services and health service clusters.

The Commission initiated this project in December 2014, at the request of the National Aboriginal and Torres Strait Islander Health Standing Committee, to use the National Safety and Quality Health Service (NSQHS) Standards to leverage improvements in care provided to Aboriginal and Torres Strait Islander people. National consultation for this project is complete, and mapping has been undertaken against the existing NSQHS Standards. Future actions include the completion of a literature review and for actions to be included in Version 2 of the NSQHS Standards.

On 24 April 2015, the Commission released the Guide to the NSQHS Standard for health service organisation boards. The guide outlines the roles boards play in ensuring safe and high quality care in health service organisations, in the context of the NSQHS Standards. The guide was developed primarily as a resource for smaller boards and boards in rural health service organisations.
The Commission has commenced the review of the NSQHS Standards and the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme, with completion expected in 2017/18. Initial analysis of the performance of Version 1 of the NSQHS Standards has now been collated, including feedback from focus groups with 450 health professionals nationally.

The draft Version 2 of the NSQHS Standards is being developed with the support of technical working groups, program committees and the NSQHS Standards Steering Committee.

Consultation and piloting of the draft Version 2 of the NSQHS Standards are scheduled to commence in August and be completed by December 2015.

The consultation process will involve:
- publication of the draft Standards on the Commission’s web site and a call for written submissions;
- focus groups with clinicians, consumers and representatives from health service organisations;
- surveys of health service organisations, owners, jurisdictions, and other interested organisations and individuals.

The Commission is also planning to pilot the draft Version 2 of the NSQHS Standards with health service organisations and accrediting agencies. Three levels of engagement are available to pilot sites depending on the resources available to a health service organisation.

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<td>Option 1</td>
<td>Completion of a survey focusing on the implementation issues associated with Version 2 of the NSQHS Standards</td>
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<tr>
<td>Option 2</td>
<td>Completion of a survey focusing on the implementation issues associated with Version 2 of the NSQHS Standards Completion of a self-assessment against Version 2 of the NSQHS Standards. This could include all standards or a selected number of standards that the health service organisation may wish to focus on.</td>
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<td>Option 3</td>
<td>Completion of a survey focusing on the implementation issues associated with Version 2 of the NSQHS Standards Completion of a self-assessment against Version 2 of the NSQHS Standards Participation in an external onsite assessment by an approved accrediting agency against Version 2 of the NSQHS Standards</td>
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In May 2015, the Commission reported on a project undertaken in collaboration with the Royal Australian College of General Practitioners (RACGP) to review the quality of general practice accreditation. The RACGP and the Commission have agreed on a governance and reporting framework for general practice accreditation. The framework outlines roles and responsibilities of organisations involved in the accreditation of general practices in Australia. It also outlines the data to be collected and reported from general practice accreditation and approval process for accrediting agencies to assess to the RACGP Standards.
Feedback on the proposed scheme is being sought through a public consultation process that commenced in July with the release of a consultation paper. The feedback from the consultation will inform the final model general practice accreditation scheme.

A report to the Department of Health on the outcomes of the General Practice Accreditation project is being drafted.

The Joint Working Party between the Independent Hospital Pricing Authority (IHPA) and the Commission has continued to investigate pricing for safety and quality. The Sub-Committee on Best-Practice Pricing for Clinical Quality Information has explored best-practice pricing and ways to provide hospital-level information on safety and quality to clinicians (in the specified clinical domain of hip fracture care).

Sub-committee members met four times in 2014/15 to discuss options to design and implement best-practice pricing for hip fracture care in Australia. The work was informed by domestic and international consultations, a review of literature and analyses of national activity and cost data. The sub-committee has written a report that recommends that IHPA develop a national best-practice price that incentivises care that aligns with the Commission’s Hip Fracture Clinical Care Standard (CCS). The CCS has been distributed for community consultation in May 2015.

In their June meeting, the Joint Working Party endorsed the sub-committee’s recommendations report. The recommendations will be presented to the Commission Board and IHPA Board in August 2015.

There is currently no nationally consistent surveillance of surgical site infections (SSI) in Australian Hospitals. The development of a SSI surveillance guide will assist health services in providing evidence to demonstrate compliance with NSQHS Standard 3: 3.2: Surveillance for healthcare associated infections.

The Commission has commenced work on the development of a surveillance implementation guide for surgical site surveillance using the Centres for Diseases Control (CDC) National Healthcare Safety Network (NHSN) definitions and methodology. A survey undertaken in 2014 identified that most jurisdictions were using (or planning to adopt) the NHSN definitions.

The SSI implementation guide for the surveillance of SSI will include: establishing the purpose of surveillance for SSI; an agreed case definition outlining the inclusions and exclusions for SSI surveillance; how to apply the case definition; calculation of SSI rate; selection of procedures for surveillance; risk adjustment; post-discharge surveillance; case studies/examples; confirming SSI: case review and case validation; and benchmarking.

The Commission has been requested to lead the development of a national antimicrobial resistance (AMR) and antimicrobial usage (AU) surveillance system. This work is referred to as the Antimicrobial Use and Resistance in Australia (AURA) Surveillance System Project.

The AURA Surveillance System will support the Commission’s NSQHS Standard 3: Preventing and Controlling Healthcare Associated Infections, and operate within the

The establishment of the AURA Surveillance System involves eight concurrent streams of work; passive and targeted surveillance across the hospital and community settings, for both AMR and AU. The AURA Surveillance System will use existing surveillance programs as the foundation to enhance surveillance and analysis capability of AMR and AU nationally. The AURA Project consists of the key components detailed below.

**National Antimicrobial Prescribing Survey**

Following last year’s successful 2013 National Antimicrobial Prescribing Survey (NAPS), the Commission is continuing work with the Royal Melbourne Hospital on the results of the 2014 survey. NAPS is a standardised auditing tool designed to assist healthcare facilities to assess the appropriateness of the quantity and quality of antimicrobial prescribing. Data collection for the 2014 survey opened in October 2014 and closed in February 2015. At the time of its closing, 426 individual hospitals had registered, with 248 of those hospitals contributing to the data. Of these, 197 were public hospitals and 51 were private.

The findings of the key indicators were similar between 2014 and 2013 surveys. In 2014, approximately one-quarter (24%) of prescriptions were non-compliant with guidelines and 23% were deemed to be inappropriate. Surgical prophylaxis remains a significant concern, with 40% of these prescriptions assessed as inappropriate, mainly due to incorrect duration and dose, and absence of an indication for an antimicrobial. As a result of this finding, the Commission is in discussions with the Royal Australasian College of Surgeons with the goal of improving the appropriate use of antibiotics for surgical prophylaxis.

The findings of the 2014 NAPS were recently published in the *Antimicrobial prescribing practice in Australian hospitals: results of the 2014 national antimicrobial prescribing survey*; an electronic version of this report is available on the Commission’s web site.

**National Antimicrobial Utilisation Surveillance Program**

As part of building more broadly-based surveillance, the Commission has engaged SA Health to develop a more comprehensive 2014 National Antimicrobial Utilisation Surveillance Program (NAUSP). NAUSP provides national data on AU in 129 adult acute care hospitals, which includes 111 public and 18 private hospitals; all states and territories are represented in the program.

2014 NAUSP showed that the usage rates vary considerably between hospitals for some antimicrobials, providing the contributing hospitals with detail to assess usage rates against peers. The data also showed that Australian usage rates continue to be greater than in the Netherlands and Sweden, and on par with Denmark (being the only countries with comparable data).

The findings of the 2014 NAUSP were recently published in the *Antimicrobial use in Australian hospitals: 2014 report of the national antimicrobial utilisation surveillance program*; an electronic version of this report is available on the Commission’s web site.
Standardised definitions of ‘resistance’ and susceptibility testing methodology for laboratories

The Commission is working on definitions of resistance as they relate to the AURA Surveillance System and to promote standardisation of susceptibility testing approaches in use by Australian laboratories. The Commission continues to liaise closely with key organisations including the National Pathology Accreditation Advisory Council (NPAAC) and the Royal College of Pathology of Australasia (RCPA) to implement a standardised susceptibility testing methodology for AMR against international standards.

Targeted AMR surveillance systems

As part of developing the AURA Surveillance System, susceptibility data on isolates identified as AURA Priority Organisms will be collected from existing targeted programs, supported by jurisdictions and the Department of Health. These programs include the National Neisseria Network (NNN) and the Australian Group on Antimicrobial Resistance (AGAR). The Commission is working with these groups, and the Department of Health, to identify the most appropriate method for integrating annual susceptibility data into the AURA Surveillance System for *Staphylococcus aureus*, *Enterococcus* species, *Enterobacteriaceae*, *Mycobacterium tuberculosis*, *Neisseria gonorrhoeae*, and *Neisseria meningitidis*.

National Alert System for Critical Antimicrobial Resistances

The Commission will develop a National Alert System for Critical Antimicrobial Resistances (NASCAR) to allow for the early recognition and communication of critical antimicrobial resistances (CARs) across Australia. The resulting heightened awareness of CARs through NASCAR would lead to earlier identification of possible spread, and enable action at the local level; jurisdictional levels; and national level.

The Commission is consulting with state and territory clinicians and experts, the Public Health Laboratory Network and the private laboratory sector on the establishment and operation of NASCAR. Feedback continues to be supportive of the initiative, and those consulted acknowledged the need for a formalised alert network to enable early recognition and communication of critical AMR.

Partnership between the Commission, Queensland Health and other states and territories to enhance passive AMR surveillance

The Commission is working with the Queensland Health OrgTRx system to enhance passive AMR surveillance.

The Australian Capital Territory (ACT) and Tasmania have pilot sites and are scheduled to complete the pilots by September 2015.

Pharmaceutical Benefits Scheme

The Commission has been working with the secretariat of the Drug Utilisation Sub-Committee (DUSC) of the Pharmaceutical Benefits Advisory Committee to obtain historical data and subsequently access to data from the Pharmaceutical Benefits Scheme (PBS). The PBS captures approximately 90% of all community antimicrobial use in Australia.

The DUSC recently published a detailed analysis of AU data from the calendar year 2013 (www.pbs.gov.au/info/industry/listing/participants/public-release-docs/antibiotics-oct-14-feb-15). The Commission has applied to the External Request Evaluation Committee of the Department of Human Services for PBS data on antimicrobials for the years 2005 to 2014 to form the baseline trends. Methods for how the Commission can have ongoing access to PBS data are under discussion.
The National Patient Blood Management Collaborative (the Collaborative) commenced in May 2015 following a competitive expression of interest process where 46 applications were received. Eleven health services, some of which are the result of partnerships between two applicants, were included in the Collaborative and include public, private and not-for-profit health services from metropolitan and rural areas. Subsequently, a large private hospital requested to be included in the final participating cohort, with no cost to the Commission.

The approved Collaborative participants are:

An orientation session for approved health services and members of the Patient Blood Management (PBM) Project Reference Group, and Expert Panel was held with the Commission’s Project Team and the Improvement Foundation in May, by webinar. The session covered the Collaborative methodology; key aspects of PBM; the Collaborative aim and change principles; measuring for improvement; the model for improvement; and an overview of the Program. The Orientation is available by qiConnect and also by YouTube – www.youtube.com/watch?v=uxiyMeg6M38.

A training session for project coordinators was held in May 2015, where participants were introduced to the Collaborative methodology, change principles, the model for improvement, PBM measures, data collection, submission and qiConnect, and building the network team. This was followed by the first learning workshop for teams participating in the Collaborative.

The learning workshops are an integral component of the Collaborative to ensuring that the Collaborative teams share ideas for improvement, measure and benchmark
outcomes, and contribute to the future direction of best practice. Teams will develop and trial strategies, new initiatives in clinical practice and organisation of services locally that promote PBM. Teams will come together to share knowledge on the actions and processes used to make change, and discuss outcomes and impacts on patients and their health service.

A comprehensive Participant’s handbook was prepared as a resource for the Collaborative and aims to provide a starting point for participants in addressing the challenges faced in delivering improvements in the quality of care for patients in regard to PBM. It combines evidence-based guidance with practical examples drawn from the field. It provides an introduction to the Collaborative and information about the support that participants will receive and how they can gain the most benefit from the Collaborative.

The Commission will monitor progress of sites using data entry and input of PDSAs (based on the PDSA – Plan Do Study Act – model for quality improvement) into qiConnect site, which is an interactive web portal designed for teams participating in the Collaborative to:

- input Collaborative data collected about elective procedures performed
- receive regular feedback graphs on data submission
- check how the team’s performance changes over time
- compare a team’s performance with other teams participating in the Collaborative
- log PDSA cycles
- participate in discussions, share resources and information.

Feedback graphs are accessible on qiConnect, and available for viewing within a few minutes following a successful data submission. Measures are displayed in such a way that makes it able to track improvements over time.

A project has been undertaken by the Commission to develop resources that will support a reduction in radiation exposure to children from CT scans. The project was funded by the Department of Health following a national Round Table convened by the Commonwealth’s Chief Medical Officer, Professor Chris Baggoley. The Round Table was convened to consider the release of an Australian study, led by Professor John Mathews, which linked the ionising radiation used in CT scans in childhood to a slight increase in developing cancer later in life.

The project, to produce a range of resources, has been undertaken in consultation with states and territories; the Australian Radiation Protection and Nuclear Safety Agency (ARPANSA); medical colleges; professional bodies; and peak groups that work in the area of child health. The resources are directed at influencing decisions at a number of points across the patient journey, and including parents and carers in this approach.

The project is now nearing completion and a national workshop is being planned to showcase the resources and the learnings from the Project. The resources include:

- parent and carer brochure designed to support requesters to explain the benefits and risks of the procedure
- A3 poster for GPs and medical imaging practice waiting rooms, with the aim being to raise awareness of the associated issues
- fact sheet for referrers, reminding them of the benefits and risks and the importance of considering alternative imaging options
oral health CT brochure to support dental health care professionals in explaining the benefits and risks of a cone beam CT scan

internet landing page, hosted with Health Direct Australia, to support coordinated access to information for consumers, requesters, medical imaging service providers and oral health care practitioners.

A public summary of the project’s findings is also expected to be released in September 2015.

Insulin chart pilot

The Commission concluded a pilot of a national insulin chart in 2014. The intent of the chart is to optimise insulin prescribing and the management of diabetic patients in hospitals by standardising safety features.

The form was evaluated positively and improved monitoring of blood glucose levels (BGLs), but the pilot demonstrated an increase in the number of missed doses, and in BGLs in the upper range of 12-20 mmol/L.

Further design work was undertaken, and the chart was

- revised by an expert advisory group, chaired by Queensland endocrinologist Dr Merryn Thomae
- subjected to a detailed human factors analysis by the Queensland Health Clinical Skills Development Centre (University of Queensland).

The pilot of the revised chart was reviewed in the April and pilot sites identified. The Commission is liaising with those hospitals with regard to participation in the pilot, and to support ethics committee reviews. The pilot will last five months. A spreadsheet has been developed to support local data collection, and training and education material developed. Baseline, end-of-pilot and qualitative data will be analysed in December 2015 and January 2016, with a view to issuing a national chart in 2016.

Priority setting for the development of clinical practice guidelines

The Commission and the National Health and Medical Research Council are seeking to develop a coherent national approach to the selection, funding and development of clinical practice guidelines in Australia. The Commission’s focus in this work is on prioritisation.

The Commission has commenced a Prioritising National Clinical Practice Guideline Development project to develop a prioritised list of clinical practice guidelines for Australian development. The first phase of the project was completed in 2014 and delivered a list of criteria to be used to prioritise the future development of national clinical practice guidelines. The criteria were endorsed by the Australian Health Ministers’ Advisory Council (AMHAC) in November 2014.

The AMHAC-endorsed criteria for prioritising national clinical practice guideline development are:

1. The clinical area has the potential to significantly benefit the quality of patient/consumer care and health outcomes
   AND

2. The clinical area is:
   a) high prevalence or represents a significant burden of disease (especially for high health needs or vulnerable populations) and / or
b) imposes high costs on health service funders, users (consumers/patients/carers), service providers, insurers and any opportunity costs incurred (i.e. consider the trade-off between the benefits achieved from assigning resources to the development of one particular guideline and the potential consequences for not supporting another) and/or

c) is a Government health priority topic.

AND

3. There is potential to:
   a) reduce risks and harms to consumers/patients/health service users, and/or
   b) reduce unwarranted variation in prevention, diagnosis or treatment, and/or
   c) derive better quality and value care by reviewing treatments that may be over-utilised, under-utilised or of low value and/or
   d) provide evidence-based advice in areas where there is new care, rapid change, uncertainty about clinically-effective and cost-effective care, inappropriate practice or contested evidence.

AND

4. There are no other current, valid or relevant guidelines available or applicable to the Australian context.

The next stage will be to produce a concise list of priority topics for national clinical practice guideline development. This list would be used to guide funding and other decisions relating to the creation of new clinical practice guidelines. In addition, a proposed process for developing future iterations of the list will be developed.

   ect ha e

1. Refine the initial list of priority topics and the proposed process (including nomination form) following consultation with the jurisdictions (June 2015).
2. Undertake broad consultation of the initial priority list with the sector, jurisdictions and partner organisations, including an online survey and a series of workshops to review the list and the proposed process.
3. Review and revise the priority list and proposed process following consultation.
4. Seek AHMAC and Council of Australian Governments (COAG) Health Council approval of first prioritised list and discussion of the proposed process for future iterations of the priority list. It is anticipated that this process would be repeated or reviewed periodically (every three to five years) to ensure the priorities are still appropriate and relevant.
CPMC Report
6 August 2015

Apologies from the CEO for this meeting

HOT ISSUES

Intern Review
Like others Medical Deans has been consulted during the review and we have provided further verbal feedback. Medical Deans has stressed that it is very keen to work collaboratively with all stakeholders, particularly health care providers to ensure the product leaving medical school is consistent across schools and work ready for PGY1. Medical Deans will continue to implement a number of key performance benchmarking and collaboration activities including the projects listed below to ensure school's graduates are of high quality regardless of what medical school or program they are from.

Progressing Quality Assurance Collaborations with AMC
As noted previously, AMC and Medical Deans are working together on 2 projects to assist in developing capacity for robust assessment and analysis. AMC will hold the first of its clinical training workshops for new clinical academics from our member schools on Saturday 25 July in Melbourne. Meetings will also begin with the 13 medical schools who are participating in a pilot written assessment item sharing and benchmarking project.

Collaboration with AIDA
Following the outcome of the positive review of the 20112-15 Medical Deans and AIDA will be signing a new 2016-18 Collaboration Agreement on August 10 in Townsville.

5 Year National Data Report
Medical Deans hopes soon to publicly release a 5 year trend data report on the findings of over 12,700 final year Australian medical students from 2010 to 2014 taken from the MSOD surveys. Over 82% of final year students participated in these surveys. We thank the Commonwealth for funding this important workforce planning tool.

Graduate outcomes similar across Australia and New Zealand
For the first time Medical Deans, funded by the Commonwealth, undertook an assessment benchmarking project in 2014 examining the performance of final year medical students in all medical schools in Australia and New Zealand. Data from 19 out of the 20 consenting schools showed consistent performance across all schools when using standardised multiple choice questions in final or penultimate year exams. (data were not available from one school).

MEDICAL DEANS UPDATES

Announcement of new Executive
Medical Deans appointed its new Executive Committee at its recent AGM in Canberra. A link to the Press Release is provided http://www.medicaldeans.org.au/a-new-leadership-team-for-medical-deans/
Announcement of new CEO


There will be a news piece in the Aug 3 edition of the MJA.

New Sydney offices

Medical Deans main office has finally moved. We can now be found at:

Level 3, 261 George Street, Sydney NSW 2000
Ph +61 2 8084 6557
[www.medicaldeans.org.au](http://www.medicaldeans.org.au)

Our LIME Network team are still based in the University of Melbourne offices.

The June newsletter is now available

This can be found at:

MSOD and Data Linkage Project update

Medical Deans is progressing work on the new MSOD and Data Linkage project funded by the Department of Health for a further 2 years. Next steps include the establishment of cross-agency governance and technical groups to oversee the data linkage phase. Medical Deans continues to recruit final year medical students to the MSOD via a revised online survey. 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](http://www.medicaldeans.org.au/exciting-workforce-planning-development-medical-schools-outcomes-database-to-realise-its-potential-through-data-linkage.html)

LIME Network update

A new Deed of Variation has been executed with the Department of Health to fund Medical Deans to continue the work of the LIME Network for a further 12 months until 30 June 2016.

UPCOMING EVENTS

- Signing of the AIDA_Medical Deans 2016-18 Collaboration Agreement, Townsville, 10 August 2015
- LIME Connection VI Conference – Townsville, 11-13 August 2015

Professor Nicholas Glasgow
President, Medical Deans

Professor Judy Searle
CEO, Medical Deans
Confederation of Postgraduate Medical Education Councils (CPMEC)

Briefing for Committee of Presidents of Medical Colleges (CPMC) Meeting – 6th August 2015

We would like to highlight the following developments in prevocational medical education and training:

1. **Review of Internship**
CPMEC membership has been closely involved in consultations with the Intern Review Team and made written submissions on the Discussion Paper and the Options Paper.

We believe that the most urgent need is to establish and implement a national curricular framework based on the Australian Curriculum Framework for Junior Doctors (ACF). The next review of the ACF (scheduled for later this year) is an opportunity to address perceived gaps in prevocational experience and to develop learning resources to support the educational goals of prevocational training, including national dissemination of many existing high quality materials produced for local use. It is also an opportunity to develop a national consensus approach to post-PGY1 prevocational curricula by better integration with College curricula, particularly for generic components.

2. **Changes to CPMEC Structure**
CPMEC has broadened its Board structure to allow for the appointment of independent Directors to have a more broader-based representation of the prevocational medical education and training community.

3. **Prevocational Accreditation**
CPMEC has developed a database of interstate surveyors for Postgraduate Medical Councils to utilise in their accreditation surveys as appropriate.

This briefing can be made available to all attendees at the CPMC meeting.

*A/Prof Terry Brown, Chair, CPMEC – 28th July 2015*
COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES

Minutes of the 110th meeting of the
Committee of Presidents of Medical Colleges

Held at Parliament House
Parliament Drive, Canberra ACT
Thursday 14 May 2015

Present
A/Professor Michael Hollands Chair
A/Professor Stephen Shumack President, Australian College of Dermatologists
Dr Anthony Cross President, Australasian College for Emergency Medicine
A/Professor Lucie Walters President, Australian College of Rural and Remote Medicine
Dr Genevieve Goulding President, Australia and New Zealand College of Anaesthetists
Professor Bala Venkatesh President, College of Intensive Care Medicine
A/Professor Frank Jones President, Royal Australian College of General Practitioners
Dr Lee Gruner President, Royal Australasian College of Medical Administrators
Professor David Watters President, Royal Australasian College of Surgeons
Professor Michael Permezel President, Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Professor Malcolm Hopwood President, Royal Australasian College of Psychiatrists
A/Professor Chris Milross President, Royal Australia and New Zealand College of Radiologists
A/Professor Peter Stewart President, Royal College of Pathologists of Australasia
Dr Catherine Yelland replacing Professor Nicholas Talley, President, Royal Australasian College of Physicians
Dr Brad Horsburgh replacing Mark Daniell, President, Royal Australian and New Zealand College of Ophthalmologists

CEOs of Medical Colleges:
A/Professor David Hillis CEO, Royal Australasian College of Surgeons
Mr Tim Wills CEO, Australian College of Dermatologists
Ms Alana Killen CEO, Australasian College for Emergency Medicine
Ms Marita Cowie CEO, Australian College of Rural and Remote Medicine
Ms Linda Sorrell CEO, Australia and New Zealand College of Anaesthetists
Mr Phillip Hart CEO, College of Intensive Care Medicine
Dr Zena Burgess CEO, Royal Australian 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 Australian and New Zealand College of Obstetricians and Gynaecologists
Mr Mirco Kabat Royal Australia and New Zealand College of Psychiatrists
Dr Debra Graves CEO, Royal College of Pathologists of Australasia
Dr David Andrews CEO, Royal Australian and New Zealand College of Ophthalmologists
Ms Michelle Thompson CEO, Australasian College of Sports Physicians
Ms Natalia Vukolova CEO, Royal Australian and New Zealand College of Radiologists

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

CPMC Minutes of 110th meeting held 14 May, 2015
**Profession Observers**

Dr Andrew Singer  Principal Medical Advisor, Acute Care Div. Department of Health  
Professor Robin Mortimer  President, Australian Medical Council  
Mr Ian Frank  CEO, Australian Medical Council  
Dr Brian Owler  President, Australian Medical Association  
Ms Anne Trimmer  Secretary General, Australian Medical Association  
Professor Peter Smith  President, Medical Deans Australia and New Zealand  
Professor Judy Searle  CEO, Medical Deans Australia and New Zealand  
Dr Brian Owler  Principal Medical Advisor, Therapeutic Goods Association  
Ms Nicola Dunbar  replacing Professor Villis Marshall, Chair, Australian Commission on Safety and Quality in Health Care

1. **WELCOME AND INTRODUCTION**

1.1 **Apologies**

At 9am Professor Michael Hollands welcomed all attendees to the meeting. Apologies were received from Professor Nick Talley (RACP), Dr Michael Jamieson (ACSP), Professor Chris Baggoley (Commonwealth), Dr Joanna Flynn (MBA), Martin Fletcher (AHPRA), Professor Anne Kelso (NHMRC), Dr Tammy Kimpton (AIDA), and Professor Villis Marshall (ACSQH). Members noted this was the 110th meeting of the CPMC, and the Chair recognised the traditional owners of the land, the Ngunnawal People.

1.2 **Conflicts of Interest and Confidentiality**

Members were asked to declare any conflicts of interest, and no declarations were made.

1.3 **Other issues**

No other issues were raised.

2. **REPORTS**

2.1 **Committee of Presidents of Medical Colleges**

Professor Hollands informed members he had met with Minister Sussan Ley’s advisor James McAdam. In this meeting, the Chair advised that CPMC would deliver a written submission to the National Review of Medical Intern Training, noting that workforce modelling was an issue of importance for CPMC. The Chair advised Mr McAdam that the movement of the Rural Health Continuing Education (RHCE) Program from CPMC to Primary Health Networks (PHNs) was inappropriate, that it is a valuable program and will be lost within PHNs.

Professor Hollands also discussed revalidation at the meeting, and how CPMC is working with Dr Joanna Flynn and AHPRA around common definitions and terms. The Chair noted that the issue of whether Continuing Medical Education (CME) is being conducted in an appropriate fashion by Colleges would also be discussed in the near future.

2.2 **Australian Medical Council**

Professor Robin Mortimer spoke to his report. The AMC will hold its next meeting in Toowoomba, QLD. The AMC occasionally meets in rural setting, which provides a good opportunity to see what issues there are on the ground. Ms Magarry has been invited to this meeting.

The National Registration and Accreditation Scheme (NRAS) review has been completed and a report provided to the AMC in April. Discussion about the report’s recommendations will occur later in the year. It is likely the AMC will remain with the Medical Board as a single discipline-specific regulatory system.

CPMC Minutes of 110th meeting held 14 May, 2015
Several items regarding accreditation were discussed, including the idea that the cost of accreditation should be met by those accredited, recognition that the current fees are not equal to the total cost of accreditation, and that 3% of the AHPRA budget goes into accreditation. Members noted the present extensive review of accreditation standards is coming to completion with no significant surprises.

The AMC has been working with MDANZ on benchmarking for medical schools – a project that was defunded when Health Workforce Australia (HWA) was moved into the Department of Health. While the project is not continuing, MDANZ and AMC are discussing making the AMC’s calibrated item bank available to medical schools as an alternative to the benchmarking model. 12 out of 21 schools are currently willing to participate.

The AMC hosted a workshop in March on Generalism in Patient-Centred Care and its impact on Medical Education, Workforce Development and Deployment of Health Care Systems. The outcomes of this workshop will feed into a second workshop later in the year. The AMC has also undertaken some work on intra-professional education, as well as assessing medical students’ fitness to practice.

Professor Mortimer advised that the previous mechanism for recognising of medical specialties has been changed. Now an application can be made directly to the Medical Board of Australia for a decision. The Medical Board has asked the AMC to advise it on an appropriate process for recognition. It was also noted that any regulations must be approved by the Office of Best Practice Regulation.

Professor Hollands opened discussion on the cost of the accreditation process, noting that usually Colleges are 99% compliant and resources are being spent largely on the final 1%. It was also noted that looking for fault can lead to a lack of appreciation for how positive the process has been. Mr Ian Frank noted that accreditation has reached a point where it needs review, and that some recommendations will come out of the NRAS review. It is the AMC’s intention to seek advice about this issue. It was recognised that Colleges have come a long way and improvement has been dramatic.

Professor Peter Smith (MDANZ) noted that if clients have to meet the full costs of accreditation, it raises the question about what a reasonable cost to accredit a College or Medical School might be. It was noted that this may depend on how long the College or School has existed and how successful it has been with accreditation in the past.

Mr Frank noted that if accreditation is to work well, it needs to sit on top of a self-reflection process by each institution, which can make accreditation simple.

Prior to the meeting, CEOs had discussed the significant variability of assessment panels, and that some consideration could be given to a review of the training of assessment panels, or having some standards for the panels. Professor Mortimer noted that concrete examples would be useful and a path forward could be a formal piece of correspondence to the AMC. Dr Lee Gruner (RACMA) noted that this problem has existed for a while, and an effective and positive approach is for the people involved in assessment to collaborate.

Professor Smith noted that the current process for recognising medical specialties does not address what will be important for medicine in the future.
The example of genopathology was given. Dr Singer noted that this concern is a matter for ministers and political will would be required to push this agenda.

Members discussed medical students’ fitness for practice, which was an issue brought up by medical students on the AMC last year. Anecdotal reports of aberrant behaviour at medical student level prompted considerable debate and the formation of a group to consider this issue at the AMC. A key concern was that hospitals may not be advised by medical schools when students are under investigation about issues that could potentially cause harm to patients.

It was noted that medical schools are constrained by their university’s legal processes. Professor Smith advised that if an incident occurs involving a medical student at a hospital, universities are not concerned, as it is a professional issue, not an academic one. Universities are interested in whether the student is passing their exams, and medical schools need a very good case to terminate an enrolment based on professional misconduct.

The outcomes of the AMC’s Generalism workshop were summarised by Dr Hillis. Key questions that arose included what the AMC, and leaders in the health sector can do to encourage generalism. When the AMC report comes out, it will highlight the issues.

### 2.3 Chief Medical Officer

Dr Andrew Singer spoke to the Chief Medical Officer’s report and provided an overview of the budget. Significant items included:

- The review of the MBS now has a budget line item attached to it, being $34m over next 4 years. Dr Singer noted it is a wide-ranging review, and not about cuts but rather about analysing Medicare to remove areas that are not meeting people’s needs.
- Pharmaceutical Benefits Advisory Committee (PBAC) decisions have now all been included in the PBS, including drugs for late stage breast cancer and melanoma.
- The Sixth Community Pharmacy Agreements will be announced once negotiations are concluded.
- Funding will be provided for the national medical stockpile, which is a combination of drugs and protective equipment set aside for national disasters or pandemics.
- Funding is being increased for the National Critical Care and Response Centre in Darwin.
- Immunisation – the No Jab No Play policy will be implemented. Funds have also been allocated for catchup immunisations for adolescents.
- Cancer prevention – there will be new cervical screening processes, moving from pap smears to HPV test (every 5 years). Also a national screening register is being set up.
- $2.2m is being provided over 2 years to improve systems for organ donation, such as extending time off under the living donor reimbursement scheme from 6 to 9 weeks.
- The Royal Flying Doctor Service will receive more money in return for improved efficiencies.
- The Government is commencing a National Drugs Campaign via the Ice Taskforce.
- Workforce – the changes to GP training will continue to roll out. Scholarship programs are being consolidated. The Medical Rural Bonded Scholarship (MRBS) Program will cease. The 100 places from the Program will be rolled into the Bonded Medical Places (BMP) Scheme. Return of service has been reduced to one year across the board. This is on the back of 2-3 reviews that indicate that the bonding programs are poorly targeted and deliver poor outcomes, including medical students entering them without any intention of fulfilling their obligations.
- Minister Nash will make an announcement in the coming week about changes to GP rural incentives.
- The Patient Controlled Electronic Health Record (PCEHR) has been renamed ‘My Health Record’. The National E-Health Transition Authority (NEHTA) is being wound up, and the Australian Commission on e-Health will commence in July 2016. There will be a trial in some jurisdictions for an opt-out rather than opt-in system for participation in the My Health Record system. The Government is also trying to encourage practitioners to get involved.
- The Medical Research Future Fund is now being funded in ways other than a GP copayment. $10m will be provided in 2015/16 and $400m over forward estimates as the fund starts growing. The detail on corporate governance is being worked out and the NHMRC will have a role, but will not be the only player.

Dr Singer also noted the National Mental Health Commission Final Report of the Review has been released. The Government will work on the creation of a new National Mental Health Plan, and a group will be formed to implement recommendations from the Review.

There is currently an efficiency review of the functions of the Department of Health, and a restructure is likely which may include the realignment of divisions and functions.

A/Professor Lucie Walters (ACRRM) asked whether, with the adoption of the Modified Monash model for rural classification and the focus on GPRIP incentives, whether there is potential for the Government to consider junior doctor training in rural Australia. Dr Singer noted there was nothing in the Budget to suggest so, and that the matter best be progressed through the Minister.

Dr Brad Horsburgh (RANZCO) noted that the NRAS review has been submitted to MCOH and this Council will disclose the outcomes in August. He raised a concern that the medical profession has been moved into juxtaposition with boards without any oversight for scope of practice. Dr Singer advised that discussions about this have occurred with Mr Snowball and that many have concerns about how scopes of practice are administered. The most likely outcome will be that the AHMAC committee will advise on issues of scope of practice.

Prof Hollands raised a further concern regarding the AHMAC committee which because it is populated by employees of health departments rather than clinicians, the expertise of the profession is considered irrelevant.

RANZCO has a suggestion that the committee be changed to reflect a broader base of concern, and be comprised of a retired Supreme Court judge as Chair, a specialist medical practitioner, a general practitioner, chair of CPMC, a member of public, a nurse and a health economist.

Dr Singer noted that medical registration is about protection of title not scope of practice. The ministerial advisory council have a strong view in COAG that HWPC is the best place to deal with this. Usually AHMAC committees don’t involve external people.

Professor Hollands noted that there is expertise in the community that can be used to help avoid problems, rather than necessarily needing to change decisions. The profession is concerned that the expertise of the profession is irrelevant, and as a result decisions that are made don’t get implemented into the workplace very effectively.

Dr Anthony Hobbs (TGA) agreed that clinical expertise is needed in decision making, and appreciated that the AHMAC situation would be problematic from CPMC point of view.
Dr Hobbs advised that the Department of Health Secretary, Martin Bowles, is keen to improve engagement of clinicians.

Dr Singer noted that there are plenty of other mechanisms where the expertise of clinicians is being sought, and this goes hand in hand with workforce planning. He noted that there is the opportunity for clinicians to have influence regarding models of care. It was also noted that increasingly the views around using regulation as a tool is diminishing with the current government.

Professor Hollands noted that in hospital environments, people are realising that if you engage people, you can create change. Dr Hobbs noted that clinicians are currently working to provide MSAC with advice about MBS items that need review.

Professor Malcolm Hopwood (RANZCP) noted that Colleges have a strong interest in the MBS review, and asked how the structure allows for Colleges to contribute. Dr Singer advised that detail around the structure has not been worked out. The Minister has said she will be looking for clinical expertise to inform the review.

A/Professor Walters (ACRRM) queried whether the return of service requirements for existing scholarship holders will be changed with the consolidation of scholarship programs. Dr Singer advised that return of service would not change for existing holders. He also noted that ongoing support for people in bonded positions was being considered in light of connecting the medical training pipeline. A/Professor Walters declared that ACRRM would like to participate in this process.

Professor Hopwood spoke to the issue of integration of community health care, noting that the anticipated decrease in the cost of inpatient care by 2017 was optimistic. He raised concern that it is too rapid a change. Dr Singer noted that while the Commission’s response to the report had been released, the Government response had not. Professor Hopwood declared that RANZCP is keen to contribute.

Professor Jones (RACGP) noted that the changes to after-hours work were good, and it will cut the cost to the system. Dr Singer mentioned that it was not clear yet how the changes will be implemented.

Dr Anthony Cross (ACEM) asked whether the scope of the TGA would be increasing or decreasing as a result of the Medicines and Medical Devices Regulation Review. Dr Hobbs responded that the Minister is considering this currently. Submissions for the first tranche of submissions carried a strong theme of retaining the regulator. Dr Hobbs noted the TGA has a strong reputation, and he would be surprised if the scope of regulation is dramatically reduced. A second tranche of submissions is still to come.

2.4 National Health and Medical Research Council
It was noted that Professor Anne Kelso was an apology for the meeting. The report was tabled for consideration.

2.5 Medical Board of Australia
Dr Flynn was also an apology for the meeting, and the MBA Report was tabled for consideration.

2.6 Australian Indigenous Doctors’ Association
Dr Tammy Kimpton was an apology.
2.7 **Australian Commission on Safety & Quality in Healthcare**

Ms Nicola Dunbar introduced the project *Recognising and Responding to Clinical Deterioration*. The Commission is looking to encourage ongoing work in the area, and there has been a positive response from a number of Colleges. The Commission would like to discuss with Colleges how it can provide helpful information to them, with the topic of deterioration being a starting point for this.

The Commission is also working on implementation of standards, health variation, clinical care standards, and an End of Life statement which will be available in coming weeks.

Professor Hollands asked how engaged hospitals had been for the deteriorating patient work.

He noted that a key challenge is training junior medical officers who are not on an accredited program. Hospitals need resources to train junior doctors to respond appropriately to deteriorating patients. Colleges have good training programs and should be engaged in the process.

Ms Dunbar noted the Commission has been working closely with hospitals, and is supported by an advisory group made up of clinicians. Responsibility for ensuring people can provide care in line with standards is shared, which can add to the complexity.

Professor Hollands noted that intensive care high dependency services in hospitals have few resources for that group of doctors; while conversely, Colleges have excellent programs for their trainees. There needs to be resources for national programs that can be adapted for use across the country.

Dr Catherine Yelland (RACP) stated that the RACP is having discussions with the Clinical Excellence Commission (CEC) in NSW regarding the incorporation of their resources and standards into RACP curricula. It was noted that the CEC has done some good work around the deteriorating patient in NSW.

Professor Bala Venkatesh (CICM) raised the topic of rapid response teams with regard to the deteriorating patient. In Queensland, they are trying to reduce hospital Standardised Mortality Ratios (SMR) by following the Alfred Model. This includes a senior clinician in a position specifically to report directly to the rapid response team.

Ms Dunbar noted that Safety and Quality Standards are not prescriptive about the model that should be used, as they need to apply across all health services across Australia. It was recognised that there are issues around models used and resources.

Professor Hollands requested that the End of Life work be brought into the deteriorating patient work, as there is currently a disconnect between a hospital’s functional level and strategies used to develop implementation. Ms Dunbar noted that the Commission was trying to link the two areas together. The Commission will also try to achieve embedding End of Life requirements in the standards for the deteriorating patient.
A/Professor Frank Jones (RACGP) raised the danger of duplication within Colleges and societies, and the importance of recognising who the Commission’s target audience is.

Ms Dunbar stated the Commission is aware there is a lot of work happening in Colleges around End of Life, and that despite investment in End of Life over the years it still is not working effectively. This is why standards are being developed to attach to various models. The Commission is currently aiming at high policy level, and will then need to dive down to particular environments and determine how the standards can be used.

2.8 Australian Medical Association

The AMA Secretary-General, Ms Anne Trimmer spoke to the report, noting the Budget’s freeze on indexation for GPs instead of the previously proposed co-payment. The AMA hopes that if the work of the MBS review is fruitful, there might be some reduction in the freeze.

Ms Trimmer mentioned that the AMA would like to see a clinician-led MBS review, and recognised that the Compliance Review is more of a departmental review. The AMA is pleased about the last minute saving of the Australian Institute of Health and Welfare (AIHW).

Ms Trimmer noted the $1.7B in savings stated in the Budget will take a while to understand, however the AMA noted that there will be some savings arising from government discontinuity of funding peak healthcare organisations such as those relating to disease and prevention.

In April, the AMA held a Roundtable on sexual harassment in the workplace. Ms Trimmer noted that the response from doctors and trainees when the issue became public was enormous. In the report on AMA trainee survey, sexual harassment in the workplace remains an issue. Ms Trimmer noted that apart from being about the health and wellbeing of doctors, the issue also impacts the attractiveness of medicine as a profession.

Ms Trimmer mentioned that the AMA wrote to the chair of the Australian Health Ministers’ Advisory Council (AHMAC) regarding the outcomes of the Roundtable and will also write to the CPMC. A key message from the Roundtable was the need for Colleges and jurisdictions to have policies that promote the inclusion of females such as flexible employment and training opportunities. Some Colleges do this well, others do not. There is also a need for Colleges to address sexual harassment in the workplace. Some positive work is occurring in NSW Health, reaching out to young doctors on these issues and putting the right processes in place. The AMA is asking AHMAC to address the issue across the country, by utilising the success of more local programs. The Roundtable also identified that training and awareness of sexual harassment should occur in medical school.

Ms Trimmer noted that the AMA had a productive meeting with AHPRA to discuss the practitioner experience of the regulatory process.

A doctors’ health agreement between AHPRA and the AMA for national service to deliver a doctors’ health advisory service to medical students and practitioners has been signed. Ms Trimmer noted that it is an aim of the Medical Board of Australia to ensure doctors and medical students are able to access the service. There will also be supplementary services available, such as web services and helplines.
The AMA has a proposal with the Minister about an ongoing program for rural-based GP training. It was noted that when young doctors in training are exposed to community-based practice, they often decide to practise in that setting upon qualification.

Professor Malcolm Hopwood (RANZCP) noted that CPMC would like to record a formal note of congratulations on the successful Roundtable, and thanks to the AMA for its leadership on the issue of Bullying and Harassment in the workplace. It was noted that the Colleges are all genuinely interested in the issue and future developments.

Professor David Watters (RACS) noted that the issue was brought into the media by a surgeon. RACS has taken a proactive stance: setting up an expert advisory group who will conduct a study of trainee surgeons and IMGs; setting up a counselling support program where all College trainees and IMGs will receive four free consultations a year; strengthening a better complaints process; and conducting a literature review. RACS is happy to share the review when it is completed.

Professor Hollands mentioned that addressing a poorly performing medical student is a real challenge. Often the person responsible is the employee of an area health service. Getting the balance right between Colleges and employers to get a meaningful response to the issue is a challenge. Professor Watters noted that it is important that Colleges do not avoid the issue because it is a tricky one, and that this has been part of the problem in the past. He also noted that often complaints don’t come through Colleges, however it is anticipated that more will be received this way in future. Dr Gruner noted that medical administrators receive a lot of the complaints regarding medical students, and that RACMA could be a great resource in this space.

Professor Yelland noted that while the protective fall-back is the workplace, the real power comes from the training position. The risk for trainees is via the power relationships with their supervisor. Professor Yelland also mentioned the need to tackle the issue of discrimination on selection panels for training jobs.

Ms Trimmer noted that bullying and harassment is impactful on health and wellbeing of trainees, and there needs to be an integrated response.

Professor Hopwood queried whether the hospital or the College is the responsible agent. He noted that that Colleges have a role and need to be involved earlier rather than later in the process.

Mr Frank mentioned that surveys of trainees have been used for a while, and it has become apparent that processes are not enough. There’s a reluctance of trainees to be involved in the regulation process as it may impact on their future employment prospects. Specifically, speaking out may result in poorer career prospects.

Professor Hollands noted that until the perpetrator of the bullying or harassment appreciates their behaviour was inappropriate, nothing will change, and it is a challenge to effect that change. Professor Watters stated that a number of people do not realise they are doing it, and will respond to counselling and complaints. Others who are sociopathic or predator types will not respond, and they will end up being fired or in court.

Dr Gruner noted that there is a need to get senior hospital management across this issue as well, and this area needs to be invested in.
2.9 Medical Deans Australia and New Zealand

Professor Peter Smith, President MDANZ, spoke to the report, noting that an evaluation of the Rural Clinical Training and Support (RCTS) Program, from which Rural Clinical Schools are funded, is currently underway. Funding under the Program has been extended until December 2015, at which point outcomes of the review will be able to inform future funding.

MDANZ met with Minister Ley a fortnight prior to this meeting. Professor Smith indicated that the Minister was particularly interested in rural health and rural training pipelines, and had no interest in new medical schools or training new doctors. Professor Smith noted that this could be a good opportunity for Government, Colleges, medical agencies and medical schools to work together to develop that pipeline.

Professor Smith mentioned that deregulation of universities would continue to be unlikely because of opposition in the Senate. However, universities are concerned that cuts to university funding were still detailed in the forward estimates.

MDANZ is collaborating with the AMC on the issue of professionalism, and selecting the right person with the right attitudes. Professor Smith also mentioned that concerns regarding students usually relate to professionalism, in particular, sexual harassment and bullying, rather than clinical concerns.

Professor Smith raised the issue of medical students that have mental health problems. Currently it is unclear who the medical school should report this to. Confidentiality can limit the transfer of such information between agencies. There is a need to figure out how to effectively report this, and also the most appropriate way to help practitioners improve their behaviour.

The Medical Students’ Outcomes Database (MSOD) has received an additional two years’ funding. This is important as the Database tracks how student aspirations determine professional decisions later in life. Funding for the Leaders in Indigenous Medical Education (LIME) Network has also been extended.

Professor Smith noted that he will step down as President of MDANZ in June, and Professor Nicholas Glasgow, Dean, ANU Medical School is the President Designate.

Professor Bala Venkatesh (CICM) asked if there are any projections on the number of medical students coming into the system for future years. Professor Smith noted that there has been a doubling of medical school throughout in recent years, but there is no interest in increasing number of Commonwealth Supported Places (CSPs). Dr Singer noted that based on current estimates, Australia will need all the graduates coming through. The main problem will be that in the next 4-5 years there will be a relative excess while baby boomers retire. By 2025 it should balance out. The other concern is that distribution continues to be a problem. Professor Judy Searle (MDANZ) noted that the current output is 3,700 medical graduates, a number which is fairly stable. Professor Smith noted due to mal-distribution, in the future, graduates may not be able to choose the specialty they want or where they practice. This is an issue that could be addressed by the National Medical Training Advisory Network (NMTAM).

Dr Anthony Cross (ACEM) asked Professor Smith whether any new medical schools will be opened and the response was no.

CPMC Minutes of 110th meeting held 14 May, 2015
3. GENERAL BUSINESS

Introductions
Professor Hollands introduced Dr Wendy Southern, Deputy Secretary of the Department of Health.

3.1 Dr Wendy Southern – Deputy Secretary Department of Health

Dr Southern addressed the group, describing her recent arrival in the Department and background in the portfolios of Prime Minister and Cabinet, and the Department of Immigration. Dr Southern is responsible for the Population Health, Health Workforce, and Indigenous and Rural Health Divisions of the Department.

The Department is focused on Budget measures, particularly health workforce reform, relating to the recommendations of the review of health workforce programs undertaken a couple of years ago, and also Health Workforce Australia (HWA) being absorbed into the Department.

Dr Southern discussed the new consolidated scholarships program for 2016, which will bring together medical, nursing, and allied health professions. This will create efficiencies. All recipients, except those who identify as Aboriginal or Torres Strait Islander, will be required to work in a non-metropolitan area for a year. The bonded programs, the Rural Medical Bonded Scholarship (MRBS) Scheme and the Bonded Medical Places (BMP) Scheme will be combined in 2016, with their return of service period reduced to one year in an area of workforce shortage or a rural area under the Modified Monash model. The General Practice Rural Incentives Program (GPRIP) will also adopt the Modified Monash model.

Consultation with Colleges will commence regarding reforms to specialists training, as announced by the Minister earlier in the year.

New geographic boundaries have been announced for general practice regional training providers. A General Practice training advisory committee has also been announced, with appointments currently under discussion between Colleges and the Department. The Minister will appoint clinicians and the independent Chair.

Professor Hollands noted that CPMC appreciates the focus on primary health care, and questioned how the Government will be able to determine the success of the scholarships. Dr Southern mentioned that the ability to return to fundamentals is important, as is evaluation prior to changes. Also, there can be an iterative collection of information as the program processes to make changes along the way. Dr Southern stated that the Department wants to be better at evaluation, and will be establishing a better evaluation framework.

Professor Hollands asked whether the decision to scrap RHCE was irrevocable. A similar concern was voiced about scholarships, that a lot of effort has been put in, followed by a decision that dilutes the program without evidence.

Dr Southern noted that there will be objectives of governments for doing particular things which are different to the objectives when the program started. Some of the decisions are based on politics of the day, some on what has changed in the landscape.
Professor Walters (ACRRM) asked Dr Southern whether scholarship holders will continue to be supported in their professional choices. Colleges have a role in continuity of care for identity formation, and the Department should collaborate with Colleges about the development of new scholarships and subsequent implementation. Dr Southern noted that there will be time to do this.

Professor Walters also noted that there is anxiety in the bonded support scheme, the Rural Australia Medical Undergraduate Scholarship (RAMUS) Scheme, and the John Flynn Placement Program (JFPP) regarding the provision of ongoing mentorship for groups of medical students as they develop their professional identity.

Professor Jones (RACGP) noted that this is about the progression of GP training, and there is also anxiety amongst Registered Training Organisations (RTOs) about what information is being provided through to them about GP training.

Professor Hollands asked if it is absolutely decided that RHCE will be rolled into Primary Health Networks, or whether it is possible to keep it at CPMC. Dr Southern took this question on notice and discussion ensued about the value of RHCE. Mr Davidson (RHCE Manager) noted that the most recent funding round (Seven) provided about $1 million for projects that delivered CPD to rural specialists, as well as individual grants to support rural doctors attend CPD events. Mr Davidson noted that RHCE worked on the premise that rural doctors should not be penalised with a lack of CPD opportunities just because they choose to practice rurally.

**ACTION:** Ms Magarry to send Dr Southern information on the RHCE Program

Professor Hollands asked whether plain packaging was still a priority at the Department. Dr Southern noted it remains a priority, and the Government is about to begin the next phase of its anti-smoking advertising campaign. There is an area of focus around e-cigarettes, and work is underway through AHMAC regarding this, and also in making an impact on key sections of smokers, such as young women. There is a broad recognition that plain packaging is working. Dr Southern noted that the Department will have a statement on e-cigarettes once AHMAC has completed its work, hopefully by mid-2015.

Dr Yelland noted that RACP has some advocacy on e-cigarettes currently. RACP does not support e-cigarettes until more evidence is produced. Harm minimisation is also a major consideration.

Professor Watters raised the obesity epidemic. Dr Southern noted that the national strategic framework around chronic conditions is being considered by Health Ministers. The Government is also looking at the issue with the Primary Health Care Advisory Group.
3.2 The Hon Sussan Ley – Minister for Health and Sport
Minister Ley was welcomed to CPMC by Professor Hollands. The Minister acknowledged the Chair and College representatives including Ms Magarry in her address to the group, with a focus on the recent Federal Budget.

The Minister noted the re-launch of e-health as My Health Record, and continued investment in workforce through STP, the General Practice Training Program and scholarships.

Overall spending in the health portfolio will increase by $2.3 billion in the next year, as MBS and PBS costs rise and continue to be met. $34 million will be spent to review the MBS and Medicare, and a taskforce will be appointed for this purpose. The Government would like this review to be completed within four years. A scoping study on this will take place by October 2015.

$4 billion worth of listings will be taken out of the Pharmaceutical Benefits Advisory Committee (PBAC), including drugs that cure Hepatitis C, which will be listed from July 2015.

The Minister stated that the theme of budget is about harvesting efficiencies and savings, and reinvesting them, and about helping clinicians with their practice, so the things that do not work well are addressed.

The Government is close to finalising the Sixth Community Pharmacy Agreements, which will be announced shortly.

The Government will continue to find offsets, maintain a patient-focus, ensure that consumer groups and patients are represented when it comes to the supply of medicine, and ensure that healthcare is safe, affordable and effective for consumers.

Professor Hollands noted that CPMC is appreciative of the Department’s efforts to be more open and communicative. He noted that this reflects on the dilemma of CPMC, namely provision of expert advice despite a common perception of self-interest. CPMC represents the peak clinical body, and are actually clinicians in busy clinical practice.

A/Professor Peter Stewart (RCPA) noted that RCPA welcomes that MBS review, and considers it an opportunity to create a contemporary MBS schedule. RCPA has also embraced the Choosing Wisely campaign. Professor Stewart asked if the Minister had information on how MBS review committee members will be selected and if CPMC or individual Colleges will be able to play a part.

Minister Ley noted that the review led by Professor Bruce Robinson, and a high level steering committee to be announced shortly. There will then be representations as required based on what the group will do. The Minister will want to use CPMC expertise from time to time.

Professor Hollands mentioned that there is a lot of concern among busy practising clinicians that having representation on the Committee which could reflect on the day to day busy and active use of the MBS is needed. This way, an active clinician can say that the Government has done a good job.
The Minister agreed, and stated she wanted the Schedule to reflect real practice in the real world. The Minister noted that the review will be in parallel to the Medical Services Advisory Committee (MSAC) process, not through it. Decision must be made by people respected by their peers otherwise the review will lack clinical credibility.

Professor Hollands noted that an active clinician on steering committee would give it credibility. Professor Watters stated that the Minister had been given good information, and CPMC’s advice could be trusted as the group wants patients to be treated well.

Professor Jones suggested that the Review would require frontline GPs to give advice, to inform how it will work with general practice.

Dr Yelland (RACP) noted that with regards to the Choosing Wisely campaign, some Colleges already have five lists. Also, the College is aware it needs to maintain a balance between independence and implementing policy in practice. A conversation will need to take place about those two things. RACP does not want to be seen as an arm of government. Dr Yelland also noted the development of new emerging specialties such as adolescent medicine, and that there is currently some difficulty in becoming recognised.

The Minister noted that the creation of new specialties would need to go through AHPRA, however if it is relevant to state and territory councils, she would be happy to give it some attention.

The Minister noted that the GP will be at the forefront of My Health Record. The Government will run two opt-out trials involving Primary Health Networks, GPs and the hospital system. The trials will be large, and once any problems are identified and resolved, the Government will move to a national system.

Professor Hollands asked the Minister how the appeals process will work, how decisions will be made and how people can feed into the system. RANZCO had a legal case regarding the responsibilities given to optometrists. Situations such as this could be avoided if a level of appeal could be implemented.

Dr Brad Horsburgh (RANZCO) suggested that a group could be formed, chaired by an ex-judge, including specialists, a GP and other clinicians to help resolve these issues before they get to court. The Minister stated she would be happy to take a proposal about how it could work in practice. She also mentioned she was uncomfortable about Government or Government Departments arbitrating in this space. Dr Horsburgh noted that RANZCO has a model that would meet with broad acceptance. It would not give veto power to the medical profession, but medical professionals would contribute to each decision. The Minister expressed acceptance of the idea in principle.

Professor Walters noted that ACRRM was pleased that announcements regarding GPRIP would be forthcoming, and asked the Minister if any consideration would be given to an expert reference group for junior doctors and a rural training pipeline. The Minister suggested Professor Walters discuss this with her advisor, James McAdam.

Professor Hollands thanked the Minister for attending.

CPMC Minutes of 110th meeting held 14 May, 2015
Minutes for Confirmation

4. Minutes of previous meeting held 19 February 2015 were accepted by members.

4.2 Business arising from the minutes. Members proceeded to discuss governance matters.

Governance

5.1 Chair’s Report including duty statement for approval

Professor Hollands noted most of the issues had been covered previously, and commented that there seems to be a genuine interest in consulting with stakeholders with the current Government.

Professor Hollands requested feedback on the proposed Terms of Reference.

Dr Anthony Cross (ACEM) suggested time commitments of the Chair are variable.

Ms Linda Smith (RACP) queried administrative relationships. Professor Hollands clarified that this point related to Colleges hosting CPMC for meetings.

Professor Hollands noted that Presidents had discussed that a major liability was the amount of time it takes the CEO to undertake her duties. The CEO’s duties have increased in scope – CPMC has convened more forums and has been asked to attend more government related meetings and also respond to more documents. Professor Hollands proposed that it is time for CPMC to invest in some secretariat support, as it would be cheaper than the CEO working more hours. This would mean an increase to the budget to sustain the position.

Professor Hollands stated that he will write to presidents to seek consideration at their executive councils, noting that presidents gave their unanimous support on the night prior to the meeting. This support also extended to clearing the accrued leave debt for the CEO.

ACTION: Professor Hollands to write to College Presidents seeking their Executive Councils’ support to fund a secretariat for the CPMC

Professor Hollands raised a parallel issue in how funding should be provided by Colleges, and suggested the funding model proposed by Ms Magarry and discussed with Colleges was the best of multiple models considered.

Professor Hollands proposed to remove the ‘Administrative Support for the Chair’ item entirely from the Terms of Reference.

Professor Hollands thanked Dr Lee Gruner for the support that she had provided during his time as Chair, including standing in as Chair on several occasions. He noted that Professor Michael Permezel will take on that role going into the future.

Professor Hollands noted that often an individual College would like a particular issue emphasised, and that there should be a tool to identify and discuss issues outside of meetings.
Currently the executive consists of the President, the President Elect, the Deputy President and one more. Members were asked if they were happy with the idea of an executive.

Support was received from RANZCP and CICM. It was noted that this is the same structure as individual Colleges had, and it could be appropriate for the executive to have teleconferences between meetings.

Discussion ensued about how CPMC should publicly declare its support on any issue, and whether it should comment if Colleges do not unanimously agree. It was suggested that stating that ‘most Colleges’ agree could weaken the CPMC.

Professor Michael Permezel (RANZCOG) noted that often Colleges put in individual assessments or standards without any consultation with other Colleges. Intercollege consultations about submissions would be very helpful. Professor Watters mentioned that this would best be done when documents are at a draft level. Professor Hollands suggested that this item could be discussed at a future date, and perhaps included as an agenda item for the following meeting.

Professor Permezel suggested that CPMC is an inappropriate name for the organisation, and will bring a discussion paper regarding name change to the next meeting.

Members gave In-principle support to develop the CPMC executive. Professor Hollands noted that a proposed structure for the executive would be raised at the next meeting. Professor Watters suggested that it would be worth including another CEO on the executive.

**ACTION:** Develop a proposed structure for an executive at the next meeting.

It was noted that if a new executive arises, the Chair’s Position Description would need to be revised. It was also noted that the language “manage the CEO” is not normally used on boards, and the phrase “work with the CEO” is used. Professor Hollands took this on notice.

Professor Hollands raised a concern that the CEO had accrued leave and this matter would be dealt with via separate communication including the proposal for the office to be closed for a two week period over the Christmas period.

5.1.2 Chief Executive Officer’s Report

Ms Magarry spoke to the report, noting a key achievement in completing RHCE Funding Round 7, and executing a large number of contracts. Ms Magarry thanked Mr Michael Davidson (RHCE) for his work to facilitate that.

Ms Magarry noted that the Hon members Catherine King, Andrew Laming and Minister Ley had attended this meeting. An invitation to the meeting was extended to all relevant ministers and MPs. Many replies were received stating the members were unable to attend due to Budget and other Parliamentary commitments.

Members agreed that February or August would be good alternative times for another Parliament House meeting, with post budget being favoured as Ministers may have more to say.
5.1.3 Financial Statements: 3rd quarter 2014-15
Members noted that the statements historically showed that interest increased from $2,000 to $12,000. This was explained as to do with bookkeeping prior to Ms Magarry’s appointment, specifically that RHCE money (and the associated interest) was not shown in the correct place. Ms Magarry advised that CPMC was solvent and could pay its bills.

5.1.4 CPMC budget 2015-16 – for approval
Professor Hollands requested that members consider a larger amount than $20,000 for secretariat support. The Chair noted it would cost approximately $80,000 per year.

Professor Hopwood (RANZCP) asked what the CPMC’s arrangements were for the auditors. Ms Magarry noted that new auditors were appointed in 2013-14 in line with the principles of good governance. Auditors are appointed by the Board at each AGM.

5.1.5 Changes in Directors
Members were directed to the meetings papers regarding changes in directors.

5.2 Sub-Committee Reports
5.2.1 Education subcommittee (in abeyance)
Members noted the education subcommittee is in abeyance.

5.2.2 Indigenous Health subcommittee
Professor Hollands updated members, noting he had met with AIDA and discussed trying to promote the engagement of Indigenous doctors in Colleges.

Ms Magarry noted that AIDA is seeking to have the separate collaboration agreements merged into one – presently AIDA has 3 separate agreements. It was being considered for the AIDA symposium in September.

Mr Tim Wills (ACD) observed that CPMC has a lot to gain in terms of engaging with Indigenous engagement through the experience of particular Colleges. CPMC could help all Colleges come to one view on Indigenous engagement, and that could be valuable for AIDA.

Professor Hollands mentioned that all Colleges have some initiatives to work with Indigenous doctors. The cancellation of the Indigenous Knowledge Initiative and smoking ceremony was a missed opportunity for Presidents to demonstrate a commitment to Indigenous initiatives.

Members noted that it would be hard for CPMC to have an initiative itself, however as a group, CPMC could consider individual Colleges’ programs.

General discussion ensued, and the involvement of CPMC in individual Colleges’ reconciliation action plans was raised. A link on the CPMC website to each College’s action plan was suggested, and it was noted that this would need to be updated every one or two years to show progress. Professor Hollands suggested using the COMC meeting as an opportunity to review individual Colleges’ progress in this domain.
Mr Wills noted that when MDANZ decided to pursue action on Indigenous recognition and support, it went successfully and grew substantially. Members agreed that no further action would be taken at this stage.

5.3
5.3.1 National Medical Training Advisory Network – note 6.4
Discussion regarding NMTAN occurred at item 6.4.

5.3.2 IHPA stakeholder Advisory Committee – minutes
Members noted the IHPA stakeholder Advisory Committee minutes.

6. Strategy
6.1 Revalidation is a set agenda item and Professor Hollands advised that he had sought a meeting with Dr Joanna Flynn to pursue discussion with regards to the MBAs process. He will report back at the August meeting.

6.2 CPMC Strategic Plan ‘Towards 2017’
Ms Magarry noted that the development of a Strategic Plan had proceeded from the strategic planning discussion at the November 2014 meeting. Various issues have been discussed, including purpose and strategic goals being the same. Ms Magarry presented the plan for approval. Professor Hollands requested feedback. General support from Presidents and CEOs was received.

6.3 RACGP: Homeopathy position statement
Professor Jones (RACGP) spoke to the position statement, noting that about 30% of GP patients see alternative practitioners, although there is no scientific evidence for homeopathy. Comments were sought from members.

Dr Yelland noted that RACP has a process for endorsing papers. While the College would agree to endorse it, it has a requirement of substantial input either to the content or commenting. RACP has a collection of comments to forward to RACGP. RACP will endorse the statement as part of the CPMC, but co-badging will be a longer process through RACP.

Dr Cross (ACEM) asked if pharmacists should be consulted. Professor Jones noted they had been already, and their position was that if it is not doing any harm, the statement should go ahead.

Professor Venkatesh (CICM) queried what the ultimate intent of the document is. Professor Jones noted that RACGP will progress the document to government as RACGP’s position.

Professor Hopwood noted that RANZCP welcomes the document with minor technical changes, declaring this to be a good issue for CPMC to pick up on, particularly as the evidence is clear. Members also noted that it creates more strength if CPMC and NHMRC agree on a point and are providing that advice to patients.

Professor Watters (RACS) declared his complete support for it, and that RACS would gladly be part of a joint statement. This would need to be cleared through the RACS Executive though.

Support was also received from RANZCO and RANZCOG.
Dr Gruner (RACMA) mentioned that CPMC should not be concerned about what health insurers say on this topic.

Discussion ensued about how to present the document. Professor Jones noted that on the CPMC website, the statement should say ‘Endorsed by CPMC’, then on each College’s website it could say ‘Endorsed by CPMC, and our College’.

Professor Hollands suggested that CPMC endorse the document, and all Colleges are free to make contributions to it, then CPMC will endorse the revised document, and upload to website.

Members noted that CPMC would need a process for these sorts of approvals.

6.4 Discussion with Chair, National Medical Training Advisory Network – Professor Horvath

Professor Hollands welcomed Professor John Horvath back to CPMC, recognising him as a former CPMC Chair. Professor Horvath spoke briefly about CPMC’s history to members.

Professor Horvath, noted that NMTAN is the body Colleges are working with on workforce issues. It is part of the Department, advisory in nature, and must craft its advice to be credible, evidence-based and in a manner that does not inflame the States/Territories.

The work of NMTAN will change dramatically following the 2015 Budget with the major review of the MBS and models of care. There will be two committees focusing on what is in the MBS and how it is used. There is also a committee on primary care and mental health.

The new Department of Health Secretary has restricted the Department to a Whole of Health strategic view, and NMTAN resources will change to reflect this.

NMTAN is advisory to AHMAC, but is a Commonwealth committee. It has refined work around health workforce 2025. It is undertaking a workforce review, specialty by specialty as there is no baseline for whether the workforce is appropriate or not.

Psychiatry will be the first of the specialties to be review by NMTAN. Issues include the difficulty in referring someone to a psychiatrist, the specialty has a large IMG population, and there are difficulties in trainee placements.

Anaesthesia is the second specialty that will be examined. There are a number of other players in this field, such as GPs and nurses doing anaesthetics, and NMTAN is about 12 months away from completing that review.

NMTAN is also undertaking some new work, examining the workforce Australia should have for dealing with chronic disease. There is a good scoping paper that has been developed across the Department. NMTAN will need to consider what models of care there are, and how to deliver a workforce that contributes to this sensibly.

Other work includes examining training capacity, and specifically what is currently un-utilised or semi-utilised. The private sector and rural and remote training will be considered, and also what needs to be provided to Colleges so they can deem the training to be appropriate.
Professor Horvath recognised that there was concern amongst Colleges about the future of the STP. He advised that the Government will use STP more strategically to address shortages rather than leaving that to states and Colleges.

Professor Horvath also acknowledged the role of CPMC and a number of Colleges who are working very effectively with NMTAN.

Concern was raised that the ANZCA President, nor CEO was aware of the next meeting with NMTAN, and it was recommended for future communications to be made through CEOs.

Professor Permezel (RANZCOG) raised the issue of the influx of overseas trained doctors, and whether the immigration status of OTDs should be changed. Professor Horvath noted that when Australia reaches the stage when OTDs are not needed there will be a national cap. He mentioned that one problem relates to the inability to differentiate between various categories of IMGs on their visas.

Professor Watters (RACS) asked how NMTAN is considering the number of hours in a week, and how long it takes to train somebody. There is an issue that the cost of overtime is expensive in Australia, but affordable in NZ. Professor Horvath noted he would need to discuss the issue with modellers however MNTAN looks at the progressive contribution of trainee to country.

Dr Horsburgh (RANZCO) queried how NMTAN interact with Districts of Workforce Shortage (DWS). Professor Horvath noted that DWS is not a part of NMTAN, however there is discussion about how to improve the linkages between DWS and workforce projection work. NMTAN can send through material on this to the RANZCO secretariat. It was noted that workforce shortage is a state issue, and that while the startling shortages are obvious, it is unclear what an area’s need is versus the area’s desire to have a certain number of doctors.

Professor Hollands expressed that CPMC is keen to work with NMTAN, noting that there are synergies between the organisations. Professor Horvath replied that NMTAN is happy to attend any future meeting.

6.5 Health impacts of climate change – proposed global advocacy initiative
Dr Yelland spoke to this item, noting that RACP has a working group on climate change. There are many issues being explored, such as impact on pacific islands, the health of older, frailer people, and broader health effects of climate change. Dr Yelland asked the group how involved CPMC would like to be.

Professor Hollands suggested that CPMC would look at RACP climate change material, and as RACP suggests ways forward, CPMC members can consider each one. RACP will keep in contact with CPMC regarding progress and the related summit on 12 October 2015.

6.6 Review of the MBS
This matter was discussed in the general discussion as well as with the Health Minister.
7. Other Business: Meeting Evaluation
   Members agreed that the meeting was successful and that having CEOs at part of the meeting was helpful. CEOs agreed that continuing to have a meeting prior to CPMC was also a good idea. The one criticism of the meeting was that using a long table did not work and preference was given to café style, even separate tables for smaller spaces.

7.2 Next Meeting: ANZCA Melbourne 6 August 2015

Professor Hollands brought the meeting to a close at 3:30
COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES
Actions from the 110th meeting held 14 May 2015

3.1 Dr Wendy Southern – Deputy Secretary Department of Health

ACTION: Ms Magarry to send Dr Southern information on the RHCE Program

5. Governance
5.1 Chair’s Report including duty statement for approval

ACTION: Professor Hollands to write to College Presidents seeking their Executive Councils’ support to fund a secretariat for the CPMC

ACTION: Develop a proposed structure for an executive at the next meeting.

CPMC
CPMC + Prof Permezel
Committee of Presidents of Medical Colleges

Item 3.3 Chairs Report

An update to be provided by the Chair, Professor Michael Hollands on activity occurred since the last meeting.

- AHPRA – MBA meeting
- NMTAN meeting
- RHCE

With reference to the discussion with the Australian Medical Association at the May meeting and work occurring generally in relation to professionalism, one of the themes which comes through in discussion is of how best to manage the poorly performing medical student, taking into consideration a seeming reluctance of the Universities to manage poor professional performance with the hospitals where the student displays the unprofessional behaviour.

A recommendation from a member College has been to discuss this matter to develop and perhaps even consider medical school by medical school perhaps through the Medical Deans group.

Recommendation: Directors note the report

Recommendation: Directors note the information.
Committee of Presidents of Medical Colleges

Item 3.4 CEO Report to the Board of Directors August 2015

1. Governance Management
   - CPMC changes in Directors have been lodged with ASIC to reflect the turnover of Directors. Insurances negotiated and updated for business, liability and travel.
   - A discussion on membership fees in the context of assuring financial stability and trading the full year is listed at 3.7.
   - I met with in-coming CPMC Chair Professor Talley on 22nd July on his request. The meeting covered the CPMC company structure, Constitution, Executive, management of advocacy, policy and government relations, financial strategy, risk management, Parliamentary and strategic issues.
   - Preparation for the November Annual General Meeting is underway with regards to audit, and reporting.

2. Strategic Management
   - COAG Review of Medical Internship- Professor Permezel and I attended the consultation regarding the Options Paper underpinning the national review of medical internship. Professor Andrew Wilson was supported by the NSW Health policy team. The discussion was useful in identifying the range of consultation undertaken by the reviewers and how these contributed to the development of the options paper. While it was clear there was no appetite for ceasing the internship, the reviewers did identify that change was necessary to better meet the health needs of the population and training doctors to specialty. CPMC provided a response on 10 July, 2015 – as attached.
   - Meeting with AHPRA Chair and MBA- discussions were held with the MBA Chair regarding AHPRA, audits and the revalidation conceptual development, as outlined in item 6.2. Some considerable internal discussion has occurred regarding the connection between the CPD Managers network and their Colleges interaction with external bodies.
   - I attended the AMC General Meeting held in Toowoomba on 25-26 June. The AMC report at item 2.1 highlights what was covered. The July CPMC newsletter show cases the site visits.
   - Workforce - I attended NMTAN 19 May. I am dealing with the data mining request matter via coordinating engagement between the Department and the Colleges.
   - I have worked with AIDA on the Collaboration Agreement and this is set out in item 4.2.
   - I have registered to attend the Medical Deans conference scheduled for 7-9 October in Hobart.
   - RHCE – as National Director I have managed the program in the absence of the National Manager. I have managed the RACS acute neurotrauma site visit to coincide with the final Program Management Committee meeting for the RHCE program at Cairns campus of James Cook University.
   - Advocacy Program for 2016 is underdevelopment, pending the release by Parliament of the 2016 Sitting Week calendar. I have planned for engagement activity in 2016 comprising four Ministerial meetings, similar with Cabinet Ministers relevant to Health, Education, Immigration and Finance portfolios. The CPMC budget will need to expand to reflect travel and accommodation for these additional costs. Teleconference costs as well.
   - Met with RACS Policy and Advocacy Ms Amy Kimber 29 July 2015 on common issues.
3. **Financial Management**
   - CPMC secretariat managed to operate within budget allocated for the financial year, and the balance sheet shows the company in a reasonable cash position. It should be noted that this outcome is a result of managing enhanced engagement both nationally and internationally (New Zealand and Canada’s IAMRA meeting) in 2014-15.
   - The interim audit and preparation for the annual audit has been completed. End of financial year, BAS/IAS processes completed. Phasing the budget for 2015-16 has occurred. Q1 2015-16 running on reserves to mid-August - invoices have been despatched to Colleges.
   - RHCE individual grant payments and College payments have been managed by CEO and these payments are relating to funding round 7.

4. **Representation**
   - Represent CPMC on the Department of Human Services stakeholder engagement committee, but no meetings have been held in the last quarter. Some email exchanges in relation to the fraud management policy development work the Department is currently undertaking.
   - Attended Senate Estimates meetings and monitoring responses to questions on notice as applicable to workforce and review of MBS.
   - Represent as proxy for Chair, the NMTAN
   - Represent the CPMC on the Australian Medical Council’s Progress Reports Working Party – the recent meeting on 28 July 2015 AMC was held in Canberra, reviewing three Colleges.
   - Various communications with senior Departmental officials concerning the Curtin Medical School and related workforce development activities eg, data mining request from Health.

5. **Communications**
   - Coordinated the MJA article on special edition for August 2015.
   - Communique developed post the May meeting & despatched widely including CMC New Zealand.
   - Update to Twitter as appropriate;
   - Introduced a monthly newsletter.

6. **Other**
   This report to Board Directors is a summary of activity undertaken in the quarter. It does not include the liaison and coordination activity associated with preparation of the quarterly Board meetings. This activity generally falls under ‘meeting management’ and comprises inter alia,
   - As Company Secretary issuing a meeting notice in accordance with Constitution and ASIC requirements, coordinating the agenda items from members, and
   - Liaising with College venues to organise venue, order catering, manage site issues; liaison with guest speakers and their relevant personnel regarding their topic; travel management; administrative /event management such as name plates etc;
   - Organising the College Presidents dinner and paying deposits, sorting menus and prep;
   - Drafting up all Board papers covering each item and clearing the profession observers papers for questions to be asked on the day.

CPMC 6 August 2015 meeting
Committee of Presidents of Medical Colleges

Item 3.5 Financial Statements

CPMC ended the 2014-15 financial year with a net profit of $26,922. This is not the audited amount but a guide. The interim audit was clear and the leave liability was dealt with. The audit will take place in August, and shown at the November Annual General Meeting.

Cash at bank as at 30 June 2015:

- Operating account: $19,747.92
- Maxi account $104,855.04

The RHCE grant funds are managed separately from the CPMC accounts however as at 30 June 2015 the RHCE account held $804,368.96 and all of these funds are committed.

The Q1 expenses are being met from reserves until 2015-16 subscription fees are paid.

Variance Analysis

Over the full year 2015-16 variances against budget have been noted in the following areas:

- Interest received - the high interest bearing account has delivered good results and helped to contribute to achieving a surplus;
- Reduction in Sitting Fees and Other Fees – government departments have continued to cease paying sitting fees for many committees and this trend will continue.
- Capital equipment – a planned upgrade of computers will occur in 2015-16 financial year as a service agreement is being negotiated to cover hardware, website and IT –email support.
- 4 year sub-lease signed with ANZCA featuring a small rise for CPI
- Activity related expenses such as Board member international travel

Outcome

CPMC travelled reasonably well against budget and met higher than expected costs of travel and meeting expenses due to general price rises.

Moving forward in 2015-16 the operational budget has been adjusted to reflect these expected costs and phased for monthly variance analysis.

Recommendation

The Board notes the financial result for the year ending 30 June, 2015 and the ongoing issue of subscription fees.
## Balance Sheet

**As of June 2015**

### Assets

<table>
<thead>
<tr>
<th>Current Assets</th>
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<td>Bank Accounts</td>
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<td>COP: Westpac Cheque 42-3262</td>
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<td>COP: Westpac Maxi 42-3588</td>
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<td>Other Current Assets</td>
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<tr>
<td>Trade Debtors</td>
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<td><strong>Total Other Current Assets</strong></td>
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<td><strong>Total Current Assets</strong></td>
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### Total Assets

|       | **$970,496.74** |

### Liabilities

<table>
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</thead>
<tbody>
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<td>GST Liabilities</td>
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<td>GST Paid</td>
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<td>Provision for Holiday Pay</td>
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<td>Provision for Long Service Leave</td>
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<td><strong>Total Other Current Liabilities</strong></td>
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<td><strong>Total Current Liabilities</strong></td>
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</tbody>
</table>

### Total Liabilities

|       | **$908,300.44** |

### Net Assets

|       | **$62,196.30** |

### Equity

<p>| | |</p>
<table>
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<tr>
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<td><strong>Total Equity</strong></td>
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This report includes Year-End Adjustments.
**Item 3.6**

**GOVERNANCE ISSUES – CHANGES IN DIRECTORS**

The following changes in Directors have occurred since the May 2015 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>
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<tr>
<td>Stephen Shumack</td>
<td>ACD</td>
<td>Ceased</td>
<td>May 2015</td>
<td>June 2015</td>
</tr>
<tr>
<td>Christopher Baker</td>
<td>ACD</td>
<td>Appointed</td>
<td>May 2015</td>
<td>June 2015</td>
</tr>
<tr>
<td>Mark Daniell</td>
<td>RANZCO</td>
<td>Ceased</td>
<td>May 2015</td>
<td>June 2015</td>
</tr>
<tr>
<td>Brad Horsburgh</td>
<td>RANZCO</td>
<td>Appointed</td>
<td>May 2015</td>
<td>June 2015</td>
</tr>
</tbody>
</table>
Committee of Presidents of Medical Colleges

Item 3.7: Other Governance Matters

Introduction

This item is related to the annual subscription fees and financial stability of the company.

Funding CPMC: CPMC is a company limited by guarantee, established in 1986. Throughout this time various modes of funding company functions have been in place but for the last decade there has been a formula for calculating subscription fees which is comprised of a base fee with two increments. While historically this has meant the larger the College the higher the fee, there has been no review and the only change was in 2010 when members received a series of discounts, from 45% in 2010 and 2011 to 50% in 2012. However the effect from these discounts was destabilising and in 2012-13 the company recorded a negative outcome for that financial year.

Financial and Risk Strategy: The Board agreed to a strategy in 2013-14 financial year aimed at establishing sufficient reserves to assure stability, manage known risks and provide for any unforeseen circumstances. The Board agreed to a risk management plan recommending the maintenance of full subscriptions until 2016. CPMC’s CEO and Company Secretary has worked to this strategy, having achieved a surplus in 2013-14 and 2014-15.

Economic Modelling: The internal economic modelling to review membership fees aimed at modernising and simplifying processes and achieving greater equity was discussed by College CEOs and also Presidents but no agreement was reached at the May 2015 Board meeting. CEOs did agree on developing a set of principles. Subscriptions for this financial year will be based on the existing model. Invoices have been despatched.

Annual Operating Budget: All of the costs of running CPMC have risen over the past year and the management fee charged back from the RHCE program has ceased. The sole source of income for 2015-16 is the member subscription fees which for 2015-16 generates $265,400. The annual operating budget for 2015-16 is $292K (if funded for $35K assistance) and will draw from the last amounts of charging back from RHCE to cover full expenses.

In 2015-16 CPMC will continue to focus on strategic policy and there are challenges likely to arise from the MBS review, workforce policy generated out of government not necessarily lead by the sector, and regulatory policy discussions on validating doctors. There is a plan to convene more policy meetings, a planning day and convene executive meetings (face-to-face & telephone). These have been factored into the 2015-16 budget along with a capital upgrade to equipment.

Options for addressing the subscription fees include establishing a small review team which looks at spreading fees more equitably, through to a simple flat fee which applies to all members.

Recommendation: Note information and discuss the process for reviewing annual subscriptions to take effect from 2016-17 financial year.
Committee of Presidents of Medical Colleges

Item 4.2 AIDA-CPMC Indigenous Health sub-committee

Representation at this meeting will be from Dr Kali Hayward, Vice-President AIDA. Dr Tammy Kimpton is an apology.

CPMC has a Collaboration Agreement in place with some deliverables such as holding an Indigenous Knowledge Initiative. This was extended at the February subcommittee meeting. The Medical Deans has also negotiated a Collaboration Agreement for signing in the near future. There is merit in having a tripartite agreement which would enable greater collaboration amongst the training organisations involved in medicine and this is under discussion.

At a meeting with AIDA CEO and team in June, I indicated that given the challenges experienced to-date there is merit in better utilising the AIDA symposium. There are two meetings to note as outlined below and which will feature in the AIDA symposium program.

The AIA 2015 symposium will be held on 16-19 September 2015 at the Stamford Grand in Glenelg, South Australia.

1. AIDA 2015 Conference 17 September 2015 Growing Our Fellows workshop 2-5pm

The workshop will feature Presidents or their representatives and AIDA members and function to provide advice for AIDA members on specialist Medical Colleges as well as pathways for these Colleges.

2. AIDA-CPMC Indigenous Health Sub-committee Meeting 17 September 2015 18:30-2100

Members of the AIDA-CPMC IHSC and Presidents/CEOs of Colleges will meet over dinner.


- AMC Indigenous Planning Advisory Group

Australian Medical Council Indigenous Planning Advisory Group was set up by the AMC to assist them develop a more effective and visible strategy for engagement with Indigenous health organisations, students and medical practitioners. A communication is attached to the AMC report at item 2.1 noting that the AMC will verbally update the group on the outcomes of the 30th July meeting.
Committee of Presidents of Medical Colleges

Item 5.1 National Medical Training Advisory Network

The minutes from the NMTAN are considered by government to be Level 2, confidential information and are not for circulation accordingly.

To summarise the meeting held 19 May, 2015 it was attended by most members of the NMTAN, the Department of Health and guests from RANZCP and the COAG National Internship reviewers. An update on the Federal Budget was given along with a summary of the decision process associated with the announcement of a new Medical School at Curtin University. Some members questioned the role of NMTAN in that discussion.

The Medical Training Review Panel data sub-committee was discussed in the context of a decision at the February meeting to transfer the management of the report to NMTAN and to retain the expertise of the sub-committee members. The NMTAN data management sub-committee is now chaired by NSW Health’s Robyn Burley.

An update on the Chronic Disease Management sub-committee was given in the context of it having met twice and needed to be engaged with the Primary Health Care Advisory Group to avoid duplication of effort. Professor Richard Doherty, RACP agreed to take on the chairing of the group. There was a scoping paper in draft form provided for comment with the expectation that certain aspects of the work may need to be adjusted for over time.

An update on the psychiatry project was provided in the context of the data modelling exercise having been completed, and showing a high reliance on OTDs, and there remains a challenge with regards to only having snapshot level data.

A presentation on the data analysis capacity tool was provided which is a simple tool to enable easy and quick visualisation of large data sets. In this same discussion some feedback was provided in relation to the medical specialty fact sheets which are simple, one page snapshots for Colleges and future trainees to refer to.

The next meeting is 22nd September, 2015 in Melbourne.

A separate issue in relation to the data mining project arose as a result of correspondence received by Colleges on 20 July 2015, and which due to the confused connection between workforce data and STP review, the Department has been asked to meet with all Colleges via their CEOs meeting in the afternoon following the CPMC meeting. CPMC CEO is attending that meeting.
Committee of Presidents of Medical Colleges

Item 5.2 IHPA Stakeholder Advisory Committee

There was an expectation that the IHPA would cease to function in 2015, however it has remained and there are two more meetings left for 2015.

The SAC is comprised of representatives who advise IHPA on developments and decisions within the health industry and act as a liaison point for peak national health advocacy bodies and IHPA.

Members of the SAC represent the following organisations:

- Australian Health Service Alliance
- Pharmaceutical Society of Australia
- National Rural Health Alliance
- Catholic Health Australia
- Mental Health Council of Australia
- Committee of Presidents of Medical Colleges
- Private Healthcare Australia
- Australian Medical Association
- Australian Private Hospitals Association
- Medical Deans of Australia and New Zealand
- Federation of Ethnic Communities' Councils of Australia (FECCA)
- Australian Health Care and Hospitals Association
- Consumer Health Forum Australia
- Medical Technology Association of Australia (MTAA)

Most states and territories have indicated their intention to maintain ABF after the Commonwealth Government moves its proportion of public hospital funding to a block funding model with growth based on a combination of the Consumer Price Index and population growth from 2017-18.

Dr Tony Sherbon resigned as CEO and his last day was 29th May, 2015. Since then there has not been appointment made public.

Background

The IHPA is an independent government agency established by the Commonwealth as part of the National Health Reform Act 2011. IHPA was established to contribute to significant reforms to improve Australian public hospitals. A major component of these reforms is the implementation of national Activity Based Funding (ABF) for Australian public hospitals. The implementation of ABF provides incentives for efficiency and increases transparency in the delivery and funding of public hospital services across Australia. IHPA’s primary function is to calculate and deliver an annual National Efficient Price (NEP). The NEP is a major determinant of the level of Australian Government funding for public hospital services and provides a price signal or benchmark for the efficient cost of providing public hospital services.
Committee of Presidents of Medical Colleges

Item 6.1 Update on College Systems to Address Bullying and Sexual Harassment

Media coverage of allegations of sexual harassment and bullying of trainees was discussed at the May meeting in the context of the establishment by the RACS of an Expert Advisory Group on discrimination, bullying and sexual harassment.

The Australian Medical Association also conducted a Roundtable on this matter which was attended by most Colleges. CPMC attended and also provided written feedback to the AMA regarding the issue.

There was also a Four Corners investigation which aired on 24th May 2015 detailing allegations of abuse and bullying in some of Australia’s major teaching hospitals. This prompted

The RACS expert advisory group has finalised its processes to engage with stakeholders and released an Issues Paper and Background Briefing paper seeking input via submissions, which closed on 20 July, 2015.

The Medical Journal of Australia is planning to publish three articles, and an editorial linked to these articles on the topic of sexual harassment in the medical profession in their issue of 17 August, 2015. CPMC Chairman Professor Hollands contributed to the topic by providing a commentary.

The President of ACRRM requested this item be listed on the agenda to receive information on what other Colleges were doing on this matter.

The Chair to introduce item.
Committee of Presidents of Medical Colleges

Item 6.2 Revalidation – regulatory policy issue

In early June CPMC met with the Chair of AHPRA Dr Joanna Flynn and the MBA’s Dr Joanne Katsoris at the AHPRA offices in Melbourne. Professor Hollands discussed regulatory policy and in particular audits and potential moves towards revalidation. The MBA has engaged Dr Julian Archer from the Collaboration for the Advancement of Medical Education Research at Plymouth University to conduct a literature review and provide some advice about the concept of revalidation for Australia. The report is expected in November and there was some discussion about holding a workshop to discuss it with representatives from the membership. More on this in due course but expect the invitations to go out in late August supported by the MBA.

CPMC will work with its internal CPD network to discuss the issues associated with maintaining a CPD record, preparation for audit by a College and then potentially by AHPRA. This is because if there are process issues which need smoothing out it will be worthwhile settling them before any preparatory work is undertaken for a revalidation process.

Revalidation is an item for regular discussion at CPMC meetings. The Chair will introduce this item to open up for general discussion.
Committee of Presidents of Medical Colleges

Item 6.3 Government Relations Update

- **Secretary's Breakfast**

Professor Permezel attended the Secretary of Health’s breakfast forum on 23rd June, 2015 and reported the meeting was attended by key departmental officials but no politicians. Three Colleges were represented separately (RACP, RACGP, ACRRM), amongst the approximately 32 key health bodies in attendance.

Key topics discussed included the Medicare Review and the unclear nature of the composition of the oversight committee, issue of no additional funds and the high demand for representation on the committee. In relation to the MBS rebate freeze the Department noted potential adverse impact on service delivery. The announcement of the establishment of the Curtin Medical School and difficulties with placements for undergraduate and postgraduate medical training was noted.

On the matter of the establishment of Primary Health Networks the Department reported that it was certain that these will be the best placed to distribute resources. A level of concern was shown towards PHNs due to the duplication of work across all 31 PHNs and re-working Medicare Locals into another name. The PHN Boards are likely to have significant responsibility.

On the workforce policy matter of ‘madistribution’ this was discussed in the context of being an area of interest for the current Health Minister. The Secretary raised the possibility of “Rural Bonding” for newly graduated specialists. It was acknowledged that multiple strategies would be needed to address this policy issue.

Professor Permezel may wish to add to the above points.

- **MBS Review**

The Taskforce met on 8 July in Canberra and was attended by over 100 stakeholders, all with an interest in how to improve the system through MBS reform. The Taskforce Review is chaired by Professor Bruce Robinson who advised the meeting participants that part of his role was to communicate on process with regards to the review itself and timelines along with expected outcomes. The Taskforce will publicly release a discussion paper in September this year for submissions. There will be a large number of discipline specific review panels convened to undertake detailed analysis of specific MBS items. Advice on which MBS items should be examined first was sought on the over 6000 items on the schedule. Any reform of the MBS must include having sufficient flexibility to allow for changes in scope of practice and to-date that matter has not been discussed by the Chair or Minister. CPMC wrote to the Health Minister regarding representation on the Taskforce. Professor Talley may wish to add to the above points as a member of the Review Taskforce.

- **Independent Review of NRAS**

In a response from the Department attached, the final report of the review has been made available to Health Ministers but it is not yet public.

CPMC meeting 6 August 2015
Professor Michael Hollands  
Chair  
Committee of Presidents of Medical Colleges  
6/14 Napier Close  
DEAKIN ACT 2600

Dear Professor Hollands

Thank you for your correspondence of 21 May 2015 to the Minister for Health and Minister for Sport, the Hon Sussan Ley MP, regarding the Medicare Benefits Schedule (MBS) Review Taskforce and the National Registration and Accreditation Scheme (NRAS) Review. The Minister has asked me to reply.

As you will be aware, on 4 June 2015 the Minister announced membership of the MBS Review Taskforce chaired by Professor Bruce Robinson. Membership of the group includes doctors with expertise in general practice, surgery, pathology, radiology, public health and medical administration, who work across both the public and private health sectors, as well as consumer representation and academic expertise in health technology assessment. The full list of committee members and more information can be found at www.health.gov.au/HealthierMedicare

Professor Robinson has expressed a strong commitment to engaging a wide range of stakeholders in the broader review process. This will ensure that the process remains fair and representative of the composition of both Australia’s health workforce and health consumers. The Taskforce is expected to establish working groups to implement its work programme over the next two years. These working groups will comprise experts with experience directly relevant to the item or items they are assigned to review. These working groups will provide many more opportunities for experts to be involved in reviews.

In regard to the independent Review of NRAS, I am advised the final report has been presented to Health Ministers but is yet to gain their approval for public release. The NRAS Review report is an important document for Health Ministers to consider the future regulation of health practitioners in Australia. The Health Ministers will carefully consider the recommendations, including any further consultations, before implementing any changes to the Scheme.

Thank you for raising these matters.

Yours sincerely

Ffion Cahill  
Assistant Secretary  
Medicare Reviews Unit  
29 June 2015

GPO Box 9848 Canberra ACT 2601
Telephone: (02) 6289 1555
Committee of Presidents of Medical Colleges

Item 6.4 Credentialing and Extended Scope of Practice

A position paper on Credentialing and Scope of Practice for Surgeons has been attached to stimulate discussion on this topic. This paper is to be introduced by Professor David Watters, President, Royal Australasian College of Surgeons.

Discussion points include credentialing, extended scope of practice, six principles that would tend to apply to all specialties and even extended scope by other health practitioners, not just doctors and medical specialists. These principles could be adopted more widely if other Colleges were in agreement.

Recommendation: Directors note the position paper and discuss.

Attachment: Position paper on credentialing and scope of practice by RACS
Credentialing is the process used to verify a surgeon’s qualifications, experience, professional standing and other relevant professional attributes for the purpose of forming a view about their ability to deliver surgical services in a particular health service.

Scope of Practice refers to the range of practice or type of procedures, which an individual can perform. It is important to note that an individual’s scope of practice is dependent upon the local environment, and therefore may vary from institution to institution.

Key principles include:

- This is an organisational governance responsibility
- Patient safety is paramount
- Quality of care must be ensured
- The capability and role of the health service must be considered
- Processes must be fair, transparent and legally robust
- Credentialing should be reviewed on a regular basis

Committees, which define credentialing, and scope of practice for surgeons

- Should have a core membership of medical practitioners from a range of clinical disciplines.
- Should include or co-opt a member from the relevant surgical discipline.
- Should include non-medical organisational and or community members
- Should be convened prior to the appointment of a surgeon, at least every five years of a surgeon’s appointment, and at times where an unplanned review of a surgeon’s scope of clinical practice is requested.
- Members of the committee must declare any conflicts of interest.
- Members of the committee must be indemnified by the health service.
- There must be an appropriate appeals mechanism
- The College is prepared to provide external advice or assistance.

When reviewing credentials the committee should seek

- Proof of medical registration, indemnity insurance, specialty qualifications and compliance with continuing professional development.
- Evidence of recent practice & experience
- Referee reports
- To understand how a surgeon’s practice will interlink with the roles of the health service
- Assurance about the safety of any proposed procedures in the context of the health service

The Appeals Process committee should:

- Include members with the necessary skills and experience to provide informed and independent advice
- Include no members involved in the original decision
- Follow the rules of procedural fairness
- Provide an independent review of an application
- Include within its memberships at least one surgeon who practises in the field relevant to the scope being reviewed, and preferably from another hospital or health service
- Include a RACS nominee
- Allow the attendance of a support person for the surgeon
SPECIFIC ISSUES

Community need

- Surgeons are trained within nine specialties. Their scope of practice will usually be restricted within that specialty. However there are many examples where practice within another surgical specialty is an appropriate response to community need (An example would be a rural general surgeon performing surgery on a child, where there is no paediatric surgical presence).
- Sub-specialisation is an increasing trend. However the scope of practice of a well-trained generalist should not be unduly constrained as a consequence.
- The scope of practice may differ for emergency as opposed to elective care. Emergency care will generally require a wider scope than elective care.

Credentialing for individual procedures vs. a range of practice

- In some situations it may be possible to define a scope of practice down to the level of a list of specific surgical procedures. This can cause problems dealing with unexpected emergency cases, and is increasingly difficult the more general is an individual's practice.
- An alternative approach is to credential areas of practice, outlining types or groups of procedures, and thus allowing needed flexibility. This can be too open ended.
- There is no easy answer to this matter. Credentialing committees should be encouraged to develop workable solutions that suit a particular health service.

The role of published guidelines

- A range of organizations and societies have published documents or guidelines on matters such as training or case numbers required to perform various procedures.
- Such documents should be regarded as of an advisory nature only, and cannot replace the need for an individual credentialing committee to form its own opinion about any specific matter. The College is able to provide expert advice.

Notification to regulatory authorities

- The MBA & MCNZ have a requirement that medical practitioners report any restrictions imposed on their practice.
- By defining a scope of practice, a credentialing committee is effectively placing restrictions on an individuals practice. This is a normal process and does not require notification.
- If a credentialing committee uncovers serious concerns about a surgeon this should be reported to MBA/MCNZ.

Introduction of new services

- Hospitals and health services should have in place policies, structures and procedures for determining how new services should be introduced.
- These determinations should be based on considerations such as safety, support services and staff training,
- Surgeons wishing to incorporate new services within their scope of practice must undergo appropriate credentialing.

Performance appraisal

- Health services should regularly appraise surgeon performance. The College has published a Multi-Source Feedback Tool designed for this purpose. (LINK)
- All surgeons are obligated to participate in a continuing professional development program, which includes appropriate surgical audit.

The RACS representative should:

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<table>
<thead>
<tr>
<th>Division:</th>
<th>Fellowship and Standards</th>
<th>Original Issue:</th>
<th>Jan 2009</th>
</tr>
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<tbody>
<tr>
<td>Document Owner:</td>
<td>Director, Fellowship and Standards</td>
<td>Version:</td>
<td>2</td>
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<tr>
<td>Authorised By:</td>
<td>Professional Development and Standards Board</td>
<td>Approval Date:</td>
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</table>
• Understand the resources required for proposed clinical activities
• Understand the competencies required of a surgeon
• Understand the technical requirements for the proposed clinical activities
• Assess & verify the qualifications, training and experience required of a surgeon to undertake the proposed scope of practice
• Confirm that the surgeon is compliant with CPD requirements
• Be clearly notated as representing the RACS. (Other surgeons on the committee are not official representatives of RACS, but may make decisions on their own behalf.)
• Have no conflict of interest
• Make comment from RACS' point of view

The appropriate Regional Office of the RACS can provide advice concerning an appropriate representative.

B i b l i o g r a p h y


Chief Executive Officer
Professional Development and Standards Board

Division: Fellowship and Standards
Document Owner: Director, Fellowship and Standards
Authorised By: Professional Development and Standards Board
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Original Issue: Jan 2009
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<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>
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<tr>
<td></td>
<td>1  2  3  4  5</td>
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<td>2 The materials provided were</td>
<td>Confusing .........................Informative</td>
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<td>1  2  3  4  5</td>
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<tr>
<td>3 The broad focus of the meeting was</td>
<td>Operational....................... Strategic</td>
</tr>
<tr>
<td></td>
<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>
</tr>
<tr>
<td></td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>5 The discussion was</td>
<td>Unfocused......................... Focused</td>
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<tr>
<td></td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>6 The issues covered were</td>
<td>Not very important ........ Very important</td>
</tr>
<tr>
<td></td>
<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></td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>8 Inclusion of CEOs in the post Morning Forum was</td>
<td>Operational....................... Strategic</td>
</tr>
<tr>
<td></td>
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</tbody>
</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