<table>
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<tr>
<th>Item #</th>
<th>Time</th>
<th>Agenda Item</th>
<th>Presented by</th>
<th>Paper</th>
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<tr>
<td></td>
<td>8:30am</td>
<td>Tea – coffee on arrival</td>
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<td>1</td>
<td>9AM</td>
<td>Meeting formalities 113th MEETING</td>
<td>Chair</td>
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<td>1.1 Attendance and Apologies</td>
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<td>1.2 Conflicts of Interest and Confidentiality</td>
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<td>1.3 Other issues – guests CMC New Zealand and CEO, RCGP, NZ</td>
<td>Chair</td>
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<tr>
<td>2</td>
<td>9AM</td>
<td>Committee of Presidents of Medical Colleges</td>
<td>Prof. N Talley</td>
<td>✓</td>
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<tr>
<td>2.1</td>
<td>9:10</td>
<td>The Australian Medical Council</td>
<td>Prof. J Sewell</td>
<td>✓</td>
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<td>2.2</td>
<td>9:20</td>
<td>Commonwealth Chief Medical Officer</td>
<td>Prof. C. Baggoley</td>
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<td>2.3</td>
<td>9:30</td>
<td>National Health &amp; Medical Research Council</td>
<td>Prof. Anne Kelso</td>
<td>✓</td>
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<tr>
<td>2.4</td>
<td>9:40</td>
<td>Medical Board of Australia &amp; AHPRA</td>
<td>Dr J. Flynn</td>
<td>✓</td>
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<td>2.5</td>
<td>9:50</td>
<td>Australian Indigenous Doctors’ Association</td>
<td>Dr Kali Hayward</td>
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<td>2.6</td>
<td>10AM</td>
<td>Australian Commission on Safety &amp; Quality in Healthcare</td>
<td>Prof Villis Marshall</td>
<td>✓</td>
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<td>2.7</td>
<td>10:10</td>
<td>The Australian Medical Association</td>
<td>CEO Anne Trimmer</td>
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<td>2.8</td>
<td>10:20</td>
<td>Medical Deans of Australia &amp; New Zealand</td>
<td>Prof Glasgow</td>
<td>✓</td>
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<td>2.9</td>
<td>10:30</td>
<td>Confederation of Postgraduate Medical Education Councils</td>
<td>Prof. R. Tarala</td>
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**11.00 – 11.30am**

Morning Tea for Profession Observers, College Presidents and CEOs
## Committee of Presidents of Medical Colleges

### 2 JUNE 2016 MEETING

**Item 1.1 Attendance and Apologies**

**College Presidents in attendance**

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Professor Nicholas Talley</td>
<td>Chair, Committee of Presidents of Medical Colleges</td>
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<tr>
<td>Associate Professor Anthony Lawler</td>
<td>President, Australasian College of Emergency Medicine</td>
</tr>
<tr>
<td>Professor Bala Venkatesh</td>
<td>President, College of Intensive Care Medicine of Australia and New Zealand</td>
</tr>
<tr>
<td>Dr Michael Harrison</td>
<td>President, Royal College of Pathologists of Australasia</td>
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<tr>
<td>Dr Frank Jones</td>
<td>President, Royal Australian College of General Practitioners</td>
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<tr>
<td>Professor Lucie Walters</td>
<td>President, Australian College of Rural and Remote Medicine</td>
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<tr>
<td>Professor Peter Jenkins</td>
<td>representing Royal Australian and New Zealand College of Psychiatrists</td>
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<tr>
<td>Professor Michael Permezel</td>
<td>President, The Royal Aust &amp; NZ College of Obstetricians and Gynaecologists</td>
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<tr>
<td>Dr Genevieve Goulding</td>
<td>President, Australian and New Zealand College of Anaesthetists</td>
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<tr>
<td>Dr Greg Slater</td>
<td>President, The Royal Australian and New Zealand College of Radiologists</td>
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<tr>
<td>Professor David Watters</td>
<td>President, Royal Australasian College of Surgeons</td>
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<tr>
<td>Dr Bradley Horsburgh</td>
<td>President, Royal Australian and New Zealand College of Ophthalmologists</td>
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<tr>
<td>A/Professor Chris Baker</td>
<td>President, Australasian College of Dermatologists</td>
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<tr>
<td>Professor Michael Cleary</td>
<td>President, Royal Australasian College of Medical Administrators</td>
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<tr>
<td>Associate Professor Mark Lane</td>
<td>President-elect, Royal Australasian College of Physicians</td>
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<tr>
<td>Dr Adam Castricium</td>
<td>President, Australasian College of Sports Physicians</td>
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**College Chief Executives in attendance**

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<tr>
<td>Mr Tim Wills</td>
<td>CEO, Australasian College of Dermatologists</td>
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<tr>
<td>Dr Peter White</td>
<td>CEO, Australasian College of Emergency Medicine</td>
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<tr>
<td>Dr Zena Burgess</td>
<td>CEO, Royal Australian College of General Practitioners</td>
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<tr>
<td>Dr Karen Owen</td>
<td>CEO, Royal Australasian College of Medical Administrators</td>
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<tr>
<td>Ms Linda Smith</td>
<td>CEO, Royal Australasian College of Physicians</td>
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<tr>
<td>Ms Alana Killen</td>
<td>CEO, Royal Aust and NZ College of Obstetricians and Gynaecologists</td>
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<tr>
<td>Dr Bronwen Ross</td>
<td>CEO, Royal College of Pathologists of Australasia</td>
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<tr>
<td>Dr David Andrews</td>
<td>CEO, Royal Australian and New Zealand College of Ophthalmologists</td>
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<tr>
<td>Ms Laina De Winne</td>
<td>Royal Australian and New Zealand College of Radiologists</td>
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<tr>
<td>Mr Phillip Hart</td>
<td>CEO, College of Intensive Care Medicine of Aust &amp; NZ</td>
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<tr>
<td>Mr Andrew Peters</td>
<td>CEO, Royal Australian and New Zealand College of Psychiatrists</td>
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<tr>
<td>Associate Professor David Hillis</td>
<td>CEO, Royal Australasian College of Surgeons</td>
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<tr>
<td>Ms Marita Cowie</td>
<td>CEO, Australian College of Rural and Remote Medicine</td>
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<tr>
<td>Mr John Ilott</td>
<td>CEO, Australian and New Zealand College of Anaesthetists</td>
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*...2/ see over for Profession Observers in attendance & guests*
Committee of Presidents of Medical Colleges

Profession Observers in attendance
Associate Professor Jillian Sewell AM  President, Australian Medical Council
Professor Christopher Baggoley  Commonwealth Chief Medical Officer
Dr Joanna Flynn  Chair, Medical Board of Australia
Mr Martin Fletcher  CEO, Australian Health Practitioner Regulation Agency
Ms Anne Trimmer  Secretary General, Australian Medical Association
Professor Anne Kelso  CEO, National Health & Medical research Council
Professor Nicholas Glasgow  President, Medical Deans Australia and New Zealand
The Hon. Carmel Tebbutt  CEO, Medical Deans Australia and New Zealand
Dr Jag Singh  CEO Confederation of Postgraduate Medical Education
Councils
Dr Kali Hayward  President, Australian Indigenous Doctors’ Association
Professor Villis Marshall  Chair, Australian Commission on Safety and Quality in Health Care

In Attendance:
Ms Angela Magarry  CEO CPMC
Ms Sarah Srikanthan  SRSA - CPMC

Apologies Received
Dr Catherine Yelland  Royal Australasian College of Physicians
- Replaced by President-elect Associate Prof. Mark Lane
Professor Malcolm Hopwood, RANCP President, replaced by Prof. Peter Jenkins

Mr Ian Frank  CEO, Australian Medical Council
Dr Andrew Singer  Principal Medical Advisor, Department of Health
Professor Brian Owler  President, Australian Medical Association
Dr Joanna Flynn  Medical Board of Australia

1.2 Conflicts of Interest and Confidentiality
Verbal update
Committee of Presidents of Medical Colleges

2 June 2016 meeting

1.3 Guests

There are three official guests for the Morning Forum, the Chair, Council of Medical Colleges, New Zealand Dr Derek Sherwood and CEO, Ms Sue Ineson, along with the CEO of the Royal College of General Practitioners Ms Helen Morgan-Bander. This paper provides a brief summary of them with photos.

Council of Medical Colleges, New Zealand (CMC)

CMC is the collective voice for the Medical Colleges in New Zealand and through its members provides a well-trained and safe medical workforce serving the best interests of the New Zealand community. CMC brings together 14 member Medical Colleges who provide support to over 7000 specialist medical practitioners working in a range of 35 specialties in the New Zealand health system.

CHAIR: Dr Derek Sherwood MBChB(Otago) FRCS(Ed), FRANZCO

Since 2014 Dr Sherwood is the Chair of the Council of Medical Colleges in New Zealand (CMC).

Dr Sherwood is an Ophthalmologist.

He did his Ophthalmology training in the UK passing his FRCS final exam in Edinburgh in 1987. He returned to NZ in 1990 as a consultant ophthalmologist and returned to Nelson in 1996 where he has practiced at Nelson Public Hospital and Privately.

As well as General Ophthalmology and Eye Surgery he has maintained a special interest in Paediatric Ophthalmology and Strabismus surgery.

He has previously been involved in providing eye surgery in Nepal and the Pacific Islands but over the last 10 years in addition to his busy clinical practice he has been preoccupied with improving Eye Health Services in New Zealand firstly in his role Chairing the Diabetic Retinopathy Screening Group and then Chairing the Save Sight Society and more recently Chairing the NZ Branch of the Royal Australian and NZ College of Ophthalmologists.

CEO: Ms Sue Ineson

Ms Sue Ineson is the Executive Director for the Council of Medical Colleges New Zealand. Since late 2013, Sue has been working in Qatar for the Supreme Council of Health developing policy advice for the Qatar Council for Healthcare Practitioners and researching and giving advice on patient advocacy systems for the Supreme Council of Health.
Committee of Presidents of Medical Colleges

The Royal New Zealand College of General Practitioners (RNZCGP) is the professional body that provides training and ongoing professional development for general practitioners and rural hospital generalists, and sets standards for general practice. This meeting is being attended by Ms Helen Morgan-Bander, Chief Executive Officer

Helen joined the College as Group Manager Membership Services in October 2011 and was appointed as CEO in October 2012. She brings to the CEO role more than 15 years of senior management experience in the public and private sectors. Her previous roles include being Head of Corporate Affairs for ANZ, New Zealand’s largest bank; Director of Marketing and Communications at Victoria University; and Strategic Communications Manager in the Office of the Prime Minister.
Committee of Presidents of Medical Colleges

2.1 Chair’s Report: Laureate Professor Nick Talley

Welcome to the 114th meeting of the Committee of Presidents of Medical Colleges.

I would like to acknowledge the Wurundjeri people as the traditional owners of the land upon which we meet and pay my respects to elders past and present.

We have great pleasure in welcoming guests from New Zealand with the Chair of the Council of Medical Colleges, Dr Derek Sherwood, their CEO Ms Sue Ineson, and the Royal New Zealand College of General Practitioners Chief Executive, Ms Helen Morgan-Bander in attendance.

We welcome Mr Phil Truskett to the meeting as the new President of the RACS.

In place of RACP President, Dr Catherine Yelland is Associate Professor Mark Lane who is the newly elected RACP President-elect. I would also like to welcome Professor Peter Jenkins on behalf of Professor Malcolm Hopwood, from the RANZCP (psychiatry).

We extend a warm welcome to Associate Professor Charlie Corke as the new President of the College of Intensive Care Medicine and farewell Professor Bala Venkatesh.

This will be a full meeting for all of us and we are grateful to the profession observers for agreeing to make their papers more widely circulated within the Colleges.

But before I conclude I would like to draw everyone’s attention to the fact that this will be the final meeting for Professor Chris Baggoley as Australia’s Chief Medical Officer. Angela has done some research and told me that Chris was appointed as CPMC Chairman in 2000 having been President of the Australasian College for Emergency Medicine. At the time, Chris is noted as having said he was committed to increased communication with individual member colleges, politicians and the government bureaucracies.

And of significance is that at that time CPMC was preparing a business plan and had a focus on organising workshops. We have indeed come a long way!

Thank you everyone.
Report to Committee of Presidents of Medical Colleges
2 June 2016

1. Directors and Council

1.1 Meetings of the Australian Medical Council Limited

The general meeting of the Australian Medical Council will be held on 17 June in Sydney Olympic Park. The format for the June meeting will involve holding a forum style meeting with presentations from local stakeholders. As previously advised, the Council holds meetings in rural, regional and outer metropolitan locations to assist it understand local issues and the challenges faced. This year the Council is interested to hear about issues and challenges for medical education, clinical and community health services in the greater western Sydney region and particularly:

- The health and health care of Aboriginal and Torres Strait Islander people;
- Refugee health services, health outcomes and health care priorities; and
- Clinical placement and other health and education challenges for greater western Sydney

The Australian Medical Council regards this meeting as a unique opportunity to engage with clinicians, educators, students 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 communities and healthcare services.

The CPMC is represented at AMC Council meetings by Professor Nicholas Talley, as the CPMC nominee, and Ms Angela Magarry who attends Council as an observer.

2. National Issues and Initiatives

2.1 National Registration and Accreditation Scheme – Health Ministers’ 2014 Review of the Scheme

As noted in November 2015 the independent reviewer’s final report review of the National Registration and Accreditation Scheme was submitted to the Ministerial Council in December 2014. The final report raised concerns about the ‘cost, transparency and duplication of existing accreditation arrangements and prescriptive approaches to accreditation functions.’ Following consideration of the final report the Ministerial Council announced in August 2015 a ‘further comprehensive review of accreditation functions’ specifically relating to the cost, scrutiny, duplication and prescriptive approaches to accreditation functions (which includes program accreditation and overseas trained practitioner assessment).

The AMC has advised the Ministerial Council that it will contribute to the proposed additional review of accreditation as it considers fit for purpose
accreditation to be an important and useful driver of innovation in education and training. However, the AMC is of the view that not only was the analysis in the original review limited in its attempts to define terminology to ensure presentation of accurate data but also financial data arbitrarily selected from multiple financial years and operational costs had nothing to do with the accreditation of programs included in the inflated figures for accreditation in medicine.

While the terms of reference for this additional review are yet to be finalised, it is expected the review will be completed by December 2016.

2.2 AMC position on bullying and harassment

In 2015 following the report of the Expert Advisory Group to the Royal Australasian College of Surgeons (RACS) into allegations of discrimination, bullying and sexual harassment within the College and its related environment, the AMC issued a media release endorsing the RACS position on discrimination, bullying and sexual harassment. The AMC also confirmed that its position is now reflected in the accreditation standards for specialist education and training. Given its formal endorsement of the RACS position, the AMC is preparing a general policy statement on bullying and harassment for issue to those individuals involved in AMC activities, but who are not staff of the AMC and subject to the staff policy on bullying and harassment.

3. Accreditation

3.1 Specialist Education Accreditation Committee

The AMC Specialist Education Accreditation Committee last met on 17 March 2016 and considered a range of matters regarding the accreditation of specialist medical programs, as outlined below.

3.1.1 Accreditation Assessments

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). The 2016 assessment will cover the education and training programs and the continuing professional development program of the College. The College is the first to be assessed under the new standards. The team will undertake site visits to a range of accredited training sites from 16 to 20 May and hold meetings with College committees from 23 to 26 May.

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). The AMC team is conducting a full reaccreditation assessment in November 2016 which will address all the accreditation standards. The 2016 assessment will include education and training programs covering training in the recognised specialties leading to the award of Fellowship of the Royal College of Pathologists of Australasia (FRCPA).

3.1.2 Update on the implementation of the revised accreditation standards

The revised standards for specialist medical programs were implemented on 1 January 2016. Matters for noting include:
1. A majority of the standards are the same or similar to the 2010 accreditation standards. The AMC has edited the standards to improve clarity and consistency. Overlaps and duplications have been removed. Standards that covered two or more issues have been split into separate standards. Education providers are expected to meet this group of standards in 2016. AMC is implementing new standards as follows:

2. There are 14 new standards that align with other requirements such as Medical Board of Australia or Medical Council of New Zealand requirements, trainee wellbeing and patient safety. Education providers are expected to meet these standards in 2016.

3. There are 20 other new standards not covered by (1) and (2). For these new standards, in 2016 education providers may indicate how they plan to address the requirements of each standard over the next 12 months.

The AMC has undertaken the following activities to support colleges and assessment teams with the implementation of the standards in 2016:

- The AMC held a workshop on 24 September 2015 for the specialist colleges undergoing an accreditation assessment in 2016 (RANZCO and RCPA) and early 2017 (RACDS). The workshop provided an opportunity to discuss:
  - key changes to the accreditation standards and what is expected of colleges in meeting the new standards in 2016
  - an overview of AMC systems and processes
  - collegiality and quality improvement elements of AMC assessments
  - how the AMC is working together with the Medical Council of New Zealand, Dental Council of Australia and Dental Council of New Zealand
  - new policies and national developments which affect the accreditation activities of the AMC
  - changes to AMC accreditation fees and charges
  - AMC monitoring of accredited programs.

- The annual accreditation workshop was held on 3 March 2016. The workshop was attended by team chairs, new team members and key representatives from the colleges being assessed in 2016. Further information about the accreditation workshop is provided in item 3.1.3

- The AMC will be holding a session with the 2016 assessment teams on the revised standards on the day before the preliminary team meeting.

- The AMC has held teleconferences and meetings with colleges to discuss requirements for progress reporting in 2016.

3.1.3 Specialist education and prevocational standards accreditation workshop

The AMC held its annual accreditation workshop for specialist education and prevocational standards accreditation on Thursday 3 March 2016. The workshop brings together participants in two AMC accreditation processes: the assessment of specialist medical programs and continuing professional development programs (accreditation of specialist medical colleges) and the assessment of intern training accreditation authorities. Attendees include the chairs of the AMC assessment teams for 2016, new accreditation assessors, the Chair and Deputy Chair of the Specialist Education Accreditation
Committee and the Chair of the Prevocational Standards Accreditation Committee, the AMC staff who support the accreditation functions, and other key stakeholders in the accreditation process. For the first time, the annual workshop also included representatives of the organisations undergoing accreditation in 2016: Censor in Chiefs of the specialist colleges being assessed, senior staff of the postgraduate medical councils being assessed, and representatives of trainee committees from specialist colleges being assessed.

The workshop provided an opportunity for participants to:

- review their role in the AMC’s 2016 accreditation of education providers and accreditation authorities, and application of AMC accreditation standards and policies
- reflect on the environment in which the AMC accredits, taking account of previous AMC findings, and developments across the sector that may affect accreditation
- consider how the AMC accreditation assessment team and education providers/accreditation authorities work together
- work in small groups to develop techniques for interacting in accreditation teams and with education providers/accreditation authorities in an accreditation site visit.

3.2 The Prevocational Standards Accreditation Committee

The AMC Prevocational Standards Accreditation Committee has 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.

3.2.1 Accreditation of Postgraduate Medical Education Council of Queensland

In 2014 the AMC granted initial accreditation to the Postgraduate Medical Education Council of Queensland as an intern accreditation authority for Queensland. The Medical Board of Australia subsequently approved PMCQ as an intern training accreditation authority under the registration standard, Granting general registration as a medical practitioner to Australian and New Zealand medical graduates on completion of intern training.

The scope of intern training accreditation work of PMCQ accreditation changed significantly as a result of this work, and the AMC has been monitoring the impact of the change on PMCQ’s accreditation status.

On 21 December 2015, PMCQ advised that it will not be providing intern accreditation services in 2016, and therefore AMC assessment is not required. The AMC has informed the medical board of this decision. The decision has no immediate impact on the accreditation of health services in Queensland.

3.2.2 Review of the national standards for programs and domains for assessing intern accreditation authorities

In 2015 AMC evaluation and review processes identified a number of areas, specifically in the Intern training – Domains for assessing accreditation authorities and Intern training - National standards for programs that would benefit from review.

Issues concerning trainee wellbeing, bullying, discrimination and harassment in medicine were prominent in the media in 2015. The AMC considered these issues in relation to standards for accreditation of specialist training programs,
and through the Prevocational Standards Accreditation Committee agreed that they need to be considered for intern training accreditation processes and standards.

The AMC also considered that a stronger focus on how the standards and processes contribute to safety and quality in health care is warranted. The AMC proposes to strengthen the national standards and domains to make expectation around junior doctor wellbeing and patient safety more clear.

The group reported to the April 2016 meeting of the Prevocational Standards Accreditation Committee, which accepted the changes proposed by the review group, with some minor amendments, and agreed that the revised documents are ready for consultation.

The AMC is currently conducting a consultation on the changes, and plans to submit the revisions to the September meeting of Directors for approval. The changes proposed are regarded as minor, and link closely to changes already approved by the Directors and the Medical Board of Australia for the specialist medical program accreditation standards.

4. Indigenous Advisory Group

Background

As advised in 2015, AMC Directors established the Indigenous Planning Advisory Group (IPAG) to take forward the AMC’s work in raising the quality and responsiveness of its leadership in Indigenous health and the needs of its practitioners. The membership of the Group included both Indigenous and non-Indigenous representatives. The group was co-chaired by Associate Professor Noel Hayman and Dr Greg Phillips. The membership included a representative from CPMC – Associate Professor Brad Murphy. The work of the IPAG concluded at the end of 2015 with the presentation of its final report to AMC Directors and Council in November. The final report contained a number of recommendations one of which was to discontinue the IPAG and set up a smaller group – the Indigenous Advisory Group – comprising the stakeholder leaders to carry forward the work plan and recommendations of the Indigenous Planning Advisory Group.

This Indigenous Advisory Group met for the first time in April 2016 to discuss priorities, resources and timeframes. As per its Terms of Reference the Indigenous Advisory Group is tasked with:

a) developing a statement of AMC purpose and commitment to Indigenous health;

b) developing an acknowledgement statement that includes Aboriginal and Torres Strait Islander and Māori art images and people in AMC offices and on its publications including letters, emails, website, reports etc;

c) developing formal agreements with the Australian Indigenous Doctors Association (AIDA); Te Ohu Rata o Aotearoa – Māori Medical Practitioners Association (Te ORA); and the Leaders in Indigenous Medical Education (LIME)

Members of the Advisory Group will present a draft statement of the AMC purpose and commitment to Indigenous health to the AMC Council in June 2016. The Advisory Group will meet four times in 2016.
5. Assessment and Examinations

5.1 International Research Initiative

A team from the AMC attended and presented at the 13th Asia Pacific Medical Education Conference (APMEC) which was held in Singapore in January. The presentations included examples of work being undertaken by the AMC in relation to workplace-based assessment and the application of technology to the delivery of OSCE assessments through the AMC National Test Centre (NTC). Both presentations generated some interest in the research potential available at the NTC. The NTC Research Group, which is chaired by Professor Liz Farmer, has been developing a research agenda for the AMC with a particular focus on performance analysis of the AMC clinical examinations. A number of projects are planned or have already been initiated to draw on the significant body of data that the AMC is acquiring through the NTC. To illustrate this, the clinical examinations conducted in the calendar year 2015 yielded the following data:

- 2369 candidates were examined at the NTC
- 37,904 examination stations were captured on video
- 6,317 total hours of video recordings are available for review
- 350,000 individual assessment marks have been recorded through the tablet scoring system

The fact that the AMC not only has the individual data for each of the examinations conducted but also has the video footage of the performance of the individual candidates, examiners and role-players represents a unique research opportunity. It is now proposed to capitalise on this unique set of data and research material by establishing an international research collaboration to identify and progress research projects based on the opportunity presented by the NTC.

5.2 AMC & Medical Deans Australia and New Zealand Collaborative Benchmarking Project

The AMC & Medical Deans Collaborative Benchmarking Project commenced in October 2015, with an initial workshop undertaken at the National Test Centre, Melbourne for participating university representatives. A total of 14 of 21 medical schools are participating in the pilot project using AMC sourced multiple-choice question items selected from the AMC MCQ bank of items. At this point in time the project is on target with AMC, Medical Deans and individual universities working collaboratively to ensure adherence to security and anonymity protocols.

6.1 Workshops

Review of AMC National Workshop on Workplace Based Assessment (WBA)

On 4 April 2016, the AMC held a national workshop on workplace based assessment. As well as providing an opportunity to share experiences between established and potential WBA program providers, the workshop was an opportunity for face to face feedback on the revised DRAFT AMC Accreditation of Workplace-based Assessment Providers: Standards and Procedures and draft nationally available assessment forms, which could be a resource for new providers.
There were more than 60 attendees, including representatives of established WBA providers, potential new providers, WBA candidates and graduates, jurisdiction and Medical Board representatives, members of the Board of Examiners, the Results Group, and the Prevocational Standards Accreditation Committee (PreVAC) and AMC staff.

The workshop covered a number of important issues including the potential for greater standardisation of assessment through enhanced AMC resources and guidelines and more explicit definition of high level requirements based on evidence (which might lead to decreases in assessment points in some programs). Other matters included the clarification of the flexibility providers have in meeting requirements, the relationship between the review of candidates’ results, through the results group of the Board of Examiners and the work of the PreVAC. There was also considerable discussion as to whether WBA is an assessment program or a training program that uses workplace based assessment to test candidates.

Following discussion at the workshop the Prevocational Standards Accreditation Committee has considered the proposal for a WBA development group as part of the research agenda of the AMC. The Committee agreed that good links between the PreVAC and the WBA development group would be valuable in ensuring that what is learned from the accreditation of WBA providers informs and is informed by this work.
Medical Board of Australia and AHPRA report to the meeting of the CPMC on 2 June 2016

Revalidation

The Medical Board of Australia (the Board) has been considering how best to ensure medical practitioners maintain and enhance their professional skills and knowledge and remain fit to practise medicine. The Board is using the term ‘revalidation’ although it has not decided what ‘revalidation’ will look like in Australia or whether that will ultimately be the name that is used.

The Expert Advisory Group (EAG), chaired by Professor Liz Farmer, has had two meetings and will meet again in late May. The EAG’s report to the Board, due in the second half of 2016, will provide expert advice on revalidation, including one or more models for revalidation in Australia and advice to the Board on how to pilot the models so that they can be evaluated for effectiveness, feasibility and acceptability. The members of the EAG have been selected for their individual expertise in medical regulation, performance management, assessment of medical practitioners, medical education, and safety and quality. Members have been appointed as individuals rather than representatives of any organisation.

The Board is also establishing a Consultative Committee to provide a forum for discussion and exchange of views on what medical practitioners should do to demonstrate ongoing fitness and competence to practise. The committee will provide feedback to the Board on the feasibility and acceptability of the proposals models and options for piloting models of revalidation and the implementation of any proposed revalidation activities and provide advice to the Board on wider consultation regarding revalidation.

The Board has recently sought nominations for membership of the consultative committee from representative organisations including the CPMC as well as the Australian Medical Council, Australian Medical Association, Medical Deans Australia and New Zealand, Australian Indigenous Doctors’ Association, Health Workforce Principal Committee of the Australian Health Ministers’ Advisory Committee and the Medical Council of New South Wales. The Board will also appoint community members, individuals from Health Complaints Entities, a person from a pre-vocational training organisation and a professional indemnity insurer.

The first meeting of the Consultative Committee will occur in August 2016.

As well as the process of consultation through this Committee, the Board will continue to consult widely including with Colleges directly and through CPMC and looks forward to CPMC’s input to the ongoing work on revalidation.

Social research

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

The research will canvas the views of medical practitioners with surveys to be sent out to 15,000 randomly selected doctors in late May. A sample of members of the public will also be surveyed for their views in relation to trust in the medical profession and their expectations about medical practitioners demonstrating that they are maintaining their knowledge and skills.
Doctors’ health programs

In April, the Board and Australian Medical Association (AMA) announced that the expanded doctors’ health services would start nationally from 1 May 2016. The Board is providing $2 million (including GST) annual funding which will increase by CPI each year. The Board has partnered with the AMA, which is establishing and administering the health programs at arms’ length from the Board and the Australian Health Practitioner Regulation Agency (AHPRA), through a subsidiary company called Doctors’ Health Services Pty Ltd (DrHS).

The services will be nationally consistent and available to doctors and medical students across all states and territories.

The first services will start in New South Wales, the Australian Capital Territory, South Australia and the Northern Territory with the NSW Doctors’ Health Advisory Service providing services for doctors in NSW and the ACT and Doctors’ Health SA providing services in SA and the NT. Other states will follow.

The scope of services to be provided around the country is comprehensive and through a local presence will include:

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

Further information is available in the joint media release from the Board and the AMA.

New cosmetic guidelines

The Board has issued Guidelines for registered medical practitioners who perform cosmetic medical and surgical procedures. Cosmetic medical and surgical procedures are performed by medical practitioners with a range of different qualifications including specialist plastic surgeons, cosmetic surgeons and cosmetic physicians. By setting guidelines that apply to all medical practitioners, regardless of their qualifications, the Board is doing what it can to make sure that all medical practitioners practise within their skill and ability and provide safe care to their patients.

The Board received a large number of submissions and there was broad support for more guidance in this area of medical practice.

The Guidelines come into effect on 1 October 2016, giving medical practitioners time to comply with them. They include:

- a seven-day cooling-off period for all adults before major procedures
- a three-month cooling-off period before major procedures for all under 18s and a mandatory evaluation by a registered psychologist, general practitioner or psychiatrist
- a seven-day cooling-off period before minor procedures for all under 18s, and when clinically indicated, evaluation by a registered psychologist, general practitioner or psychiatrist
- the treating medical practitioner to take explicit responsibility for post-operative patient care and for making sure there are emergency facilities when they are using sedation, anaesthesia or analgesia
• a mandatory consultation before a medical practitioner prescribes schedule 4 (prescription only) cosmetic injectables, either in person or by video consultation, and
• medical practitioners must provide patients with detailed written information about costs.

The Board has also made recommendations to other authorities about safety concerns that it identified but which are outside the Board’s scope of powers. The Board has referred concerns about inconsistencies in drugs and poisons legislation across jurisdictions, and licensing and regulation of private health facilities, including the use of sedation and anaesthesia, to state and territory governments.

The guidelines are available on the Board’s website.

Review of registration standards

The Board’s public consultation on the revised registration standard for specialist registration is due to close at the end of May.

This standard sets out the Board’s requirements for granting specialist registration. The proposed changes to the current standard are mostly editorial in nature, restructuring and rewording the standard to improve readability and clarify current requirements. The Board did not propose any significant changes to the current requirements for specialist registration.

To date, the Board has received a number of submissions from both organisations and individual practitioners.

The Board appreciates the time taken by colleges to review the standard and provide their comments during both the preliminary and public consultations. Further updates will be provided to CPMC once the Board has considered the submissions.

Concurrently, the Board also consulted on the registration standard for granting general registration to medical practitioners in the standard pathway who hold an AMC certificate and that consultation is also due to close at the end of May.

Implementation of revised limited registration standards and guidelines for short term training

Limited registration standards

The Board has revised the registration standards for the four types of limited registration. Limited registration applies to international medical graduates (IMGs) who do not qualify for general or specialist registration. The registration standards for the four types of limited registration define the requirements IMGs must meet to be granted limited registration or to renew limited registration.

The revised standards are for:

• Limited registration for postgraduate training or supervised practice
• Limited registration for area of need
• Limited registration in public interest
• Limited registration for teaching or research.

The standards will come into effect on 1 July 2016 and are available on the Board’s website.

The standards have been reformatted and reworded to make them clearer, but for most, there are no significant changes to the requirements for limited registration.

The key changes to the registration standards are:

• There is a new exemption to the requirement for IMGs applying for limited registration for postgraduate training or supervised practice to provide evidence of successful completion of a medical internship or comparable, if an IMG can secure an accredited internship position in Australia (noting however, that intern positions are difficult to obtain).
• IMGs applying for or renewing limited registration for area of need to work in a general practice position for the first time in Australia, must have at least three years’ (full-time equivalent) experience working in general practice or primary care.

• The purpose of limited registration in the public interest has been made clearer:
  o this type of registration cannot be used to circumvent the need for Ministerial designation of area of need
  o IMGs coming to Australia for a short period to demonstrate a clinical technique or participate in a workshop will apply for limited registration for teaching or research rather than limited registration in public interest.

• A more streamlined process for applying for a change in circumstances. Registered medical practitioners seeking to change the circumstances under which limited registration was granted such as changes to supervision arrangements or places of practice will not be required to make a new application for registration for significant changes.

All applications requesting minor or significant changes in circumstances will be managed through the one application form. A new application for registration will only be required if the practitioner seeks to change their type of registration or if they have exhausted the number of renewals allowed under the National Law. The revised registration standards allow the Board to charge a fee for requests to change in circumstances, however, the Board has waived the fee for 2016/2017.

New Guidelines: Short-term training in a medical specialty for international medical graduates

The Board has developed Guidelines: Short-term training in a medical specialty for international medical graduates who are not qualified for general or specialist registration. These will also come into effect on 1 July 2016.

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

IMGs in this pathway are either qualified specialists, or specialists in training in other countries, who wish to have additional training in Australia for a short period of time (usually up to two years).

The name-change of the pathway makes it clearer that the ‘short-term training in a medical specialty pathway’ does not lead to an approved qualification for specialist registration. The IMG must confirm that they do not intend making further applications for registration in Australia at the end of the specified training period. If they wish to seek specialist registration they must apply through the college for the ‘specialist pathway – specialist recognition’.

The guidelines clarify the roles of the specialist medical colleges and the Board in assessing and registering IMGs seeking short-term specialist training but the eligibility criteria for registration in this pathway have not changed.

The guidelines are available on the Board’s website.

Profession specific summary of the annual report

The Medical Board has published its summary for 2014/15. This summary of the annual report provides a focused view of the Medical Board’s work drawing data from the 2014/15 annual report of AHPRA and the National Boards.
From the report:

- there were 103,133 medical practitioners registered in Australia on 30 June 2015; an increase of 3.8% compared to 2013/14
- 41% of registered medical practitioners are female
- there were 212 mandatory notifications made (including NSW), compared to 351 last year
- Boards took ‘immediate action’ to limit a medical practitioner’s registration in some way 199 times nationally, a 19% decrease compared to last year
- 82% of immediate actions led to regulatory action
- 74% of panel hearings resulted in disciplinary action
- 92% of tribunal hearings resulted in disciplinary action, and
- 1,697 medical practitioners were being actively monitored on 30 June 2015.

Through 2014/15, the Board and AHPRA continued to focus on improving the notifications experience for both notifiers and practitioners. Streamlining the notifications process and improving communications continues to be a major priority in 2015/16.

State and territory summaries of the annual report are also available on the AHPRA website. The summaries provide national data focusing on each state and territory. The reports provide national comparisons to show how the state or territory compares with the national average and where possible, we provide two years of data, to identify and track trends over time.

IAMRA 2016 registrations now open

Registration for the International Association of Medical Regulatory Authorities (IAMRA) 12th International conference on medical regulation is now open. The conference will be held from 20 – 23 September 2016 in Melbourne jointly hosted by the Medical Board of Australia and AHPRA.

The conference brings together international medical regulators, policy makers and medical educators to share ideas, experiences and learn from each other. Held biannually, IAMRA conferences attract approximately 250 to 350 delegates, from over 30 different countries.

The call for abstracts has now closed and the program will include a diverse range of international and local speakers. The conference social program will showcase Melbourne to our international guests. A preliminary conference program is available on the IAMRA 2016 website.

Online registrations are now available and the early bird rate closes on 23 June 2016.

IPAC conference

The International Physician Assessment Coalition (IPAC) conference will be held before the IAMRA conference on 18 and 19 September 2016 in Melbourne.

The purpose of IPAC is to:

- advocate and promote high standards for performance assessment of physicians
- provide a forum for the development and sharing of new concepts and new approaches in performance assessment of physicians
- facilitate international cooperation and collaboration by developing a sustainable network for those who conduct performance assessment and remedial programmes
- encourage and support research, policy analysis and policy development related to performance assessment and regulation of physicians
- establish a repository for existing knowledge and expertise regarding performance assessment and remediation of physicians.
Registrations for the IPAC conference are also now open – available through the IAMRA website.

**Senate inquiries lapse following announcement of election**

Following the dissolution of the Senate and the House of Representatives for a July election, the Senate inquiry into ‘Medical complaints process in Australia’, focusing on the Medical Board of Australia and the Australian Health Practitioner Regulation Agency, has lapsed, before a final report could be released.

The Senate Standing Committees on Community Affairs inquiry into ‘The growing evidence of an emerging tick-borne disease that causes a Lyme-like illness for many Australian patients’ has also lapsed prior to a final report.

**Dr Joanna Flynn AM**

**20 May 2016**
NHMRC Report to CPMC meeting, 2 June 2016

Structural Review of NHMRC’s Grant Program

In recent years, rising application numbers and costs of research have resulted in historically low funding rates for NHMRC’s major Project Grants and Fellowships schemes. We are therefore reviewing the structure of NHMRC’s grant program and exploring alternative models to see whether we can streamline and adapt our suite of schemes to suit current circumstances. An Expert Advisory Group of senior researchers and a working group of early- and mid-career researchers are providing advice. A paper will be released for public consultation and discussion meetings will be held around the country in July. It is anticipated that a decision about any changes will be made late in 2016 for introduction from 2018. Further information about the review can be found at http://www.nhmrc.gov.au/grants-funding/structural-review-nhmrc-s-grant-programme

Centre of Research Excellence in Infectious Disease Emergency Response Research

Rather than make an urgent call for research on Zika virus, NHMRC accelerated peer review of applications for its planned Centre of Research Excellence in Infectious Disease Emergency Response Research. The purpose of this Centre is to establish national research capacity for responding to major infectious disease threats as they emerge. Announcement of the successful team is imminent.

Medical Research Future Fund (MRFF)

Minister Ley announced the appointment of the Australian Medical Research Advisory Board in April 2016 and it held its first meeting on 4 May 2016. The Board will develop a 5-year Strategy and 2-yearly Priorities to guide the Minister in distributing funds from the MRFF. The NHMRC CEO is a member of this Board and the MRFF Strategy is expected to take NHMRC’s funding strategy into account to ensure complementarity. A call for submissions on the Strategy and Priorities was published on 6 May at https://consultations.health.gov.au/research-data-and-evaluation-division/mrff/consult_view. The deadline for submissions is 6 June 2016.

A new priority-setting framework for Targeted Calls for Research

While most NHMRC-funded research is investigator-initiated, a proportion of the budget is allocated to calls for research on specific, under-researched issues of national significance. An example is the recent Targeted Call for Research on Preventing Obesity in 18-24 year olds (successful grants to be announced soon). NHMRC is introducing a new, more strategic process for identifying and determining the priority of such issues, working with the Australian Health Ministers’ Advisory Committee and other groups and offering a web portal via which professional and community groups can make the case for targeted research funds in their area of interest.

Engagement and Impact Steering Committee

Ministers Pyne and Birmingham announced the appointment of the Engagement and Impact Steering Committee in March 2016 to provide advice to government on the national assessment of university research engagement and impact. The Steering Committee, which includes the NHMRC CEO, higher education and industry leaders, will help to develop a process that uses clear and transparent measures of non-academic impact, and industry and end-user engagement. Further information about the Steering Committee and Advisory Groups can be found at: http://www.arc.gov.au/news-media/media-releases/research-engagement-and-impact-working-groups-announced.
NHMRC public consultation: Draft Chapter 3.6: Xenotransplantation of the National Statement on Ethical Conduct in Human Research

The NHMRC is proposing to include a chapter on xenotransplantation in Section 3 of the National Statement on Ethical Conduct in Human Research 2007. The draft chapter provides advice for both researchers and HRECs, outlining institutional and researcher responsibilities and highlighting ethical considerations associated with animal-to-human xenotransplantation trials. In particular, feedback is sought on whether the draft chapter:

- provides sufficient guidance to address the key ethical issues in relation to xenotransplantation research
- provides sufficient information regarding the scope of the document
- is presented and written in a manner that is appropriate for the target audience (researchers, HRECs).

Any research involving animals must comply with the Australian Code for the care of animals for scientific purposes 2013 (the Code). Submissions regarding issues covered by the Code are outside the scope of this review. More information about the consultation can be found at http://consultations.nhmrc.gov.au/public_consultations/xeno-ethical-conduct.

Revision of the NHMRC Ethical guidelines on the use of assisted reproductive technology in clinical practice and research

In mid-2015 NHMRC’s Australian Health Ethics Committee (AHEC) consulted on Part B of the Ethical guidelines on the use of assisted reproductive technology in clinical practice and research 2007 (the ART guidelines) which provide ethical guidance for the clinical practice of ART. As part of this consultation, comment was also sought on the following three issues, in order to reach a position or provide a statement on each issue in the final version:

- sex selection for non-medical purposes,
- compensation of Australian women for the reproductive effort and risks associated with donating their eggs, and
- establishment of an Australian donor egg bank.

These and other issues have been considered by the Working Committee of AHEC reviewing the ART guidelines and a draft is currently with AHEC for consideration. It is anticipated that the revised guidelines will be released by the end of 2016.

Northern Australia Tropical Disease Collaborative Research Programme

The Northern Australia Tropical Disease Collaborative Research Programme (the Programme) will support innovative high quality teams to undertake research into the prevention, diagnosis, and treatment of tropical disease that translate research findings into outcomes for health in Australia and the region. Funded through the NHMRC under the ongoing direction of a Scientific Advisory Panel, the Programme will be a geographically diverse network linking across more than one institution. A physical presence in Northern Australia is expected for significant components of the team. NHMRC and the Department of Foreign Affairs and Trade (DFAT) established a combined application and assessment process that enabled applicants to apply for NHMRC and/or DFAT funding through NHMRC. Applications opened on 24 February 2016 and closed on 6 April 2016. Outcomes are merit-based and the peer review of applications is currently underway with results expected to be announced in the second half of 2016.

Advanced Health Research and Translation Centres

NHMRC held an Advanced Health Research and Translation Centres (AHRTC) Workshop on 5 November 2015 to seek stakeholder views on further development of the AHRTC initiative. This included how centres which focus on healthcare in regional or remote Australia could be recognised.
and ways to strengthen the involvement of the primary health care sector. A second call for submissions for recognition as an AHRTC is planned to open toward the end of the 2016.

Applications for NHMRC Translational Research Projects for Improved Health Care grants have been submitted by the four AHRTCs and are currently under review. The scheme’s objective is to support AHRTCs to conduct tightly-focussed research projects that aim to drive evidence-based improvements in health care. The scheme was developed based on advice from stakeholders.

<table>
<thead>
<tr>
<th>Outcomes of 2015 NHMRC application round</th>
<th>Applications</th>
<th>Awarded</th>
<th>Funded rate</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postgraduate Scholarships</td>
<td>231</td>
<td>69</td>
<td>29.9%</td>
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<td>Early Career Fellowships</td>
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<td>111</td>
<td>21.4%</td>
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<td>Translating Research into Practice (TRIP) Fellowships</td>
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<td>13</td>
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<td>Career Development Fellowships</td>
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<td>55</td>
<td>11.9%</td>
<td>$23,915,192</td>
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<tr>
<td>Practitioner Fellowships</td>
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<td>15</td>
<td>29.4%</td>
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<tr>
<td>Research Fellowships</td>
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<td>Project Grants</td>
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<tr>
<td>Boosting Dementia Research Initiative – Team Grants</td>
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<td>6</td>
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<tr>
<td>Centres of Research Excellence</td>
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<td>17.2%</td>
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<td>Development Grants</td>
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<td>24</td>
<td>25.0%</td>
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<td>Partnership Projects - 1st call</td>
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<td>8</td>
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<td>Partnership Projects - 2nd call</td>
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<td>14</td>
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<td>Program Grants</td>
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<td>Australia/EU Collaborative Research Grants - Commencing 2015</td>
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<td>Australia/EU Collaborative Research Grants - Commencing 2016</td>
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<td>3</td>
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<td>California Institute for Regenerative Medicine - Tools and Technologies Stem Cells Research</td>
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<td>Global Alliance for Chronic Diseases - Prevention and treatment of Type 2 Diabetes</td>
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<td>National Institute for Dementia Research - JPco-fuND</td>
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<td>NHMRC-NSFC (China) Joint Call for Research on Type 2 Diabetes</td>
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<td>Targeted Call for Research on Preparing Australia for the Genomics Revolution</td>
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<td>1</td>
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<td>Targeted Call for Research on Wind Farms and Human Health</td>
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<td><strong>2015 total for competitive grants</strong></td>
<td><strong>5847</strong></td>
<td><strong>1030</strong></td>
<td><strong>17.6%</strong></td>
<td><strong>$852,149,172</strong></td>
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</table>
Australian Commission on Safety and Quality in Health Care
Update on activities

Australian Atlas of Healthcare Variation

Development of atlas 2.0
The Australian Atlas of Healthcare Variation 2.0 (atlas 2.0) is currently in development and is scheduled to be provided to the Australian Health Ministers’ Advisory Council (AHMAC) in late 2016. The key focus of atlas 1.0 was community-based interventions, and the second atlas will primarily cover acute hospital services. Atlas 2.0 will include items in six clinical areas covering:

- potentially preventable hospitalisations
- maternity
- women’s health
- surgical interventions
- intensive care and
- cardiovascular conditions.

The development of the atlas will continue to be guided by a Jurisdictional Advisory Group and an Atlas Advisory Group. The Atlas Advisory Group is chaired by Professor Anne Duggan and has representation from a number of Colleges. To guide analysis and the clinical commentary for each clinical area and data item, topic expert groups have been established. These groups typically consist of six clinical experts and their role is to assist with:

- refining the key data items and analyses
- interpreting data, and
- reviewing clinical commentary.

Implementation of recommendations from atlas 1.0
The Commission has developed an implementation strategy for recommendations from atlas 1.0 where the Commission has direct responsibility. These recommendations include the development of clinical care standards and shared decision-making resources, and some further data analysis.

Interactive atlas
An online version of atlas 1.0 reproduces some of the content in web pages, with the entire contents (as a complete atlas and as single items) provided as PDF files. Spreadsheets containing the data for all the items are available, along with a link to the data definitions for all items.

The next iteration of the online version of the atlas will be interactive. The interactive form will allow users to view the maps in different ways and to interrogate the data in more detail.
Implementation of the National Safety and Quality Health Service Standards

A total of 907 individual health service organisations are scheduled for assessment to the National Safety and Quality Health Service (NSQHS) Standards in 2016.

All hospitals and day procedure services have now been assessed to the NSQHS Standards and are commencing their second cycle of assessment.

Results of the assessments in 2016 show 85% of health service organisations (and 82% of health service clusters) met all core actions at initial assessment. This is a small (4%) improvement on 2015 results. In 2015, three health service organisations (one public and two private) did not achieve accreditation.

From January to April 2016, 172 health service organisations were assessed to the NSQHS Standards, of which:
- 83 (48%) were assessed to all 10 NSQHS Standards
- 82 (48%) were assessed to Standards 1 to 3
- 7 (4%) were new health services who undertook an interim assessment

Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and practitioners

The Guide for managers and practitioners: Credentialing health practitioners and defining and managing scope of practice (the Guide) has been finalised.

The Guide was developed at the request of the Commission’s Private Hospital Sector Committee to support clinicians and managers responsible for defining and managing scope of practice of health practitioners and to provide practical guidance on conducting the credentialing process. This is an ancillary guide only. It does not replace or supersede state, territory or organisational policies on credentialing.

The development process for the Guide included the mapping of state and territory public sector credentialing and scope of practice policies, procedures and guidelines, and by-laws of private sector health service organisations; a public consultation process that received 55 written submissions; review by legal experts and the Australian Health Practitioners Registration Agency; and an iterative review process of a series of draft documents by critical friends including senior health service executives in both the private and public sectors.

Update on the revision of the NSQHS Standards

Draft version 2 of the NSQHS Standards

An amended draft of version 2 of the NSQHS Standards has been developed which incorporates feedback from the consultation and piloting processes.

The high level changes to the latest draft of the NSQHS Standards include:
- clarifying the intent of the overarching actions in the clinically based standards, further reducing duplication based on feedback
- ensuring the document is written in plain English
- reinstating some of the ‘clinical’ language to ensure clinicians continue to relate to the NSQHS Standards
- ensuring actions with multiple parts are consistent
- simplifying the numbering system to include only the number of the standard and the number of the action

The eight NSQHS Standards are:
1. Clinical governance for health service organisations
2. Partnering with consumers
3. Preventing and controlling healthcare-associated infection
4. Medication safety
5. Comprehensive care
6. Communicating for safety
7. Blood and blood products
8. Recognising and responding to acute deterioration

The *Reducing Harm* standard in the consultation draft of the NSQHS Standards is now included in the *Comprehensive Care* standard.

**Regulation impact assessment**
The next phase of consultation of the NSQHS Standards involves a Regulation Impact Statement (RIS). This process has two parts: a consultation RIS where stakeholders are invited to provide comment on the costs and benefits of three options; and a decision RIS which includes an analysis of feedback from stakeholders. The decision RIS will be submitted to health ministers when the draft NSQHS Standards are considered for endorsement.

The consultation RIS has been endorsed by the Office of Best Practice Regulation for release. If approved by the Commission’s Board, the consultation RIS and amended draft NSQHS Standards will be released for consultation on 7 July 2016, closing on 5 August 2016.

**Development of a National Model Clinical Governance Framework**
The Commission has undertaken to develop a National Model Clinical Governance Framework (the Framework). The Framework will describe how leaders of health service organisations implement integrated corporate and clinical governance systems through which organisations and individuals are accountable to the community for continuously improving the safety and quality of their services and ensuring they are patient-centred, safe and effective. The Framework will consider the key components of clinical governance including:

- governance and leadership;
- patient safety and quality systems; and
- clinician performance and effectiveness.

The development of the Framework will inform the current review of the NSQHS Standards, particularly Standard 1 - Clinical governance for health service organisations (currently Standard 1 - Governance for Safety and Quality in Health Service Organisations).

Supplementary materials such as easy to read guides and implementation strategies will be produced to assist the implementation of the Framework.

The Commission has established an Advisory Panel to provide advice and oversight of the development of the Framework and supporting materials. The Advisory Panel had its inaugural meeting on Thursday, 19 May 2016. At this meeting panel members agreed on the requirement for a national model framework, agreed on a working definition of clinical governance, discussed the essential components of a national model framework, and discussed the proposed method of consultation.

Following approval by the Commission Board, the Framework and supporting documents will be forwarded to AHMAC for endorsement.
Update on the national *Caring for Cognitive Impairment* campaign

The aim of the *Caring for Cognitive Impairment* campaign is to improve knowledge and care practices of cognitive impairment, provide better outcomes for patients and their families, hospitals and staff and reduce the risk of harm. The campaign will assist health services be aware of and prepare for the upcoming introduction of the Delirium Clinical Care Standard and new cognitive impairment items in version 2 of the NSQHS Standards.

The Commission’s CEO invited every hospital Chief Executive in Australia to participate in the campaign, as well as all Primary Health Networks and 41 supporting organisations.

As of 20 May 2016, 106 hospitals, 728 individuals and 16 supporting organisations have joined the campaign.

The campaign web site [cognitivem.org.au](http://cognitivem.org.au) enables individuals to commit to the campaign, and provides individual commitment certificates, which list simple, straight-forward steps tailored to the person’s role. All participants have access to resources including information sheets, campaign infographics, social media resources, webinars and regular newsletters.

Hospitals are able to share their existing initiatives and individuals are also encouraged to share their stories. The aim is provide a platform for collaboration and sharing of good practice.

**Shared Decision Making**

**Risk communication online training module**

Effective risk communication is an essential pre-requisite for shared decision making. The Commission is producing a two-hour online module for clinicians on risk communication entitled *Helping patients make informed decisions: communicating benefits and harms*. The manuscript for the module has been developed by subject matter experts (Prof Chris Del Mar and Prof Tammy Hoffmann), medical writers (RACGP) and an expert Steering Group comprised of representatives from a number of clinical colleges, the Confederation of Postgraduate Medical Education Councils and the Consumers Health Forum.

Based on the recommendations from Steering Group, two versions of the online module are being produced:

- An initial version has been successfully piloted with RACGP. Clinical examples that are relevant to GPs and related to items in the *Australian Atlas of Healthcare Variation* have been included. Production of this module will be completed in June 2016.
- Using the same generic content, adapted versions of the module will be produced for, and hosted by, a number of specialist colleges. On the advice of the Steering Group, the initial targeted group is doctors in post graduate years 1-4. It is expected that these versions will be completed in late 2016.

**Patient decision aids**

To support approaches to providing consumers better information about their health care choice and to promote appropriateness of care, the Commission is developing patient decision aids (PDAs) in priority areas related to items in the atlas and Clinical Care Standards. The topic areas include: antibiotic use; osteoarthritis and knee pain; and menorrhagia.
The Question Builder
The Commission is developing a web-based resource that can be used by patients to help them prepare for clinical consultations in community and out-patient settings. An existing tool, the Question Builder developed by the US Agency for Healthcare Research and Quality is being adapted for the Australian context. The tool will assist patients to prepare a list of questions that they would like to discuss and questions that they may be asked by the clinician.

Healthdirect Australia and the Consumers Health Forum are partnering with the Commission on this project and an advisory group, including clinical colleges and consumer organisations is guiding this work. The project is expected to be completed in late 2016.

Collaboration with Independent Hospital Pricing Authority
Hospital acquired complications (HACs) project
The Commission has undertaken a body of work with Independent Hospital Pricing Authority (IHPA) to explore the use of data that is routinely collected from patient medical records (patient medical data) to drive improvements in healthcare safety and quality. In 2013 the Commission and IHPA undertook a clinician-driven process to develop a national list of 40 high-priority HACs, categorised into 16 groups. 37 of these complications could be generated from existing data. Specifications for the other data items (Unplanned admission to intensive care unit, Unplanned return to theatre and Hospital rapid response team call) were subsequently also developed. A proof of concept study was then undertaken over 2014 and 2015 in seven public and eight private hospitals. The study confirmed that the concept of HACs was valid and relevant for safety and quality improvement, and that the underlying data was useful and of a reasonable quality.

On 1 April 2016 all First Ministers signed a Heads of Agreement on Public Hospital Funding (the Agreement). The Agreement focused on key health reforms that will improve health outcomes and decrease avoidable demand for public hospital services. Under the Agreement, HACs will inform a model to integrate quality and safety into hospital pricing and funding. It is acknowledged that while largely preventable, not all events are preventable. However, there are differences in patient safety outcomes across jurisdictions and Local Hospital Networks. The model outlined in the Agreement therefore relates to assessing performance and tying this to a funding incentive in order to improve the safety and quality of the system. The Commission will be providing expert advice to ensure the HACs suitability for incorporation into the model.

Implementation of the Agreement will be the focus of much of the Commission’s and IHPA’s work on pricing for safety and quality in 2016-17. The Commission will also be developing supporting resources for the HACs list in 2016-17 with the aim of improving clinical documentation and supporting local monitoring.

Best practice pricing update
The Commission and IHPA have established a sub-committee to investigate potential approaches to best practice pricing – with an initial focus on the management of hip fracture patients. The sub-committee’s report Best-practice pricing and clinical quality information on hip fracture care was recently published on the Commission’s website. The Commission and IHPA are now working to implement the recommendations of the report. A work plan for implementation of a best practice pricing approach for hip fracture care has been developed and work has commenced with the Australian and New Zealand Hip Fracture Registry to develop data requirements for collection of the Hip Fracture Care Clinical Care Standard clinical indicators. As outlined in their
Pricing Framework 2016-17, IHPA intends to work with jurisdictions and other stakeholders to further examine the viability and implications of implementing a best-practice pricing approach for hip fracture care in future years.

The Commission and IHPA have also completed preliminary data analysis with clinicians to explore an approach to best-practice pricing and clinical quality information in acute coronary syndromes. However, the implementation of the Agreement is the focus of much of the Commissions and IHPAs present work on pricing for safety and quality. Further consideration of acute coronary syndromes and other clinical areas for a best practice pricing approach is therefore not currently feasible.

Antimicrobial Use and Resistance in Australia (AURA) Surveillance System
The First Australian Report on Antimicrobial Use and Resistance in Human Health
The Commission is currently finalising its publication of the First Australian Report on Antimicrobial Use and Resistance in Human Health (AURA 2016). It is expected the Report will be released mid June 2016.

AURA 2016 brings together the recent work of the Commission, in collaboration with the jurisdictions and partner programs, to provide comprehensive and integrated antimicrobial resistance (AMR) and antimicrobial usage (AU) surveillance data from the acute care and community settings. It contains a range of analyses and commentary on the current state of play for AMR and AU. Importantly this report includes, for the first time, data on appropriateness of AU. This type of surveillance data has not been provided in comparable international reports.

AURA 2016 demonstrates the importance and value of AMR and AU surveillance data to inform strategies for preventing and containing AMR, and supporting implementation of the National Antimicrobial Resistance Strategy 2016-19.

With respect to AMR, AURA 2016 includes information and data on organisms that form the Priority Organisms List, or otherwise with a high public health impact, such as Enterobacteriaceae and Neisseria gonorrhoeae, providing a descriptive background on their resistance and their impact at the community and hospital levels.

AURA 2016 will raise awareness of the key emerging issues for AMR and AU, some of which include increased carbapenem use and carbapenem resistance; the emergence of resistance in gram-positives; and the appropriateness of AU in surgical prophylaxis.

The Commission is also developing a series of supplementary data which will focus on key issues raised in the report and provide in-depth discussion and analysis on issues such as Methicillin-resistant Staphylococcus aureus (MRSA); carbapenemase-producing Enterobacteriaceae (CPE); and a supplement focusing on amoxicillin with clavulanic acid, flucloxacillin and cefazolin, which are the top three antimicrobials used in hospitals.

A copy of the AURA 2016 will be provided to the CPMC members. This report will also be made available on the Commission’s website along with other AURA resources at http://www.safetyandquality.gov.au/antimicrobial-use-and-resistance-in-australia/
National Passive Antimicrobial Resistance Surveillance
The Commission continues to work with Queensland Heath to roll out OrgTRx as the national passive AMR surveillance system. Laboratory systems that are currently contributing data to this national system include the Australian Capital Territory, public and private services in Queensland, New South Wales and Tasmania, with new services to join from Victoria and South Australia.

The Commission is also working with the Northern Territory and Western Australia in relation to their capacity to participate in the national system.

National Alert System for Critical Antimicrobial Resistances (CARAlert)
In March 2016, the Commission launched CARAlert to support the timely detection and communication of critical antimicrobial resistances (CARs) across Australia.

There are currently eight CARs reported under CARAlert:

Table 1: Critical Antimicrobial Resistances

<table>
<thead>
<tr>
<th>Species</th>
<th>Critical Resistance</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Enterobacteriaceae</em></td>
<td>Carbapenemase-producing strains, or Ribosomal methylase-producing strains</td>
</tr>
<tr>
<td><em>Enterococcus species</em></td>
<td>Linezolid non-susceptible</td>
</tr>
<tr>
<td><em>Mycobacterium tuberculosis</em></td>
<td>MDR (at least rifampicin and isoniazid resistant) strains</td>
</tr>
<tr>
<td><em>Neisseria gonorrhoeae</em></td>
<td>Ceftriaxone non-susceptible or azithromycin resistant strains</td>
</tr>
<tr>
<td><em>Salmonella species</em></td>
<td>Ceftriaxone non-susceptible strains</td>
</tr>
<tr>
<td><em>Shigella species</em></td>
<td>MDR strains</td>
</tr>
<tr>
<td><em>Staphylococcus aureus</em></td>
<td>Vancomycin, linezolid or daptomycin non-susceptible</td>
</tr>
<tr>
<td><em>Streptococcus pyogenes</em></td>
<td>Penicillin reduced susceptibility</td>
</tr>
</tbody>
</table>

The system complements the current process for confirming critical resistances by confirming laboratories. Once the confirming laboratory has confirmed a critical resistance in a suspected isolate, this result is provided to the originating laboratory. A summary report is then entered into the CARAlert web portal which subsequently triggers an email and SMS alert to the relevant jurisdictional contacts, notifying the details of the confirmed CAR.

The Commission will produce monthly reports from data collected by the system to complement the alerts. These reports will collate data on the total number of confirmed CARs across Australia and their breakdown according to the patients’ residential state/territory per month and cumulatively. The reports will include CAR types, organism names, patient age ranges, and other information considered useful by the jurisdictions. A sample report is provided below:
CARAlert reports will be provided to the states and territories to support strategic responses suitable to the nature of the resistance. The information gathered through CARAlert will allow public health units and policy makers at the state and national level to receive data to inform timely response action.

The Commission will formally evaluate CARAlert in September 2016, six months following its launch, with the intent of refining the system based on the stakeholders’ feedback, and to ensure the system remains user friendly and generates useful data.

**Update on the National Patient Blood Management Collaborative**

The Commission is leading the National Patient Blood Management (PBM) Collaborative (the Collaborative), to support strategies to accelerate the uptake of PBM nationally; improve patient care; promote and support health services in the uptake of PBM guidelines; and to increase the number of patients who have their anaemia identified and managed prior to elective surgery.

A systematic review of evidence found that preoperative anaemia is independently associated with an increased risk of morbidity and mortality. Preoperative anaemia has also been found to increase the likelihood of red blood cell transfusion. Anaemia management, prior to elective surgery, can improve a patient’s pre-surgery clinical status, and reduce post-surgery morbidity, mortality and length of stay in hospital.

The Collaborative is supporting improvements in the management of anaemia for patients undergoing selected elective gastrointestinal, gynaecological and orthopaedic surgery procedures. The management of iron deficiency pre-operatively is also a focus of the Collaborative. Twelve health services nationally are participating in the Collaborative which is operating between April 2015 and April 2017. The health services include public and private hospitals in urban and rural locations. The health services do not need to participate in all surgical streams.

**Activity Reporting**

As at the end of April 2016, the Collaborative included over 6,000 patients having elective surgery procedures:

- 1,141 gastrointestinal
- 3,370 orthopaedic
- 1,519 gynaecological

**Figure 2: Number of procedures recorded by health service, by surgical stream (at end April 2016)**

Of the 6,030 procedures recorded in the qiConnect database as at the end of April 2016:
- 5,450 patients were screened for anaemia
- 2,013 were screened for iron deficiency
- 2,003 were screened for both

The percentage of patients assessed for anaemia is steadily increasing each month. The percentage of patients assessed for iron deficiency is also increasing each month, with a large improvement in recent months as focussed improvement cycles are put in place. The number of patients who received transfusions is decreasing steadily each month. The evaluation to be conducted will examine transfusions in health services which are not part of the Collaborative.

**Plan Do Study Act Cycles**
The Plan-Do-Study-Act (PDSA) cycle is the means by which the model for improvement is undertaken; it is shorthand for testing a change. The four stages of the PDSA cycle are:
- **Plan** - the change to be tested or implemented
- **Do** - carry out the test or change
- **Study** - data before and after the change and reflect on what was learned
- **Act** - plan the next change cycle or full implementation of what is learned

By making incremental changes, there is an opportunity to test the changes on a small scale and learn about the risks and benefits, before implementing the change more widely. The Collaborative teams are progressing well, with over 215 PDSAs completed to April 2016.

The Commission provides support to participants through the development of resources; via Project Co-ordinator Workshops, Learning Workshops and access to a range of clinical and technical experts who are able to support and inform specific
change. Work will commence on developing a Business Case supporting the national implementation of PBM, in consultation with the Department of Health.

**Outcomes**

By improving anaemia management for patients in the pre-operative phase of care, the Collaborative may help to reduce the risk of post-operative infections and adverse reactions from blood products; reduce the risk of transfusion related inflammatory events; reduce hospital length of stay; reduce the risk of re-admission from infectious complications of transfusion, and reduce elective surgery cancellations.
Medicare Rebate Freeze

The AMA has stepped up its campaign against the ongoing freeze on Medicare rebates, launching a range of resources for practices to use to inform patients about the impact of the freeze, including the most recent Budget decision to extend it until 2020.

These resources include a Medicare freeze poster, a template that allows doctors to print the poster in the tear off section at the bottom of prescription forms, an updated gaps poster and template letters to send to patients. These are available for download on the AMA website.

The Australian health system is one of the best in the world, with a good balance between the public and private sector. By OECD standards, the costs of our health system are moderate and we are delivering good outcomes for our patients. Despite this, the health system has been continually targeted with cuts and its future is under threat.

The Government has so far delivered a very disappointing response, with the Health Minister reportedly saying it appreciated many GPs’ efforts to keep costs down during the indexation freeze, but was disappointed “there’s no reciprocal offer to assist taxpayers with the immediate financial challenges our budget faces”.

The ALP has opposed the freeze and committed, if elected, to lifting the freeze from 1 January 2017.

Key Health Issues for the 2016 Federal Election

The AMA has released Key Health Issues for the 2016 Federal Election - a summary of the major health issues that the AMA considers must be addressed by the major parties during the election campaign and into the next term of Government, whichever party wins.
Besides the Medicare rebate freeze, the policy document covers:

- Public Hospitals;
- Removal of Pathology and Diagnostic Imaging Bulk Billing Incentives;
- Medical Workforce and Training;
- Tackling Chronic Disease;
- Indigenous Health;
- Rural GP Infrastructure Grants;
- Prevention;
- Tobacco; and
- Physical Activity.

The full document is available from the AMA [website](http://www.ama.org.au).

**Pathology and Diagnostic Imaging Bulk Billing Incentives**

The AMA has opposed the removal of bulk billing incentives for pathology and diagnostic imaging services. These incentives currently support patient access to these essential services.

This is short-sighted policy that will ultimately cost future governments and the Australian community much more in having to treat more complicated disease – disease that could have been identified or avoided through good access to pathology and diagnostic imaging services.

On 13 May the Government announced in relation to pathology services that, if elected, it would defer this policy measure and institute a range of measures targeting rents paid by pathology providers for co-located collection centres.

While the AMA was not surprised to see an emphasis on improved compliance in this announcement, the decision to redefine market value (for the purposes of rents) contradicted previous advice that the Minister for Health had determined that the current regulatory framework as it relates to prohibited practices and market rent is appropriate and is consistent with broader government competition principles.

It should also be noted that the proposal to revise the definition of market value had not been raised with stakeholders at a forum specifically requested by the Minister to discuss collection centre rents, even though it had taken place only two weeks prior.

**Private Health Insurance**

The Government has announced an expert group (the Private Health Sector Committee) to provide advice on designing and implementing the Government’s private health insurance reforms. It is not known if the PHI Consultations, established in October 2015, have concluded
and reported to the Minister. No further information from the consumer survey conducted as a part of this review has surfaced.

This committee will consider ensuring products meet consumer needs, that consumers understand what they are buying, and improving competition and the ability of insurers to manage costs.

The Government has also re-established the Prostheses List Advisory Committee (PLAC) to further develop and advise on implementing changes to the prostheses listing process recommended by the prostheses working group. It will be through this forum that the recommendations of the Industry Working Group on Private Health Insurance Prostheses Reform are pursued.

The AMA also made a submission to the Australian Competition and Consumer Commission (ACCC) on 28 April 2016 that argued that there is a lack of transparency around private health insurance and certain practices by the industry. It noted that the poor communication of changes to private health insurance policies held by consumers is symptomatic of a system designed to confuse customers to the advantage of the insurers. As a result people do not understand their health insurance product and are missing out on necessary treatment when they need it.

Back in July 2014, the President wrote to the Minister for Health outlining concerns the AMA had with Medibank and BUPA creating a pre-assessment procedure for plastic and reconstructive surgery. The AMA continued to raise this issue through subsequent letters to the Minister and a meeting with Department of Health (DoH) officials on 25 February at which the AMA presented evidence of this continued behaviour by the insurance funds. Subsequent to this meeting, the Commonwealth Ombudsman (who absorbed the PHIO) wrote to the AMA to advise that it will be undertaking a review into the practices of private health insurers ‘pre-assessing’ Medicare-eligible plastic and reconstructive surgery. This is a very good step forward to eradicating this practice by the insurers.

The AMA Private Health Insurance Report Card 2016 was launched in March. It has been very successful with over 100,000 views on the AMA website.

**Skilled Occupations List**

The AMA made a submission to the Department of Education and Training’s (DET) 2016-17 review of the SOL in January and attended consultations organised by the DET. The AMA highlighted that many of specialties and sub-specialties on the list are in a position of balance or oversupply and should be removed.
The consultation has been completed and the following occupations have been flagged for potential removal:

<table>
<thead>
<tr>
<th>ANZCO Code</th>
<th>Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>253111</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>253211</td>
<td>Anaesthetist</td>
</tr>
<tr>
<td>253312</td>
<td>Cardiologist</td>
</tr>
<tr>
<td>253315</td>
<td>Endocrinologist</td>
</tr>
<tr>
<td>253316</td>
<td>Gastroenterologist</td>
</tr>
<tr>
<td>253317</td>
<td>Intensive Care Specialist</td>
</tr>
<tr>
<td>253321</td>
<td>Paediatrician</td>
</tr>
<tr>
<td>253913</td>
<td>Obstetrician and Gynaecologist</td>
</tr>
<tr>
<td>253999</td>
<td>Medical Practitioners nec</td>
</tr>
</tbody>
</table>

**MBS Review**

The MBS review is progressing slowly.

The first set of clinical committees are finalising the rest of their recommendations. These will be available for public consultation in the near future. The Government announced the removal of 24 items in the May Budget, with an anticipated saving of $5.1 million between 2016/17 – 2019/20.

**AHPRA**

The AMA had its most recent quarterly meeting with AHPRA on 12 May 2016. Our relationship continues to be an open and collaborative one. Specific items of focus at our most recent meeting included progress report on the NRAS review, the Board’s position on revalidation, and an opportunity to raise concerns about the practice of chiropractors as well as proposals around mandatory notifications, specifically those raised by Victoria.

The AMA made a submission to the Senate Community Affairs Inquiry into the growing evidence of an emerging tick-borne disease that causes a Lyme-like illness for many Australian
patients on 30 March 2016. It noted that legitimate questions around these issues has not been assisted by some of the public commentary that ignores a number of the facts established to date, most of which was reflected in the interim report released by the Committee before the election was called.

It is unclear whether this inquiry will continue in a new parliament as its principal proponent was Senator Madigan.

**Primary Health Care Advisory Group (PHCAG)**

The Government released the report of the PHCAG in April as well as its response. At the centre of the Government’s response is the proposal for a trial of the health care home concept, linked to the voluntary registration of patients with complex and chronic disease. Importantly, the health care home is built around general practice.

While the proposal accords with many of the principles set out in AMA policy, briefings from the DoH confirm that no additional funding has been allocated for GP services and access to allied health will not be risk stratified. Funding will also be provided to practices as opposed to GPs, which differs from what we understood PHCAG preferred.

In the absence of additional funding for services in the trial, the AMA’s view is that it will not deliver better outcomes for patients. General practice is being asked to deliver enhanced care for patients, but the Government is failing to deliver the additional financial support that will be required.

**Pharmacists in General Practice**

The AMA has continued to advocate for the proposal to introduce non-dispensing pharmacists into general practice. A call for ‘ideas’ under the Community Pharmacy Trial Program was issued by the DoH earlier in the year, with the AMA joining with the Pharmaceutical Society of Australia to submit an outline of our Pharmacist in General Practice Proposal.

**Office of the Australian Information Commissioner (OAIC)**

The OAIC released a reporting in April that detailed its findings of an examination of the privacy policies of 40 general practices across Australia. The Report essentially found that no practices had a fully compliant privacy policy.

While this report did not look at breaches of patient privacy, it clearly had the potential to be twisted by the media. In this regard, the AMA worked with the OAIC and other GP organisations with the OAIC ultimately issuing a balanced press release that focused on how groups like the AMA were working to help practices improve their privacy policies. The AMA also worked with the OAIC to update some of our own materials for practices.
**ACCC Authorisation**

The AMA has an ACCC authorisation that permits general practices to engage in ‘intra-practice’ fee setting, including in negotiations with the former primary health care bodies known as Medicare Locals. The AMA applied for a minor variation to this authorisation to extend it to cover Primary Health Networks, which have taken over from Medicare Locals. This was agreed to by the ACCC on 8 April 2016.

**Work Related Self-Education Expenses**

Following media reports that work related tax deductions might be targeted in the Budget, the AMA wrote to the Federal Treasurer calling on him to rule out changes that might impact on work related self-education expenses.

The Treasurer’s office subsequently ruled out any changes and the Budget did not contain any measures to this effect. However, we understand that the Government, if re-elected, will continue to consider reform of work related tax deductions so this issue needs to remain on the radar for the profession.

**Harassment and Bullying in the Medical Workforce**

The Senate Community Affairs References Committee was asked to conduct an Inquiry into medical complaints, including the issue of bullying and harassment. In relation to the latter, the AMA prepared a submission to the Inquiry utilising the material that the AMA has already put to the Royal Australasian College of Surgeons (RACS) Expert Advisory Group. While the Inquiry will not proceed due to the election, it is anticipated that it will be revived in the next Parliament as one of its sponsors was Senator Nick Xenophon who is very likely to be returned.

**Specialist Training Program**

MYEFO saw the announcement of an additional 100 STP places by 2018, while the DoH has also conducted a consultation focusing on improving the administration and targeting of the STP. The AMA understand that the National Medical Training Advisory Network will be tasked with providing policy advice on the future direction of the STP, and both our NMTAN representatives have volunteered to be part of this process.
Medical School Places

The AMA continues to campaign strongly against proposals for extra medical student places. Health Workforce Australia’s final medical workforce report, Australia's Future Health Workforce, looked ahead until 2030. It said we should focus on improving the distribution of the medical workforce and encouraging future medical graduates to train in the specialties where they are needed.

HWA did not recommend that Australia train more doctors. Indeed, its most likely modelling scenario showed that Australia would not have a shortage of doctors by 2030 and recommended no changes to the domestic and international medical student intake until reliable workforce modelling indicated otherwise.

Most recently the AMA was asked to comment on Griffith University’s plans for the new medical school campus that will be based at the Sunshine Coast University Hospital in Kawana. Arrangements to establish this medical school involve the transfer of 35 existing medical student places from the University of Queensland, although the University has been lobbying for an additional 15 places beyond this.

While the AMA is supportive of the establishment of the Sunshine Coast campus, based on the transfer of existing places, it strongly advised the Government that it cannot support the call for an extra 15 new medical student places per year. It would be contrary to the advice of the above report as well as the National Medical Training Advisory Network. Putting more medical students into the medical training pipeline will only exacerbate the shortages that already exist in available post graduate training places.

The AMA understands that Sunshine Coast Health and Hospital Services is planning to increase the number of postgraduate training places that it provides over time. Our view is that there is more than enough scope to fill these places based on current medical graduate projections and this will be able to play a significant role in addressing local medical workforce expansion.

Council of Australian Governments Health Council National Review of Medical Intern Training

Health Ministers considered the final report of the Review of Medical Intern Training last year and commissioned the Health Workforce Principal Committee (through a Working Group) to examine the feasibility, prioritisation and sequencing of implementation of the Review recommendations. The AMA understands that the report of the Working Group has been sent back for more work and nothing is expected until later in the year.
**General Practice Training**

The Minister for Health indicated earlier this year that she wished to proceed with the proposal for ‘co-funded’ GP training places that was announced in the 2014/15 Budget. In March, the DoH provided the AMA with a confidential copy of its draft selection criteria and operational guidelines for comment.

The AMA does not support the concept of ‘co-funded’ GP training places, recognising that GPs and practices already make a substantial contribution to GP training. The AMA has made the point that if the Government is intent on proceeding with this initiative, placements should organised and administered through the existing network of Regional Training Organisations (RTO), with Colleges responsible for the selection of candidates.

**Doctors’ Health**

The AMA continues to progress the development of a national health program for doctors and medical students in Australia, with funding to support this provided by the Medical Board of Australia. Doctors Health Services Pty Ltd (DrHS) is overseeing the move to fund and coordinate nationally consistent services in every State and Territory. DrHS has finalised funding arrangements covering NSW, ACT, SA, NT (commenced 1 May 2016) and Queensland (commencing 1 June 2016).

Discussions between DrHS and the Victorian and Western Australian doctors’ health programs are ongoing, but hopefully should be finalised in the next month or two.
Regional and Rural Issues
Medical Deans continue to focus on addressing regional and rural medical workforce issues. The Federation of Rural Australian Medical Educators (FRAME) recently met to discuss a range of issues including an update on the Integrated Rural Training Pipeline (IRTP) initiatives, by the Department of Health. The IRTP has three components including the establishment of Regional Training Hubs, the Rural Junior Doctor Innovation Fund and 100 new places in the Specialist Training Programme targeted specifically at rural locations.

The IRTP aims to retain medical graduates in rural areas by better coordinating the different stages of medical training within regions and building additional junior doctor and specialist training places in rural areas. Medical Deans welcome these initiatives – what is needed to address rural medical workforce issues are viable regional medical postgraduate training programmes which allow graduates to complete training in regional locations. It is for this reason that Medical Deans has been concerned with the proposal for a new medical school in regional NSW and Victoria. Such a proposal risks diverting scarce resources away from postgraduate training and increasing pressure on rural graduates to move back to capital cities. Victorian and NSW Deans have expressed these concerns to the Minister for Health.

Review of Medical Intern Training
International expert Professor Olle ten Cate recently held a workshop on competency based medical education attended by Medical Deans and members of the Health Workforce Principal Committee (HWPC). The concept of Entrustable Professional Activities (EPA’s) was referred to in the Review of Medical Intern Training with relation to assessing work readiness and this was a valuable opportunity to meet with the originator of EPA’s. Medical Deans are working with the HWPC on the issue of work readiness and are planning a seminar involving key stakeholders later in the year.

2016 Budget
The Federal Government handed down its Budget on 3 May 2016. The Budget confirmed the April COAG funding arrangements for public hospitals which will receive an additional $2.9b over 3 years. While this was welcome news there has been significant concern expressed about the continuation of the Medicare rebate freeze until 2020. The freeze covers all MBS Services and is estimated to save nearly $1billion.

The 2016 Budget also saw the Government put its higher education reforms on hold with the release of a discussion paper “Driving Innovation, Fairness and Excellence in Australian Higher Education.” The Government has said it will not be implementing deregulated course fees as proposed in the 2014-15 Budget and the new reforms are not due to commence until 2018 (there are still savings in the forward estimates).

The discussion paper raises alternative models of flexibility for institutions to set fees for a small cohort of students enrolled in courses of clearly defined excellence or “flagship courses”. It also raises a range of other measures including reforms to the allocation of postgraduate places.

www.medicaldeans.org.au
options to adjust subsidy and student contributions and changes to HELP repayment thresholds and rates. The paper is seeking the views of the sector on the relativities between disciplines of funding clusters and to work with Universities Australia to investigate the relative cost of delivery of higher education. An Expert Advisory Panel has been established to oversee the review.

Medical Research Futures Fund
The Australian Medical Research Advisory Board supporting the Medical Research Future Fund has held its inaugural meeting. Under the Medical Research Future Fund Act 2015, the Advisory Board is tasked with determining the Australian Medical Research and Innovation Strategy and related Priorities. The Advisory Board has called for public submissions by the 6 June 2016 to inform the development of the Strategy and Priorities. Further information is available on the Department of Health consultation hub.

Leaders in Indigenous Medical Education (LIME) Network Update
The LIME Network was recently shortlisted for the Ronald Harden Award for Innovation in Medical Education. Whilst the award went to Ophthalmologists who developed a multimedia platform to assist the treatment of eye disease in Africa, there was a lot of interest in how the LIME Network operated and what it was achieving.

The LIME Project has received a Melbourne Engagement Grant to promote Indigenous pathways into medicine. The project, submitted in partnership with AIDA, will result in the dissemination of specifically designed posters, LIME Pathways into Medicine flyers, and AIDA Journeys into Medicine booklets for display at Aboriginal Community Controlled Health Organisations around the country.

A Slice of LIME Seminar was hosted by the Poche Indigenous Health Network in Sydney - Do we need traditional Aboriginal medicine working with western medicine to close the gap? It is recorded for online viewing on the LIME Network website: http://www.limenetwork.net.au/resources/slice-lime-seminars

Medical Students Outcome Database and Data Linkage Project update
The 2015 Medical Students Workforce Survey has now been completed with virtually all relevant data captured and results should be available in the next couple of months. Interest in utilising the database continues to be strong. A number of ad-hoc requests for MSOD data have recently been assessed by the data access committee.

The next phase for the MSOD is to enhance its use as a workforce planning tool by linking it with other datasets such as the APHRA medical registration data and the National Health Workforce Dataset. Privacy and legislative requirements make this a challenge however progress continues on the MSOD and Data Linkage Project (funded by the Commonwealth Government) with various linkage options currently being considered by the key partners.

UPCOMING EVENTS
Group of Eight Meeting – 21 June 16, Sydney
Medical Deans Annual General Meeting – 22 June 16, Canberra
Medical Deans Annual Conference – 12-14 October 16, Wollongong

Professor Nicholas Glasgow  Ms Carmel Tebbutt
President, Medical Deans CEO, Medical Deans