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<tr>
<th></th>
<th>7pm</th>
<th>Governance Session</th>
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<tr>
<td>4</td>
<td>Chairs report</td>
<td>Noting ✓</td>
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<tr>
<td>4</td>
<td>Minutes from 18 February CPMC meeting</td>
<td>Noting ✓</td>
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<tr>
<td>4.1</td>
<td>Executive update 24 March &amp; 10 May minutes</td>
<td>Noting ✓</td>
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<tr>
<td>4.2</td>
<td>CPMC financial statements</td>
<td>Noting ✓</td>
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<td>4.3</td>
<td>CEO Report</td>
<td>Noting ✓</td>
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<td>4.4</td>
<td>Changes in Directors</td>
<td>Noting ✓</td>
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<td>5</td>
<td>7:15 Sub-Committees</td>
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<tr>
<td>5.1</td>
<td>Indigenous Health</td>
<td>For Noting ✓</td>
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<tr>
<td>5.2</td>
<td>Commonwealth Funding Agreement: ‘Support for Rural Specialists in Australia’ and Rural Health Governance – links to</td>
<td>Decision ✓</td>
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<tr>
<td>6</td>
<td>Strategic Items for Noting</td>
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<tr>
<td>6.1</td>
<td>NMTAN 10 March 2016 update</td>
<td>For Noting ✓</td>
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<td>6.2</td>
<td>AMA Request on Generalism - Chair to meet with AMA Vice-President over morning tea</td>
<td>For Noting ✓</td>
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<tr>
<td>6.3</td>
<td>Federal Budget 2016</td>
<td>For Noting ✓</td>
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<tr>
<td>6.4</td>
<td>Submissions lodged</td>
<td>For Noting ✓</td>
</tr>
<tr>
<td>6.5</td>
<td>CPMC End of Life Care position statement</td>
<td>For Noting ✓</td>
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<tr>
<td>6.6</td>
<td>National Health Summit on Obesity -update</td>
<td>For Noting ✓</td>
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<tr>
<td>6.7</td>
<td>CMC New Zealand meeting - update</td>
<td>For Noting ✓</td>
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8pm **NB: Ms Magarry will depart here**
COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES

Thursday 2 June, 2016
Royal Australasian College of Surgeons, MELBOURNE
AGENDA

<table>
<thead>
<tr>
<th>Item #</th>
<th>Time</th>
<th>Agenda Item</th>
<th>Presented by</th>
<th>Paper</th>
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<tr>
<td></td>
<td>8:30am</td>
<td>Tea – coffee on arrival</td>
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<tr>
<td>1</td>
<td>9AM</td>
<td><strong>Professions Forum (Open)</strong></td>
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<td><strong>Meeting formalities 113TH MEETING</strong></td>
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<tr>
<td></td>
<td></td>
<td>1.1 Attendance and Apologies</td>
<td>Chair</td>
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<td>1.2 Conflicts of Interest and Confidentiality</td>
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<td>1.3 Other issues – guests</td>
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<td>2</td>
<td></td>
<td><strong>Forum Reports</strong></td>
<td>Chair</td>
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<tr>
<td>2.1</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>2.2</td>
<td>9:10</td>
<td>The Australian Medical Council</td>
<td>Prof. J Sewell</td>
<td>✔</td>
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<td>2.3</td>
<td>9:20</td>
<td>Commonwealth Chief Medical Officer No paper from the Commonwealth in caretaker</td>
<td>Prof. C. Baggoley</td>
<td>✔</td>
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<td>2.4</td>
<td>9:30</td>
<td>National Health &amp; Medical Research Council</td>
<td>Prof. Anne Kelso</td>
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<td>2.5</td>
<td>9:40</td>
<td>Medical Board of Australia &amp; AHPRA</td>
<td>CEO M. Fletcher</td>
<td>✔</td>
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<td>2.6</td>
<td>9:50</td>
<td>Australian Indigenous Doctors’ Association</td>
<td>Dr Kali Hayward</td>
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<tr>
<td>2.7</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>2.8</td>
<td>10:10</td>
<td>The Australian Medical Association</td>
<td>CEO Anne Trimmer</td>
<td>✔</td>
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<tr>
<td>2.9</td>
<td>10:20</td>
<td>Medical Deans of Australia &amp; New Zealand</td>
<td>Prof Glasgow Ms Carmel Tebbutt</td>
<td>✔</td>
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<td>2.10</td>
<td>10:30</td>
<td>Confederation of Postgraduate Medical Education Councils</td>
<td>Dr Jag Singh</td>
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<td></td>
<td></td>
<td><strong>11.00 – 11.30am</strong></td>
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<td></td>
<td>Morning Tea for Profession Observers, College Presidents and CEOs</td>
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<td>Item #</td>
<td>Time</td>
<td>Agenda Item</td>
<td>Presented by</td>
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<td><strong>College Presidents and CEOS Only</strong></td>
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<td>3.1</td>
<td>11:45am</td>
<td>United Nations High Commission on Refugees</td>
<td>Prof Talley</td>
<td>✓</td>
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<td>Regional Representative Mr Thomas Albrecht</td>
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<td></td>
<td>Briefing and discussion</td>
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<td>3.2</td>
<td>12:15pm</td>
<td>Commonwealth of Australia: Secretary, Department of Health Mr Martin Bowles</td>
<td>Prof Talley</td>
<td>✓</td>
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<td>Update and discussion on government reform agenda</td>
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<td><strong>LUNCH 1PM – 1:30PM</strong></td>
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<tr>
<td>3.3</td>
<td>1:30-1:45pm</td>
<td>Revalidation Update: Royal College of Pathologists, Australia</td>
<td>Presentation</td>
<td>✓</td>
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<td></td>
<td></td>
<td>Professor Michael Harrison</td>
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<tr>
<td>3.4</td>
<td>1:45-2pm</td>
<td>Revalidation Update: Royal Australasian College of Physicians Professor</td>
<td>presentation</td>
<td>✓</td>
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<td>Richard Doherty</td>
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<td><strong>College Presidents Only Continued</strong></td>
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<td>6</td>
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<td><strong>Strategic Policy Session continued</strong></td>
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<td>6.8</td>
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<td>Revalidation: Request for nominations to the Medical Board of Australia’s Consultative Committee</td>
<td>For Decision</td>
<td>✓</td>
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<tr>
<td>6.9</td>
<td></td>
<td>Medical Fees and Gaps - update</td>
<td>Discuss</td>
<td>✓</td>
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<td></td>
<td>Prof. Truskett</td>
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<tr>
<td>6.10</td>
<td></td>
<td>CPMC Strategic Planning Forum Report</td>
<td>Discuss</td>
<td>✓</td>
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<tr>
<td>7</td>
<td></td>
<td>Other Business</td>
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<td>8</td>
<td></td>
<td><strong>Evaluation</strong></td>
<td>verbal</td>
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<tr>
<td>9</td>
<td>2:45pm</td>
<td>Next Meeting 10 November 2016 at RANZCOG</td>
<td>For Noting</td>
<td>✓</td>
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Committee of Presidents of Medical Colleges

DRAFT

Minutes of the 113th meeting of the Committee of Presidents of Medical Colleges held on Thursday 18th February 2016 at the Royal College of Pathologists of Australasia, 207 Albion Street, Surry Hills, Sydney

Present
Professor Nicholas Talley   Chair
Associate Professor Anthony Lawler   Australasian College of Emergency Medicine
Professor Bala Venkatesh   College of Intensive Care Medicine of Australia and New Zealand
Dr Michael Harrison   Royal College of Pathologists of Australasia
Dr Frank Jones   Royal Australian College of General Practitioners
A/Professor Lucie Walters   Australian College of Rural and Remote Medicine
Professor Malcolm Hopwood   Royal Australian and New Zealand College of Psychiatrists
Professor Michael Permezel   The Royal Aust & NZ College of Obstetricians and Gynaecologists
Dr Genevieve Goulding   Australian and New Zealand College of Anaesthetists
Dr Greg Slater   The Royal Australian and New Zealand College of Radiologists
Professor David Watters   Royal Australasian College of Surgeons
Dr Bradley Horsburgh   Royal Australian and New Zealand College of Ophthalmologists
A/Professor Lucie Walters   Australian College of Rural and Remote Medicine
Professor Michael Cleary   Royal Australasian College of Medical Administrators
Dr Catherine Yelland   Royal Australasian College of Physicians
Dr Adam Castricum   Australasian College of Sports Physicians

College Chief Executives
Mr Tim Wills   Australasian College of Dermatologists
Dr Peter White   Australasian College of Emergency Medicine
Dr Zena Burgess   Royal Australian College of General Practitioners
Dr Karen Owen   Royal Australasian College of Medical Administrators
Ms Linda Smith   Royal Australasian College of Physicians
Ms Alana Killen   Royal Aust and NZ College of Obstetricians and Gynaecologists
Dr Debra Graves   Royal College of Pathologists of Australasia
Dr David Andrews   Royal Australian and New Zealand College of Ophthalmologists
Laina De Winne for Natalia Vukolova   Royal Australian and New Zealand College of Radiologists
Mr Phillip Hart   College of Intensive Care Medicine of Australia and New Zealand
Dr Mirco Kabat for Andrew Peters   Royal Australian and New Zealand College of Psychiatrists
Mr John Biviano for A/Prof David Hillis   Royal Australasian College of Surgeons
Ms Marita Cowie   Australian College of Rural and Remote Medicine
Mr John Ilott   Australian and New Zealand College of Anaesthetists

Profession Observers
A/Professor Jillian Sewell AM   President, Australian Medical Council
Mr Ian Frank   CEO, Australian Medical Council
Professor Christopher Baggoley   Commonwealth Chief Medical Officer
Dr Andrew Singer   Principal Medical Advisor, Department of Health
Dr Joanna Flynn   Chair, Medical Board of Australia
Mr Martin Fletcher   CEO, Australian Health Practitioner Regulation Agency
Dr Stephen Parnis   Vice President, Australian Medical Association
Ms Anne Trimmer   Secretary General, Australian Medical Association
Professor Nicholas Glasgow   President, Medical Deans Australia and New Zealand
The Hon. Carmel Tebbutt   Chief Executive, Medical Deans Australia and New Zealand

DRAFT 113th meeting of CPMC - minutes
Dr Jag Singh  Chief Executive Confederation of Postgraduate Medical Education Councils
Dr Kali Hayward  President, Australian Indigenous Doctors’ Association
Ms Kate Thomanns  Chief Executive, Australian Indigenous Doctors’ Association
Dr Nicola Dunbar  Director, Strategy and Development, Australian Commission on Safety and Quality in Health Care

In Attendance:
Ms Angela Magarry  Chief Executive Officer
Mr Michael Davidson  Program Manager, Rural Health Continuing Education (RHCE)

Professions Forum

1. WELCOME AND INTRODUCTION
At 9:00am, Professor Nicholas Talley opened the meeting and welcomed those in attendance.

1.1 Apologies Tendered
Professor Brian Owler, President, Australian Medical Association
Professor Anne Kelso, National Health and Medical Research Council
Professor Villis Marshall, Australian Commission on Safety and Quality in Healthcare
Professor Richard Tarala, Confederation of Postgraduate Medical Education Councils

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

1.3 Other issues
No other issues were raised.

2. FORUM REPORTS
2.1 Committee of Presidents of Medical Colleges

Professor Talley noted that workforce distribution is one of the priorities for CPMC, and that the two presentations on this issue would be delivered later in the session.

CPMC is continuing to analyse its role in the sector. The Committee recently conducted a successful planning day, focusing on issues facing the sector and how CPMC can contribute, the urgency of working more together, collaborating, and sharing resources when required.

The CPMC has formed a new executive. The group has met with the Federal Health Minister, the opposition health spokesperson, Health Secretary and the Australian Medical Council, and discussed health system reform, the Medical Benefits Schedule review, Australian workforce planning, gaps across the system, integrated care, generalism, and issues of major public health importance.

Professor Talley noted that the meeting order would be changed to accommodate attendees that needed to leave early.
2.2 **Australian Commission on Safety & Quality in Healthcare**

Dr Nicola Dunbar spoke to the Commission’s report, highlighting the continuing review of safety and quality standards, and the Australian Atlas of Healthcare Variation (the Atlas).

Regarding the review, Dr Dunbar noted that a large amount of consultation was undertaken in 2015, and that the next version of safety and quality standards would likely be available in 2017-18.

The Commission had been working with a number of people on the Atlas, and Dr Dunbar thanked those attendees that were involved, noting that many clinicians provided input in a very responsive way.

The Atlas was launched in Canberra in November 2015, and the Commission had received good feedback, including a number of letters of support from colleges.

The Commission continues to consider recommendations which have been received from Local Hospital Networks (LHNs), Primary Health Networks (PHNs), Colleges and the Department of Health, and will formally contact Colleges regarding this.

Dr Dunbar concluded, declaring that plans for the next Atlas had commenced, and that the Commission would seek advice from Colleges regarding clinical input and to ensure topics and issues are relevant.

Dr Dunbar responded to questions, noting that in the next version of the atlas, the Commission would explore issues raised in the first version, and examine new issues such as change over time and time series. The Commission will also be looking to develop an online interactive atlas, and Dr Dunbar requested that Colleges email the Commission with any ideas they may wish to put forward.

**Action:** Colleges welcome to email ACSQHC with any initial ideas about an online interactive atlas

Professor Talley noted that Colleges have a substantial amount of expertise with regards to the commentaries for the Atlas, which is vital given the potential for consumers to be misled if they do not understand the background. Dr Dunbar agreed that the process for consultation could improve. Professor Talley also noted that longitudinal data is more powerful than cross-sectional data.

Professor Talley commended the development of the Atlas.

2.3 **Australian Medical Council**

The AMC President, Professor Jillian Sewell addressed the group. New standards for specialist accreditation are in place in 2016. The AMC is working to make reporting on standards easier and more consistent. There will be an emphasis on trainee wellbeing, patient safety, Indigenous health, CPD, further training and remediation, and assessment of specialist international medical graduates. There will be a de-emphasising of individual reporting requirements on quality improvement recommendations, which are now addressed as part of Colleges’ reporting on significant developments.
The AMC and Colleges continue to have an emphasis on clinical academic pathways. The AMC Indigenous Planning Advisory Group is undertaking work to strengthen activities and engagements with the Indigenous health sector.

Professor Sewell advised that the AMC is waiting for the next stage of the Health Minister’s response to the Multiple Sclerosis report, and will be heavily engaged once that is provided. The AMC will also be engaged in the senate enquiry in the medical complaints process.

Professor Sewell and the AMC’s Chief Executive, Mr Ian Frank responded to questions. Mr Frank discussed the use of videotaping in assessments. The AMC has set up an appeals procedure and has received legal advice that it is sound. He also noted that waivers are signed by all participants.

Mr Frank noted that Australia’s Fair Work provisions are similar with regards to wrongful dismissal. In this situation there is a conciliation process before a legal hearing. Mr Frank noted Colleges may wish to develop a similar process which involves some arms-length procedure: one that resolves communications issues at the conciliation stage, and has a strong process for cases that progress further.

Dr Yelland (RACP) noted that a transition to videoed exams as a standard has major implications for Colleges that conduct clinical exams. A compromise would need to be reached, as it would be impossible to video every clinical exam in hospitals, due to logistics and cost. One potential solution could be that if you appeal, you could undertake another exam under videoed conditions. RACP welcomes the upcoming workshop on this issue.

Mr Frank suggested that examinees could be brought to sites which had recording infrastructure. He also noted that examiner behaviour and compliance can be a major issue, and that the technology could be used to feed that back into examiner training.

Professor Venkatesh asked whether there have been consent problems from candidates or examiners. Mr Frank responded that there were some concerns prior to the centre being built, but this has not been problem to date. Mr Frank agreed to share the consent form with CPMC.

**Action:** AMC to provide CPMC with the form giving a participant’s consent to have their exam videotaped.

Professor Walters queried (ACRRM) whether a refusal to give consent would impact on a participant’s ability to complete exams – the concern relating to trainees being pressured into giving consent. Mr Frank noted that to date, nobody had complained about signing the consent form.

Dr Parnis (AMA) asked that in the context of the profession of medicine dealing with bullying and harassment, has the AMC given consideration to how accreditation processes could change culture. Professor Sewell noted that this is considered when developing new standards, and the AMC is careful that wording is improved. While the AMC does not tell Colleges how to conduct its processes beyond following the standards, it expects all Colleges to have processes in place.

Mr Frank noted that a national training survey is used in the United Kingdom to help address bullying and harassment. This could be a valuable tool within Australia. The AMC continues
to push for this to occur, however the main barriers relate to who would conduct it, and how it would be funded. The AMC believes that the survey should exist, the information gathered should be shared, the AMC could potentially house it, however the appropriate place for the survey will likely depend on funding. Mr Frank noted that the General Medical Council national training survey has 99.8% compliance, because it is attached to performance review.

On the topic of clinical academic pathways, Professor Sewell advised that the AMC can ensure that the importance of research and scholarly input are emphasised in the standards. The AMC can also act as a broker to ensure that these pathways are implemented.

Professor Talley noted that this project had been led by the Medical Deans of Australia and New Zealand (MDANZ) and the Royal Australasian College of Surgeons (RACS).

2.4 Chief Medical Officer

Australia’s Chief Medical Officer, Professor Chris Baggoley was accompanied by Dr Andrew Singer, Principal Medical Officer, Department of Health. Professor Baggoley referred to the report, and began with an update on the Zika virus.

Following a brief history of the virus, Professor Baggoley noted Australia has had 31 identified cases, including 8 this year. 80% of people who contact Zika are asymptomatic. 20% can develop a rash, fever, aches, or conjunctivitis. A major concern relates to clusters of microcephaly, which can be closely associated with the Zika virus – although causality is not proven.

In Australia there is overwhelming evidence Zika is transmitted by Aedes mosquito, which is found seasonally in northern Queensland. Australia has processes to trap mosquitoes in international air and seaports. If found, chemical treatment follows, and the Department of Health works with the Department of Agriculture regarding eradication. Research on dengue fever has indicated that inhibitors can be used in mosquitos to prevent the spread of the virus.

The main concern for the population is that pregnant women can be infected and have congenital deformities. The Department of Health has been working with RANZCOG on testing processes and guidelines on how to manage people with confirmed diagnoses.

The RCPA President Dr Harrison raised a concern that page 11 of the Chief Medical Officer’s report contained some inaccuracies. In particular, concern was raised about the ‘Background’ area, still on page 11, which contests that bulk billing incentives do not work. Dr Harrison noted that the incentives were more about maintaining and increasing bulk billing rates. The word ‘maintained’ has been removed, and the concern was that this approach would effectively be rewriting history. Dr Harrison also noted that the current bulk billing rate is about 98%, which is very high and particularly difficult to increase. Professor Baggoley advised he would pass this feedback to the Ministers’ advisers.

Professor Walters (ACRRM) queried if the Specialist Training Program (STP) Report would be made available in full, and if so, when. Dr Singer advised that all Colleges have been consulted as part of the review, and a modelling project is also being undertaken by KPMG.
A paper is being prepared for NMTAN and the Health Workforce Principal Committee (HWPC), which will then be provided to CPMC. This will detail the results of the consultations and how the Department proposes to alter the STP.

Dr Singer referred to the Chief Medical Officer’s report for details, and declared there would not be any reductions in the number of positions funded. He also advised it would be unlikely that the program would be expanded by more than 100 places. The Department wants to be flexible to ensure the funded positions are filled.

Dr Yelland noted it was appropriate for the CPMC to thank the Department for their responsiveness. She advised the employment cycle for registrars begins around June, and the STP report would be needed soon in order to recruit people for next year. Professor Talley noted that Colleges did not want to be unable to fill positions for next year due to the report being provided too late.

Dr Singer advised he could not provide any guarantees on when the report would be released, beyond it being the near future. He did note that the Commonwealth was seeking to extend the funding cycle to three years.

Dr Frank Jones (RACGP) noted the Primary Health Care Advisory Group report was tabled to the Department in December, and the Medicare rebate indexation freeze continues. Professor Baggoley advised there was no current intention in the government to change the freeze.

Dr Jones also requested feedback on the My Health system, noting that RACGP has advised that there are useability, privacy, and quantity/quality issues. Professor Baggoley noted that the quantity versus quality issue regarding patient record summaries was an ongoing tension.

Professor Baggoley continued, noting that an opt-out rather than opt-in system was recommended by a Government review of the eHealth record process, and trial sites in Northern Queensland and the Blue Mountains should indicate demand. There may be pressure from patients and consumers of healthcare, and input from consumers will be important. The Safety & Quality Advisory Group will ensure that there is a sophisticated model to ensure safety and quality of this process.

Associate Professor Lawler (ACEM) noted that page 17 of the CMO report noted outcomes of the National Bowel Cancer Screening Program. He raised a concern about how the report makes the leap from increased screening to increased survival, without talking about engagement with the sector and the significant research that would be required. Professor Baggoley advised the Commonwealth was working with States and Territories on colonoscopy issues. Evidence shows that those who choose to be screened, have cancer picked up earlier than those who do not. The issue will be the capacity to undertake colonoscopy. The system is moving from a random sampling process to a regular screening process.

2.5 National Health and Medical Research Council

Members noted that the CEO, NHMRC, Professor Anne Kelso was an apology, and the report was noted.
2.6 Medical Board of Australia and AHPRA

Dr Joanna Flynn, Chair, Medical Board of Australia addressed members. Dr Flynn noted the main issues discussed at the recent joint council meeting with New Zealand were revalidation, the Ageing Doctor, and International Medical Graduates (IMGs).

The Board established an expert advisory group on revalidation in January 2016. The revalidation process is going deliberately slowly, and includes much discussion with Colleges, to help determine the difference between a college CPD program and revalidation. The Board recognises that aligning with NZ on revalidation would make sense if possible, and does not want to produce a bureaucratic system that is administratively burdensome.

The Board has also commissioned social research on consumers and practitioners to determine what they expect, and what they think would help. There is also research available internationally, so benchmarking can occur.

Dr Flynn also noted that following the National Registration and Accreditation Scheme (NRAS) review, there has been an onus on the Medical Board to undertake further benchmarking. The Board will consult with colleges on this issue. The Board needs timely, fair, transparent processes to build a system that is clear, fair, and not onerous.

Dr Flynn also highlighted the new senate inquiry into the Medical complaints process in Australia, co-sponsored by Senator Nick Xenophon and Senator John Madigan. The inquiry has broad terms of reference. The Board participated in a positive follow-up workshop with the Australian Medical Association (AMA). AHPRA is very cognisant about how complaints processes work, and has been working on timeliness and quality of processes. AHPRA has made improvements in triage, and closing complaints if they are not progressing.

The Board and AHPRA are hosting the 2016 International Association of Medical Regulatory Authorities (IAMRA) meeting in Melbourne from 20-23 September 2016. Further information is on the Medical Board website.

Professor Cleary (RACMA) noted that CPMC wishes to work closely with the Board, and asked how liaison can be enhanced to ensure colleges can be actively involved. An option could be to have a current CPMC member on the Board. Professor Cleary also asked how both parties could ensure the Board has access to appropriate experts from colleges with regards to complaints. Dr Flynn noted that the Expert Advisory Group will appoint a Consultative Committee. While the Committee will not involve all the colleges, there will be college representation.

Professor Talley agreed that this work is critical for Colleges and considered core business, noting that there needs to be links with CPMC and also direct links with each college. He also discussed timeliness of complaints, and queried what timelines will be established.

Mr Martin Fletcher (AHPRA) advised that AHPRA would welcome the interest of colleges, and that the Agency has a focus on timeliness of all complaints. Mr Fletcher queried whether it would be helpful to share information with colleges about what work the Department is undertaking with metrics, including trend data. Dr Flynn noted that the average time to finalise complaints has been significantly reduced over the past two years.
2.7 Australian Indigenous Doctors’ Association
Dr Kali Hayward, President, AIDA, and Kate Thomann, CEO, AIDA acknowledged the traditional owners of the land, and addressed the Committee.

Dr Hayward noted AIDA’s annual professional development and networking event will take place in Cairns from 14-17 September 2016. AIDA is encouraging colleges to participate, particularly in workshops, and with sponsorship. More information will be disseminated soon.

AIDA recently signed a Memorandum of Understanding (MoU) with the Australian Medical Students’ Association (AMSA), to provide Indigenous students with continued support.

AIDA is currently seeking clarity around a paper on Pastoral Care, as this is a major issue for members. AIDA continues to enjoy working with colleges, and appreciates its continuing partnership with CPMC.

2.8 Australian Medical Association
Dr Stephen Parnis, Vice-President, provided a summary of the AMA budget submission, focusing on key areas.

The AMA recognises there needs to be a balance for contributions between the two major levels of government, and a balance between private and public health care. The AMA is assertive that the federal government should not be walking away from its responsibilities regarding funding public hospitals.

The AMA considers the freeze on Medicare rebate indexation to be a co-payment by stealth.

Regarding medical workforce, the AMA recognises that challenges exist, as evidenced by an old Health Workforce Australia (HWA) item that notes Australia will be approximately 600 first year training places short in 2 years’ time.

The AMA has made comments in the Primary Health Care Review and will be interested in the ministerial response. Dr Parnis noted that medical issues are cheaper to treat in general practice than in the hospital sector, and this view needs support.

The AMA is supportive of an opt-in system for electronic health records, noting that there needs to be value attached.

The AMA notes the recent focus on public health issues, including harm from drugs and particularly alcohol, and society becoming more sedentary. There are roles for everyone to help address this, including doctors, local, state and federal governments.

The AMA also recognises that there is a patchwork of vaccination rates in Australia currently, with the lowest rates being in areas of low health literacy and low income, as well as in the most affluent areas.

Professor Watters (RACS) noted that all colleges have an interest in health problems associated with obesity, and recognise the need for a cross-sector approach to tackling it. He queried what the AMA’s approach to this issue is, and whether there would be a forum later in the year.
Dr Parnis noted that obesity is a major issue in Australia, and recognised the links between sedentary lifestyle and medical issues like depression and lower bone density. The AMA appreciates that all have an interest in this issue and have valuable contributions to make. He also noted that the interest of governments would more likely be attracted if cheaper solutions were found.

Professor Waters stated that tackling obesity will be a huge exercise, similar to reducing smoking rates. All resources will need to be marshalled, and it will take years. Dr Parnis also noted that there are fierce disputes within the professions about the best way to tackle this issue.

2.9 Medical Deans Australia and New Zealand
Professor Nicholas Glasgow and The Hon. Carmel Tebbutt spoke to the MDANZ report.

The second Clinical Academic Summit was held in November, and a working group was formed to progress the issues raised.

MDANZ has produced a document about the inherent requirements for medical schools that is available upon request. There will be a meeting in October to review any feedback on the document.

**Action:** Colleges to contact MDANZ if they wish to provide feedback on the MDANZ paper on inherent requirements of medical schools.

MDANZ is continuing to work with RACS on bullying and harassment. There is a meeting on 19 February 2016 regarding the role medical schools can play. Professor Glasgow asked the group whether a formal public statement would be beneficial to keep the public informed of the unanimity of the organisations on this matter. It was suggested this be placed on the agenda for the afternoon session.

Professor Watters advised that RACS had received support from many organisations to deal with bullying and harassment collaboratively. He noted the challenge would come when an individual allegation is made, which will test how the organisations are working together.

Professor Talley enquired about the number of medical students in the system, and Professor Glasgow replied that MDANZ is reliant on data produced through HWA. He noted that medical school numbers were sufficient, although the figures were provided prior to Curtin Medical School being announced. Professor Glasgow also noted that workforce shortage concerns relate more to career choice following graduation rather than medical student numbers.

Professor Watters queried that if Commonwealth Supported Places (CSPs) were to be cut, would universities make up the deficiency with self-funded places. Professor Glasgow responded that universities cannot charge domestic students fees to complete their medical degree (with a couple of exceptions). He also noted that deregulation of university fees is off the table currently, and there is no appetite to reduce CSPs.

Professor Talley noted that CPMC considers there to be a gap in career pathway advice within medical school.
Professor Glasgow replied that all medical schools believe they provide information about career pathways to students in many ways. However, he noted that while there is generic information that is passed on, the information that really sticks is the more personal experiences, such as meeting particular practitioners or undertaking certain experiences.

A/Professor Lawler expressed concern that there is a reliance on individual personal happenstance to determine career direction. Professor Glasgow indicated that the Rural Clinical Schools program was one example of success in facilitating experiences that lead to particular career paths. He also noted that placements and retention of doctors need to be thought about more creatively.

2.10 **Confederation of Postgraduate Medical Education Councils**
Dr Jagadishwa Singh, Chief Executive, addressed members, noting that Professor Richard Tarala was an apology for the meeting.

Dr Singh informed members that the review of internship training was supported by CPMEC as it affirms what the Confederation considers to be important. He noted that in particular, the review provided very little support for direct entry into vocational training.

In an advisory council meeting in November 2015, it was recognised that there needs to be a national consensus about prevocational training. This will be taken to the Health Workforce Principal Committee (HWPC) to set up a process.

Dr Singh also noted that career planning initiatives are important, as is providing support in prevocational years to Indigenous doctors, and improving teaching and supervision for junior doctors. Concern was also raised about the time that trainees spend in unaccredited training positions.

CPMEC considers it to be important to have a national curriculum framework for junior doctors in Australia. There is interest in how that can be upgraded to a model that includes assessment.

Professor Walters (ACRRM) was pleased to note that the Commonwealth was looking at training hubs and considering the expansion of prevocational community based training. She queried if junior doctors would be interested in undertaking rural placements. Dr Singh responded that junior doctors like to experience a range of placements.

3. **WORKFORCE PLANNING**

3.1 **Psychiatry – a specialty in shortage**
Professor Malcolm Hopwood (RANZCP) delivered a presentation to members, focusing on the current undersupply of psychiatrists and training capacity.

The World Health Organisation (WHO) notes that 1 psychiatrist is needed per 10,000 people. By 2030, it is projected that Australia will be 120-130 psychiatrists short.

The Specialist Training Program (STP) is helpful for this particularly with regards to geographic limitations. Through the STP, RANZCP has been able to increase interest in psychiatry. The College has created a Psychiatry Interest Forum – face to face and online.
1,500 members have joined (ranging from first year medical students through to those on the verge of training). This initiative is progressing well, which is important as students’ career choices can be influenced by how well a particular specialty manages its training.

Initiatives like this raise the question of how early students should be engaging in discussions about what career they wish to pursue.

Changes in mental health care delivery, such as through implementation of the National Disability Insurance Scheme (NDIS) and federal government policy shifts, can make it difficult to accurately project long term workforce shortages. Estimates may look different in five years.

Professor Hopwood concluded, querying whether the right machinery to improve health workforce is currently available. He noted that Colleges were part of the answer, but the solution must be broader.

3.2 Intensive Care Medicine - a specialty in balance

Professor Bala Venkatesh (CICM) delivered a presentation to the group, focusing on workforce balance, and the oversupply of Intensivists.

In 1999, the Australian Medical Workforce Advisory Committee (AMWAC) advised there would be an undersupply of intensivists. As a result, training changes were made, and in addition medical student intakes increased by 100%, and there was an increase in IMGs. Intensive care medicine experienced a significant increase in trainees.

By 2012, according to the Health Workforce Australia 2025 Report, intensive care medicine was in oversupply. Options were explored, including having registrars take on more work, and increasing the amount of telehealth work. CICM held a workforce summit, and the main finding was that compared to other Colleges, CICM had a high proportion of trainees to Fellows. Only 80% of new Fellows were employed as intensivists.

CICM currently has 800 Fellows, and a high percentage of this group are 60-65 years old. Professor Venkatesh noted that there are limitations to workforce modelling and issues of maldistribution are a major concern.

Options for addressing oversupply, include not to be considered a shortage specialty on the on the list developed by the Department of Immigration; a reduced medical student intake, consideration for reducing the trainee intake, and addressing reasons for maldistribution.

Professor Talley added that in an oversupply environment, a number of trainees would be concerned that they could not attain a position.

Department of Health: Dr Andrew Singer delivered a short presentation on workforce supply. He noted that while there is maldistribution, and a shortage in some areas, the Commonwealth is not concerned about oversupply. Modelling relies on data, and the Department is keen to receive data from Colleges. The Department is considering undertaking some geographical modelling, starting with General Practice later in 2016.

Dr Singer advised that the integrated rural training pathway should assist with both vocational and prevocational training places.
He also noted that a workforce review is underway at the Department of Education and Training, and that Medicine has higher quality workforce data than other occupations. A report has been formulated and decisions will be made by the Skills Minister. He also noted that STP only covers 1,000 out of 22,000 training places, so it is only part of the solution.

Professor Watters (RACS) queried what the difference between those being on an immigration list and those working in a mal-distribution area. Dr Singer responded that Area of Need is a state/territory jurisdictional decision. Statistical workforce shortage is a Commonwealth mechanism used for Commonwealth programs. The skills occupation list is unrelated, and is about the Department of Immigration attracting skilled workers, and using streamlined processes around 457 visas. He noted that there was no easy way to bring all these elements together.

Dr Hayward (AIDA) noted that there is a significant Indigenous doctor shortage across Australia and specialisations, and she would encourage CPMC to maintain that focus.

Professor Sewell (AMC) noted that there is an issue between Full Time Equivalent (FTE) numbers and broad numbers, and data can often be captured on the latter, which can be misleading. Professor Venkatesh (CICM) noted that a good measurement is FTE specialist workforce per 1,000 patient days.

Dr Singer advised that NMTAN has set up a data subcommittee. Colleges have been asked for nominations, but only two have been received so far. The idea is to develop a proper dataset to properly address workforce issues.

Professor Walters (ACRRM) asked if there was a movement of intensivists overseas and therefore a reduction in those working in Australia. Professor Venkatesh replied, noting that only a small percentage of CICM Fellows work overseas.

**Colleges Only Session at 11:30am**

4 GUESTS AND PRESENTATIONS

Professor Talley introduced the three speakers for the session: Dr Stephen Parnis, Vice President, the Australian Medical Association (AMA); Dr Lynn Weekes, CEO, National Prescribing Service and Choosing Wisely Initiative; and Professor Louise Baur, Councillor, Australian Academy of Health and Medical Sciences.

4.1 Australian Medical Association: Dr Stephen Parnis

Dr Parnis presented to the group on workforce and training. The AMA has representatives on NMTAN and has sought to increase the level of health workforce resourcing and data. There are about 30 different medical categories which attract points for immigration, and the Department of Immigration is working in a vacuum with regards to workforce planning.

On the section on prevocational training, the HWA 2025 report identified a shortage of advanced trainee placements across Australia. This has created pressure for doctors to accept substandard places.
Dr Parnis noted that Australia has an undersupply of doctors in regional areas, and there are two health ministers in cabinet from regional New South Wales, so this issue is important to them. The AMA senses a determination to establish new medical schools, but considers this a bad idea. A better approach is to attract doctors to practise in rural areas. The AMA believes that about one third of Australia’s medical student intake should be from rural Australia.

The AMA has long supported the Prevocational General Practice Placements Program (PGPPP), now called the community residency program. This program has helped supply not just rural, but perennially undersupplied metropolitan areas. There are also good regional training programs, such as the surgical training program pilot in Western Victoria.

Professor Permezel (RANZCOG) agreed that it is essential to recruit more medical students from rural backgrounds. RANZCOG has provincial programs where trainees spend five out of six years rurally, but it requires funding. Dr Parnis advised that the AMA would like more STP training places.

Dr Genevieve Goulding (ANZCA) queried whether rurality should be a selection criterion for colleges. She also raised that there are often differences between rural areas – for example, Orange (NSW) does not have an anaesthetists problem, but Dubbo does. Dr Parnis noted that it often relates to the perception of each town. Bendigo (Vic) is an example where the health workforce has been substantially improved as a result of champions within professions who have drawn trainees there.

Professor Watters (RACS) noted that metropolitan hospitals are strong lobbyists for recruiting trainees, and it is therefore important for Colleges to provide strong support when dealing with powerful individuals in cities. He also noted that appropriate hospitals need to be used for trainee training, and to ensure this occurs, appropriate STP funding must be provided.

Professor Permezel asked whether the AMA was putting pressure on medical schools to increase the number of Indigenous medical students and graduates. Dr Parnis responded that the AMA was doing this, and notes the increase in Indigenous students in recent years, although it has come from a very low base. He declared that the system needs to empower, highlight and support Indigenous doctors, including leaders like Professor Kelvin Kong.

Professor Permezel noted that the AMA has power with students and links with the Government to affect change, by tying Commonwealth Supported Place (CSP) funding to the recruitment and support of rural and Indigenous medical students. Dr Yelland (RACP) noted that Indigenous students were coming through the system, but Colleges needed to support them as they come through. Dr Parnis offered that symbolic gestures matter, such as scholarships.

Professor Talley queried that if there was a medical student bulge, and number of training places was not sufficient, should there not be more STP places. He noted that perhaps there is a need for a redistribution of medical student places.
This would mean a reduction of medical student places in some metropolitan areas, and an increase in rural and remote training.

Dr Parnis raised the concern that with the cost of medical degrees being approximately $250,000, those who decide to undertake medicine are more likely to come from privileged backgrounds – hence why Commonwealth Supported Places exist. If CSPs are removed, it would be harder for students from rural and underprivileged areas to undertake medicine. Dr Parnis also raised concerns about potentially cutting medical student numbers, and noted that the STP is important, but not the only solution. The AMA has never supported medical student bonding, and believes that if placements are made a punishment, doctors will take the first opportunity to leave.

Professor Horsburgh (RANZCO) noted that Australia has a very high doctor to head of population ratio, and nuancing medical training may be a solution. For example, there are too many training places at the University of Queensland (UQ).

Dr Parnis declared that the AMA will think about this issue further. He noted that the AMA would like more data, and that even the HWA data is beginning to become dated.

Ms Anne Trimmer (AMA) noted that there will be a reduction in the number of senior trainers as a generation of older trainers retire, but if there are still rural shortages, politicians will not be interested in cutting student numbers.

Professor Hopwood (RANZCP) noted that the bulge in student numbers is not likely to fix mal-distribution. The STP has been excellent in terms of being able to leverage infrastructure, and new ideas in that space are needed, rather than more numbers. He also noted that while leveraging infrastructure is important for training, it is important to ensure that mandatory rotations do not result in negative experiences.

Professor Talley asked what the AMA’s view on the Medicare Benefits Schedule (MBS) Review was now. Dr Parnis responded noting that he considered it unusual that at least half a dozen reviews are occurring six months prior to a federal election. The AMA has been wary of the MBS Review, and considers the Government’s number one agenda to be funding cuts. There are concerns about the Government removing and not replacing parts of the MBS. The group is interested in having a modern evidence-based MBS.

Dr Parnis continued, turning to the topic of bullying and harassment. He noted it was a profession-wide concern that will be tested, and that the AMA will be involved when that occurs. He also noted that the current issues related to health financing will influence how all Fellows practise medicine.

Ms Trimmer noted that the Private Health Insurance review indicated that there may be some profound change in prosthesis. She also informed members that the AMA Council is comprised of a number of specialties. There is currently a call for nominations for election, and the AMA would like to encourage Colleges to seek representation. This provides an opportunity for Colleges to engage more with the policy settings of the AMA.

**Action: Colleges invited to provide nominations for election on AMA Council**
4.2 National Prescribing Service (NPS) and Choosing Wisely Initiative – Dr Lynn Weekes, CEO

Dr Weekes provided an introduction to the NPS, noting it is a not-for-profit member-based organisation that works closely with Primary Health Networks.

The NPS has seen the Choosing Wisely Initiative as an opportunity for the medical community to lead the debate around quality, particularly with regards to what is considered low quality and potentially harmful care. The NPS believes it is important for Choosing Wisely to be clinician-led, which gives it power and credibility.

The initiative is about conversations: clinician to clinician; clinician to consumer; and clinician to college. The conversations are about what not to do, delivered in sets of five. For example – five questions to ask your doctor before undertaking a treatment, procedure or test.

In April 2015, the first Choosing Wisely lists were launched. The second wave will be launched on 16 March 2016 at NPS in Surry Hills. Since the launch of the first wave, more health organisations have become interested in the initiative.

RACP has been running a similar initiative known as EVOLVE with societies. Lists developed through EVOLVE will be listed on Choosing Wisely website.

After the second wave, there will be 75 list items available. NPS is keen to integrate these changes into the health system, and has a multifaceted communication strategy for this purpose.

The NPS will form networks with those who adopt Choosing Wisely early, then undertake some measurement and evaluation activities. Some efforts are already underway, such as surveys, and projects that analyse MBS data to determine any changes.

Professor Talley raised the concern that the lists may just sit on the website and not be used. He queried whether there was international experience in this area. Dr Weekes declared that that NPS is working to ensure the messages fit into the existing programs whenever possible. The NPS is also working with Colleges and building upon their experiences. The NPS is also hoping to build the Choosing Wisely initiative into recommendations that Colleges make to reviews, such as the MBS Review.

Professor Talley noted that Colleges are deeply engaged in this initiative, and commenced Dr Weekes for the work achieved to date. Dr Weekes passed her thanks to the Colleges, noting that the cross-college collaboration is working well.

4.3 Australian Academy of Health and Medical Sciences – Professor Louise Baur, Councillor

The group welcomed Professor Baur, who noted she was speaking on behalf of Professor Ian Frazer. Professor Baur delivered a presentation, explaining that the Academy was established to provide an impartial and authoritative voice for healthcare, as informed by best evidence. It seeks to promote health and medical research throughout the world, as has three main purposes:

1. Mentoring the next generation of clinician researchers;
2. Providing independent advice to Government on issues relating to evidence-based medical practice; and
3. A forum on medical research

Professor Watters (RACS) queried how much advice the Department of Health had asked the academy for to date. Professor Baur noted that the Academy has been cautious about commenting on issues because it is still largely in its infancy.

Professor Watters (RACS) also asked how the Academy could ensure that the Government values research as being vitally important for the future of Australia, and whether advocacy for research was occurring. Professor Talley, who is also Treasurer of the Academy, noted that there is capacity for such advocacy, given the current good access to government ministers. The influence of the Academy with regards to research will continue to grow.

With regards to the issue of mentoring, Professor Venkatesh (CICM), asked if the Academy formally submits grants to the National Health and Medical Research Council (NHMRC). Professor Baur responded that this was not the case and that no funds are distributed within the Academy for grant purposes but there is support for mentoring events from internal funds.

**Governance commenced at 1:30pm**

5. **GOVERNANCE**
Professor Talley welcomed the group to the Governance session, and delivered a Welcome to Country, recognising elders past & present. Professor Permezel was absent for this session from 1pm.

5.1 **Minutes of previous meeting held 12 November 2015**
The minutes of the previous meeting held 12 November 2015 were moved for acceptance by Professor Talley, and approved by members.

5.2 **Business arising from the minutes**
Ms Magarry noted that all action items from the previous meeting had been completed.

5.3 **Chair’s Report**
Professor Talley informed members that the CPMC Executive was established, had met via teleconference, and met with Government stakeholders in Canberra. He noted the executive has worked effectively for CPMC to date, and opened up the item for discussion.

Professors Watters and Venkatesh agreed that the executive had been useful and effective.

Professor Talley noted that as executive members rotate off, they will need to be replaced. Professor Yelland noted that it is important to ensure executive members have some experience with CPMC, and that to ensure success in meetings, it will need representation from big colleges as well as small. Professor Talley noted that CPMC needs an effective, balanced executive, and some balance in terms of how the group is perceived by those it meets with. It is also important to ensure the right College is represented at the right meeting.

DRAFT 113th meeting of CPMC - minutes
Professor Yelland noted that members need to remain aware of the cost that individual colleges need to pay for airfares and hotels for executive members.

5.3.1 Executive Minutes
Members noted the executive minutes.

Professor Watters suggested that the executive minutes should be circulated as soon as they are approved, rather than prior to the following CPMC meeting. Members agreed.

Action: CEO, CPMC to circulate Executive minutes to all CPMC members directly following approval.

5.3.2 Executive Government Relations Day
Professor Horsburgh (RANZCO) noted that the executive meeting at the Australian Medical Council (AMC) went very well, and it was helpful that the comments made by members regarding accreditation, harassment and bullying were euphonic.

Professor Yelland thanked Ms Magarry for her work in planning that day, with the group concurring.

5.4 Chief Executive Officer’s Report
Ms Magarry spoke to her report, noting that there had been a significant amount of activity in lead up to these meetings. Professor Talley noted that CPMC’s access to the Government is excellent currently, which allows issues of commonality for the CPMC to be prosecuted. Ms Magarry was thanked by members for her efforts to organise the meetings.

5.5 Financial Statements
Ms Magarry noted that CPMC is solvent, can pay its bills, and the amount available in reserves is exactly that which members had agreed with. The upgrade to IT systems at CPMC is almost half complete, with thanks to ANZCA.

Professor Talley noted that all members were legally responsible for the CPMC finances.

5.6 Changes in Directors
Professor Talley formally thanked all the directors that have moved on. Certificates of appreciation are provided to each upon their cessation.

Professor Anthony Lawler noted his associate professorship title.

5.7 Other Governance Matters
Ms Magarry suggested to the group that if it wanted to make changes to the CPMC constitution, it would be best to form a small group, and seek formal legal advice for the changes.

Professor Talley suggested members read the CPMC constitution, which is quite a short document, and to advise of any suggested changes.
Action: Members invited to read the CPMC constitution and suggest changes if needed by sending an email to CEO CPMC

Professor Talley invited members to discuss whether the group’s name: Committee of Presidents of Medical Colleges was the most apt, and whether it was fit for purpose. Two suggestions were:

The Council of Presidents of Medical Colleges
- The same acronym, but a more accurate reflection of members being directors in a company.
- It was suggested this also sounds stronger than Committee.

The Council of Medical Colleges (CMC)
- The acronym is symmetrical.
- There is a CMC in New Zealand – registration was seen as a potential issue, but most members believed this would not be relevant given it would be in a separate country.
- CMC is the Crime Commission in Queensland, so having this link may not be a helpful association.

Professor Venkatesh queried what the purpose of the name change would be, as it would not solve the issue of the group’s relevance to the community.

Professor Watters noted he always has to sell the value of CPMC to his council, and it would be deeply concerning to explain the change to CMC. Also, the Government knows what CPMC is, and that is the most important stakeholder to influence.

Professor Talley requested that if members had opinions on this topic, to email their thoughts to Ms Magarry. He noted that this was not an urgent change.

Action: Members invited to email thoughts about a potential name change of CPMC to CEO CPMC

5.8 Rotating CPMC Meetings
Ms Magarry opened discussion about the method for rotating CPMC meetings, noting that support is available from larger colleges in Sydney and Melbourne, and holding meetings in Canberra generally is expensive, and more so at Parliament House, due to security requirements.

Professor Cleary (RACMA) indicated that the opportunity to invite key Government stakeholders in Canberra may be helpful.

Professor Yelland noted that CPMC is a small organisation and that CPMC meetings are a costly expense already. It would be more cost effective to hold meetings in Sydney or Melbourne. Members generally agreed that holding meetings in Sydney and Melbourne would be the best approach. Professor Yelland also noted that there could be potential issues with holding meetings in Brisbane, related to whether the available facilities would be large enough to house the number of people at CPMC meetings. It was noted that potentially the AMA could provide venue options as a sign of good faith. Professor Talley advised he was keen to have the Health Minister attend CPMC, but the key issue would be timing.
6. STRATEGIC DISCUSSION

6.1 Indigenous Health Subcommittee Common Governance Forum
Ms Magarry noted that this item went out-of-session following the November meeting and there had been insufficient responses to approve the recommendation.

Members were asked to draw their attention to the proposal to join the agreements between AIDA, MDANZ, CPMEC and CPMC into a single governance forum. This suggestion had been put forward by AIDA to streamline activities across the training pipeline. The change will result in no additional cost to CPMC, and would alleviate a burden from AIDA.

Professor Talley put forward the motion that this proposal be supported by CPMC and all members agreed.

6.2 National Medical Training Advisory Network (NMTAN) - Strategic Approach
Professor Watters noted that he was impressed when NMTAN spoke to CPMC in May 2015 about workforce numbers. He raised concerns, however, about the meeting he attended in December 2015, noting that it was disturbing that NMTAN modelling seemed based on mathematicians’ assumptions about number trends rather than input from experts in the health sector.

Professor Goulding (ANZCA) also raised concerns about NMTAN, noting that the group provided ANZCA with a report and expected a response within three days, which was extremely unrealistic. She also noted that some assumptions in the report had been unrealistic, and not evidence-based, nor following the data trail.

Professor Hopwood (RANZCP) likened his experience with NMTAN to working with health economists. The NMTAN officers were not necessarily attuned to all the issues, however were quite responsive when engaged. He noted that it would be better to be talking with NMTAN than not, and that this work should be undertaken every five years with each specialty, and to use dynamic data.

Dr Jones (RACGP) noted that colleges need to be very firm with NMTAN with regards to data, as colleges know more. Professor Watters agreed, suggesting that most of CPMC’s effort needs to be at NMTAN, and the Committee needs to ensure it does not miss a meeting. He noted at NMTAN meetings there is much discussion about Career Medical Officers, and that the Chair of NMTAN is not someone to drive CPMC’s agenda. Concern was raised about the NMTAN Chair not being in touch with how specialties work. An example of which was a discussion at the meeting regarding all the Specialist Medical Officers in Australia who are unable to get a job. This issue was perceived as a good way to save money.

Professor Talley noted that the NMTAN process is very slow. He raised whether the CPMC should consider a partnership with the AMA to develop some data themselves (possibly though a professional services group like KPMG). Professor Yelland disagreed with that potential approach, considering one of CPMC’s strengths to be its independence. The CPMC could discuss workforce issues with the AMA, but should be wary of getting too close.

Professor Hopwood noted that the issues surrounding NMTAN are sensitive ones for Colleges, and it would be helpful if there was a better process. He suggested that CPMC may want to think about an approach to lobbying on workforce issues.
Other issues raised in the discussion included:

- The potential for the complexity of workforce issues across all colleges to become too much for a collective effort.
- The importance of counting FTE, rather than a head count, and measuring clinical hours, not working hours.
- It being in the best interest to keep the IMG pathway open as it saves money. The pathway is worth $1.2B.
- ANZCA has good data on trainees, but does not know about people’s work patterns in the senior third of their career, and also how people exit the workforce.
- In terms of measuring future workforce needs, it needs to be best-case/worst-case scenario. The Government wants a specific outcome and a target to aim at, but that is not realistic. Therefore a contingency plan is needed.

Professor Horsburgh (RANZCO) noted that RANZCO had recently finished installing a new health insight tool. The data collection tool cost the College $60,000 and mapped where clinics are, area of need, and determining practice expense rather than area of need expense.

Professor Talley noted he did not sense members had a strong inclination to link with the AMA on this issue. Professor Watters suggested Colleges know their own data and not rely on NMTAN.

Professor Talley requested that each college send an email to CPMC, noting where it is up to with regards to data and identifying the gaps. Members were also requested to project their workforce for the next five years. He also noted that $60,000 would not be a large amount to pay for a tool that could affect real workforce change.

**Action:** Colleges to email CEO CPMC to advise their current situation with regards to data collection, identifying the gaps, and to project their specialty’s workforce for the next five years.

### 6.3 CPMC Business plan report and roundup from strategic planning forum

Members noted the plan.

### 6.4 Fee review and capping rates

Ms Magarry noted that RACGP is concerned that its Fellows are rising at a higher rate than other Colleges’ Fellows, and therefore there should be a CPMC fee cap.

General discussion ensued key points including that:

- Fees are determined by number of active fellows only
- While this was an issue particular to RACGP at the moment, if a rule is made, it should not be RACGP-specific, and apply across the board.
- A cap is a sensible measure (general consensus)

All members agreed that there should be a cap on College fees at 15,000 active Fellows, and that this structure should stand for the next three years.

All members agreed to approve the CPMC budget with the above principle included. The CPMC budget was passed.
6.5 **Rural Health Continuing Education**
Ms Magarry noted that RHCE was in wind up mode. Work had included finalising and acquitting the contracts under Round 7, working on a transition plan, and concluding the steering committee.

In late 2015, CPMC was asked to develop a proposal to support individual specialists directly and not including college grants. A proposal was lodged at the end of last year on this basis and with a new name: Support for Rural Specialists in Australia. The proposal is likely to result in $800,000 per year for 3 years. The Department of Health has advised that the proposal should be lodged with the Minister’s Office by 19 February.

Ms Magarry noted that RACP has been supporting RHCE since about 2002, when it had a previous name. As was the case with RHCE, CPMC will be the fund holder. Ms Magarry noted that that the governance model for SRSA will need to be clear and with no conflicts.

Ms Magarry also thanked Michael Davidson for his hard work in the role of RHCE Program Manager for the past two years.

6.6 **Senate Inquiry into Medical Complaints**
Professor Talley opened up this item for general discussion.
Professor Hopwood noted that the issue of medical complaints would be public and of high risk.

Professor Talley advised that if CPMC is called upon to comment, he would like to be well prepared. He requested that Colleges provide written advice about where they are up to with bullying and harassment.

**Action:** Colleges to email CEO CPMC to provide an update on their College with regards to bullying and harassment.

6.7 **Inquiry to Private Health**
Ms Magarry informed members that the information in the Board paper aimed to update members as much as possible and noted that in her the previous day’s presentation she had observed that private health insurance premiums have been increasing at twice the inflation rate.

6.8 **MBS Review**
Professor Talley noted that this item had already been discussed. CPMC has publicly been generally supportive and also during discussions with the Department of Health. This stance will continue it unless the Committee wishes otherwise.

6.9 **Next College Presentations**
Members discussed future presentations, and decided Revalidation would be presented on at the next meeting in June, followed by a presentation on End of Life in August.
Members noted that they considered the College presentations to be particularly valuable today.

6.10 **Any other Business**
Professor Talley noted that obesity had not been discussed, and proposed that CPMC gather a summit on this topic. He suggested that the Health Minister open the summit, and that presidents and key individuals and organisations such as academies and the AMA.

_DRAFT 113th meeting of CPMC - minutes_
The day would involve an agenda to look at the issues, to define potential interventions to recommend to government, and sift through issues about tackling obesity in Australia. At the end of the summit attending parties should make a joint statement.

Professor Talley noted that such a summit gathers press and interest. It would also announce CPMC’s intention to step up into an area and have a prominent voice. Professor Talley continued that a similar event had occurred in the United Kingdom, and the outcome was the Government changing policy and laws.

Professor Yelland noted that the summit would be a good outcome for the Committee. There are a number of obesity summits already, which is a good thing, and it would be important at this summit to identify the specific health consequences of obesity, as there are many.

Professor Lawler suggested the CPMC could involve groups from a wider area, as there are many solutions that lie beyond health. Suggestions included dieticians, nutritionists, education, and exercise groups.

Dr Adam Castricum (ACSP) noted that the ACSP was finishing two papers on obesity, and such an event would dovetails well with that.

Other suggestions included bringing something new to the summit, such as the current ALT limits being incorrect as they are established from people that are well, and the ALT range should be lower. Also, members noted that timing would be key, particularly considering the federal election which could create a large impact.

Ms Magarry suggested that CPMC develop a proposal to circulate among colleges, and Professor Talley noted that Colleges may need to be asked for contributions. Colleges may also wish to consider whether a particular college would lead the event.

**Action:** Ms Magarry to draft up a proposal to host a National Health Summit on Obesity

## Evaluation

Professor Horsburgh delivered the meeting’s evaluation, noting that the Chair and the group performed well in covering a large amount of work.

Professor Talley brought the meeting to a close at 3:00
# Committee of Presidents of Medical Colleges

**Actions Arising from the 113th meeting of the Committee of Presidents of Medical Colleges held on Thursday 18th February 2016 at the Royal College of Pathologists of Australasia, 207 Albion Street, Surry Hills, Sydney**

## Action Item

### Professions Forum: 2.2
- **Action:** Colleges welcome to email ACSQHC with any initial ideas about an online interactive atlas
  - **All Colleges**

### Professions Forum: 2.3
- **Action:** AMC to provide CPMC with the form giving a participant’s consent to have their exam videotaped.
  - **AMC**

### Professions Forum: 2.9
- **Action:** Colleges to contact MDANZ if they wish a copy of its paper on inherent requirements of medical schools. Feedback will be analysed at a meeting in October 2016.
  - **Colleges**

### Colleges Only Session 4.1
- **Action:** Colleges are invited to provide nominations for election on AMA Council
  - **Colleges**

### Governance 5.3.1:
- **Action:** CEO, CPMC to circulate Executive minutes to all CPMC members directly following approval
  - **CEO, CPMC**

### Governance 5.7:
- **Action:** Members invited to read the CPMC constitution and suggest changes if needed via email to CEO CPMC
  - **Colleges**
- **Action:** Members invited to email thoughts about a potential name change of CPMC to CEO CPMC
  - **Colleges**

### Governance 6.2:
- **Action:** Colleges to email CEO CPMC to advise their current situation with regards to data collection, identifying the gaps, and to project their specialty’s workforce for the next five years.
  - **Colleges**

### Governance 6.6:
- **Action:** Colleges to email CEO CPMC to provide an update on their College with regards to bullying and harassment.
  - **Colleges**

### Other Business 6.10
- **Action:** Ms Magarry to develop a proposal for CPMC to host a National Health Summit on Obesity.
  - **Ms Magarry**
Committee of Presidents of Medical Colleges
Executive Meeting

4.2 Minutes from the 24th March and 10 May meetings of the Executive

MINUTES Held on Thursday 24 March 2016 by teleconference at 2pm AEST

1. Attendance and Apologies
In attendance were:
• Professor Nicholas Talley (CPMC Chair and RACP President)
• Dr Catherine Yelland (RACP President-elect)
• Professor Bala Venkatesh (CICM President)
• Professor David Watters (RACS President) joined at 2:10pm
• Ms Angela Magarry (CEO, CPMC)

Apologies were received from:
• Dr Brad Horsburgh (RANZCO President)
• Dr Frank Jones (RACGP President)

Professor Talley opened the meeting at 2pm.

2. Strategic planning day and report
Members of the executive noted that the report by Dr Kim Webber was received into secretariat. Professor Talley called for comment. Professor Watters (RACS) indicated supported for the report. Professor Bala Venkatesh agreed with the need for the report to go to the June CPMC meeting.

Action: List the strategic planning day report (including highlighting the list of action items) to the June CPMC agenda for discussion (AM).

3. Value of CPMC to College Councils – visibility
A discussion concerning the level of visibility of the work and value of CPMC amongst key stakeholders and College Councils occurred with Professor Talley noting greater awareness was required in certain spheres.
• Professor Watters joined the meeting at 2:10pm and confirmed the need for greater awareness of CPMC value and work within College Councils. This was agreed by Professor Venkatesh who added there was merit in enhanced awareness of CPMC within the broader College fellowship.
• A discussion occurred in relation to the mechanism for raising awareness with Ms Magarry confirming the eleven profession observer organisations who submit their reports prior to each quarterly CPMC meeting clear them as the Morning Forum is an open/public forum.
• Ms Magarry described the development of the quarterly communique and its distribution process as the current mechanism for communication. It was agreed that in addition, a one page summary from the CPMC Chair following each meeting would be useful for College Presidents to submit to their respective Councils for the purpose of educating senior office bears about CPMC and the issues it manages.

Action: Request from each of the profession observer organisations about whether their reports could be released more broadly than CPMC and to the College communications generally. (AM)

Action: Add to next CPMC agenda about profile and issue management within the broader College membership with the recommendation to produce a summary report to circulate with the profession observer papers as well. (AM)

3. The Health and Wellbeing of Doctors and Countering Workplace Issues
Professor Watters spoke to this item noting the issue is topical and was discussed in some depth at the recent tri-nations conference.
Committee of Presidents of Medical Colleges
Executive Meeting

• All agreed that the health and wellbeing of doctors was of interest to all and must be separated out from the issue of countering inappropriate workplace behaviours and workplace toxicity.
• A discussion occurred in relation to what individual Colleges are doing in relation to the issue of discrimination, bullying and sexual harassment.
• Professor Watters noted the report released on 23rd March 2016 from the Victorian Auditor-General on the matter which highlighted that DBSH was a problem.
• The request by Dr Jennifer Alexander from Doctors Health Service to brief the CPMC meeting in November was noted and it was agreed to invite her on a no commitment basis to brief the committee.
• RACS Chief Executive has a list of alternative education providers.

**Action:** Doctors Health and Wellbeing to be added to the June agenda with the accompanying paper to include a list of alternative providers of courses.

4. **Medical Fees and Gaps**
Professor Watters introduced the item from the perspective of having CPMC discuss the issue because it affects all medical specialty providers. A paper on the topic of fees and charges from the perspective of professionalism would be added to the June agenda with the RACS President leading the discussion. CPMC to liaise with RACS CEO regarding content.

**Action:** Medical Fees and Charges to be added to the June CPMC agenda.

5. **Obesity Summit**
An update on the current situation with regards to the development of the summit was provided as follows:
• A revised proposal was underway reflecting the input from the CPMC Obesity Working Group;
• A change of date to 9 November was to occur in liaison with the RACGP;
• Background policy development to occur;
• Establishment of a Scientific Advisory Group & inclusion of the Australian Academy of Health and Medical Sciences and any other interest group to occur.
• Issuing of the Sugary Drinks Tax press statement.

**Action:** revise the proposal and circulate it to the working group, with the list of names for the establishment of the Advisory Group along with logistics (AM)

6. **End of Life Care- CPMC position Statement**
An update was provided on the policy process to develop up the CPMC Position Statement on End of Life Care with most Colleges having provided input on content and have until 4 April to do so. The timing of the release was discussed with agreement that 17 May 2016 was preferred to coincide with the RACP launch and before National Palliative Care Week. Ms Magarry advised the Executive of having been in contact with the CEO of PCA regarding content and timing of any CPMC release.

**Action:** Ms Magarry to re-circulate a revised draft following comment and liaise with RACP regarding tactical media.

7. **UNHCR Regional Representative**
Correspondence from Mr Thomas Albrecht to brief the CPMC about the refugee health issues was noted and agreed to on a no commitment basis. In advance of that CPMC would request from the RACP the advice on the latest in relation to the rights of doctors on speaking out.

**Action:** List on June agenda (Colleges only session) and AM to liaise with RACP on legal advice.
8. Senate Community Affairs References Committee Enquiry into Medical Complaints

An update on the draft submission was provided.

- The Executive agreed with the submission and amendments from Colleges and requested the following additional information to be added to section B regarding complaints handling by jurisdictions & hospitals. *There are well reported serious deficiencies in many organisations and the complaints processes need to be improved.*
- The Victorian Auditor-General report was cited as an appropriate source to support the statement.
- It was agreed that while all Colleges are making a considerable effort to improve the problem they cannot do it alone and there needs to be agreed principles between all parties.
- It was agreed that *discrimination, bullying and sexual harassment* is the preferred terminology when referencing the issue with the acronym DBSH.

Professor Bala Venkatesh exited the meeting at 2:40pm. Professor Talley thanked him for his contribution to the CPMC and its working parties.

- With a closing date of 13 May to lodge submissions and for the SCARC to report by 23rd June 2016, a short discussion occurred in relation to appropriate CPMC representation at any hearing should it occur, with Professor Watters offering to represent CPMC.
- It was agreed that information to support any appearance at the hearing would include a series of dot points of what all Colleges are doing in relation to DBSH.

9. Rural Health Update

An update on the RHCE program was provided noting the recent singing of Deed of variation number 6 for the RHCE funding agreement. The proposal in relation to a new program under the title of Support for Rural Specialists in Australia (SRSA) was noted as having not progressed beyond the Department to Ministerial Office stage but likely to be part of the Federal Budget package of support for STP.

10. CPMC Financial Management

- The end of February 2016 financial statement were provided to the Executive for noting and no comments were made.
- The annual member subscription notices will be developed to support the preparation of the 2016-17 annual CPMC budget.
- The interim audit will occur to support the process for lodgement through the Board and then to the regulator.

Professor Talley closed the meeting at 2:50pm
Committee of Presidents of Medical Colleges
Executive Meeting

MINUTES 10 May 2016

1. Welcome and Apologies

In Attendance:
Professor Nicholas Talley   CPMC Chair
Dr Catherine Yelland   President-elect, RACP
Professor Phil Truskett   President RACS
Professor Bala Venkatesh  President, CICM
Dr Brad Horsburgh   President, RANZCO

Meeting was held by teleconference and commenced at 5pm.

2. Minutes from Executive meeting 24 March 2016

Members approved the minutes and noted the actions.

3. CPMC Meeting Agenda

This item was listed for discussion and approval. Ms Magarry provided an overview of the structure and content anticipated for the 2 June Morning Forum and subsequent Board meeting.

- Due to the large number of agenda items and limited time with a requirement for the meeting to conclude at 2:45pm on the Thursday, members agreed to utilise the dinner for some governance matters. Ms Magarry to split the agenda and advise all Presidents of the change.
- College Presidents will meet on Wednesday 1 June for dinner at the RACV City Club on level 1 at Number 501 Bourke Street, Melbourne commencing at 7pm.
  - In attendance will be Dr Derek Sherwood, Chair CMC New Zealand and Dr Charlie Corke, President-elect CICM will attend with Prof Venkatesh.
- This will be the final meeting for Professor Chris Baggoley as Australia’s Chief Medical Officer as he completes his term in June 2016. Professor Talley to make special mention of this.
- Professor Talley to meet with AMA Vice-President Dr Stephen Parnis over Morning tea in relation to the letter on generalism.
- Following Morning Tea the UNHCR regional representative Mr Thomas Albrechtson will address College Presidents and CEOs at 11:45am.
- At 12:15pm Health Secretary Mr Martin Bowles will address CPMC
- After lunch there will be two presentations from Colleges on revalidation – the RCPA and RACP.
- Dr Jones advised that given the size of the agenda an update on Primary Care would occur at the November meeting. Members agreed an update would be worthwhile.
- Professor Talley noted the items on medical fees and charges and doctors health and wellbeing were listed on the agenda. Dr Phil Truskett agreed to speak on these two items.
- Ms Magarry advised CEOs had been reminded of the decision to utilise the rounded out model for the subscriptions for 2016-17 and were requested to provide the number of fee-paying Australian Fellows for 2016.
- Ms Magarry advised the Executive of the completion of action items from the previous Executive and CPMC meetings.

Action: Split the agenda and advise College Presidents of governance discussion from 7-8pm on Wednesday 1 June 2016 (AM)

Action: RACS to present on the topic of medical fees at the CPMC meeting
4. Senate Enquiry status
Ms Magarry advised the Executive that due to the double dissolution all enquiries and all work of the Senate has ceased. She advised that CPMC had lodged the submission to the Senate Community Affairs References Committee and submission to the Senate Enquiry on Health.

5. Post Federal Budget issues
Ms Magarry advised the members she had attended the lock-up health briefing and sent out an analysis. Professor Talley thanked members for input to the election statement.

6. Update on Obesity Summit
Ms Magarry provided an update on the Summit, advising of the revised proposal, the addition to the CPMC website and the invitations to go to the suggested members of an Advisory Committee. Professor Talley noted that he was meeting with Angela and Ms Amanda Adrian on Tuesday 17th May at 10am in Adelaide on the Summit. All agreed progress was good.

7. CPMC Financials
Members received the most recent financial statements and noted them.

8. Travel management & Qantas
Ms Magarry advised the Executive that as a result of some concerns having been received from member Colleges who have access to the CPMC-Qantas agreement, regarding one travel management company she had undertaken a review and held a meeting with the company concerned. Specific concerns were in relation to sloppy management and holding excessive credits in the system which for many Colleges were difficult to monitor. Ms Magarry advised that there was an alternative provider capable of picking up the business and she was working to achieve an outcome which met the best interests of both Colleges and Qantas.

9. Next Executive date
- 4 August 2016 as the full CPMC meeting has been cancelled
- 20 October 2016 suggest to clear agenda for the 10 November meeting.

10. Other Business
No other business was raised and the meeting closed at 5:22pm

See over for running list of actions
### Committee of Presidents of Medical Colleges
### Executive Meeting

#### ACTIONS LIST

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>By Whom</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Dec 2015</td>
<td>Organise Government relations Day for 4th February (political engagement)</td>
<td>AM</td>
<td>completed</td>
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<tr>
<td></td>
<td>Draft up briefing notes on:</td>
<td></td>
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<tr>
<td></td>
<td>• Health Care Reform generally with a particular focus on the MBS Review;</td>
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<td></td>
<td>• Medical Training Issues including support for the STP program, workforce distribution including data gathering and planning</td>
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<td></td>
<td>• End of Life Care including an advanced care directive campaign.</td>
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<td></td>
<td>• Support for medical research including expanding clinician led research opportunities;</td>
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<td>• Indigenous Health;</td>
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<td></td>
<td>• Medicinal cannabis</td>
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<td></td>
<td>Backrounders on all the participants ✅</td>
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<td></td>
<td>Organise transport and catering ✅</td>
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<td></td>
<td>Followup letters and actions ✅</td>
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<td></td>
<td>Restructure meetings to include updates from</td>
<td>AM</td>
<td>Completed</td>
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<td></td>
<td>• Australian Academy of Health &amp; Medical Sciences,</td>
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<td></td>
<td>• National Medical Training Advisory Network</td>
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<td></td>
<td>• Primary Health Care organisation</td>
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<td></td>
<td>CPMC Planning Forum</td>
<td>AM</td>
<td>Completed</td>
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<td></td>
<td>• Convene a working Group to steer the forum</td>
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<td></td>
<td>• Convene it for 17 Feb half day</td>
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<td></td>
<td>• develop the agenda and distribute for input from the Executive.</td>
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<td></td>
<td>• Prepare a major presentation on the health system with economic analysis</td>
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<tr>
<td>24 March 2016</td>
<td>Strategic planning day and report list for June agenda</td>
<td>AM</td>
<td>completed</td>
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<tr>
<td></td>
<td>Value of CPMC to College Councils – visibility</td>
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<td></td>
<td><strong>Action:</strong> Request from each of the profession observer organisations about whether their reports could be released more broadly than CPMC and to the College communications generally. (AM)</td>
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<td></td>
<td><strong>Action:</strong> Add to next CPMC agenda about profile and issue management within the broader College membership with the recommendation to produce a summary report to circulate with the profession observer papers as well. (AM)</td>
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<tr>
<td></td>
<td>The Health and Wellbeing of Doctors and Countering</td>
<td>AM</td>
<td>Hold over</td>
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<tr>
<td>Workplace Issues</td>
<td>June agenda with the accompanying paper to include a list of alternative providers of courses.</td>
<td>to Nov 2016 mtg</td>
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<tr>
<td>Medical Fees and Gaps</td>
<td>June CPMC agenda. ✓ Obtain information from RACS ✓</td>
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<tr>
<td>Obesity Summit</td>
<td>- Revise the proposal and circulate it to the working group, with the list of names for the establishment of the Advisory Group along with logistics &lt;br&gt; - Website create ✓ &lt;br&gt; - Engage facilitator ✓ &lt;br&gt; - Develop program ✓ &lt;br&gt; - Invite scientific advisory committee ✓</td>
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<tr>
<td>End of Life Care- CPMC position Statement</td>
<td>Draft a position statement ✓ re-circulate a revised draft following comment and liaise with RACP regarding tactical media. ✓ Launch 17 May during National palliative Care Week ✓</td>
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<tr>
<td>UNHCR Regional Representative</td>
<td>List on June agenda (Colleges only session) and AM to liaise with RACP on legal advice. ✓</td>
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<tr>
<td>Senate Community Affairs References Committee Enquiry into Medical Complaints</td>
<td>Draft a submission ✓ Consult with Colleges ✓ Lodge it and determine speaking points if hearings occur ✓</td>
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<tr>
<td>Rural Health Update</td>
<td>Find out the status of the funding proposal ✓ Negotiate the agreement ✓ Finalise RHCE Action implementation plan for transition to SRSA List for the June agenda</td>
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<tr>
<td>10 May 2016</td>
<td>CPMC Agenda</td>
<td>AM completed</td>
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<td></td>
<td>Split it over the Dinner and next day and advise Colleges</td>
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<tr>
<td></td>
<td>Doctor Fees and Charges: RACS to present on the topic of medical fees at the CPMC meeting ✓</td>
<td>AM On agenda</td>
<td></td>
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</tbody>
</table>
4.3 CPMC CEO report to the 2 June 2016 meeting
This report covers the period of late February to this June meeting.

Strategy
- The report from the 17 February 2016 planning forum report was developed and discussed with members of the planning group and then Executive. The report is listed for discussion at this meeting.
- Convened the 24th March and 10th May Executive meetings and accompanying papers which are included in the paper for this meeting at item 4.2.
- Developed the Exec meets Parliament meetings as outlined in Exec action lists.
- Engagement with Ministerial advisers on issues raised by Executive, current Budget, various

Policy
- Drafted and consulted on the End of Life Care position statement which was released to coincide with the release of similar by RACP and within National Palliative Care Week.
- Drafted and consulted on the CPMC Election Statement to align with the campaigning period for political parties. Positive response from stakeholders.
- Consulted with key stakeholders and developed up the National Health Obesity Summit with accompanying proposal, project plan, and funding requests. Webpage
- Revalidation position statement – for discussion at this meeting.
- Engaged with Australian Indigenous Doctors Association concerning the joint forum
- Developed up revised proposal to fund rural specialists beyond conclusion of RHCE
- Attended the International Medical Symposium, Sydney
- Convened the Obesity Working Group to progress policy development
- Drafted the submission to the Senate Community Affairs References Committee on Medical Complaints enquiry and discussed approach with Executive, CEOs, and government.
- Drafted the submission to the Senate Enquiry into Health – lodged and on APH web.
- Qantas airways agreement + travel management service – performance assessment.
- Drafted the Op Ed on The Australian’s coverage of health and specialist incomes.

Finances
- Interim audit 2015-16 underway in May
- Budget 2016-17 presented to this meeting
- Profit and loss presented at this meeting.
- Subscriptions to be issued for 2016-17 financial year on rounded model.

Communications
- March and April CPMC News
- Budget briefing and media to Chair plus members.
- Issued sugary drinks tax media release
- Released the CPMC Position Statement on End of Life Care

Political Engagement
The caretaker provisions came into force on Monday 2nd May. The CPMC Executive will likely convene another government relations day once the General Election is completed, and Ministries have been announced. The approach will be to continue the discussions on health care reforms and workforce with Parliamentarians and to this end, continuing to receive briefings from the Health Secretary is important.

Board-in-Confidence
Stakeholder Engagement
There is a strong emphasis on stakeholder engagement as shown in the list of meetings below.
I have also been appointed to the Australian Council on HealthCare Standards, on Council via my role as Director on the Australasian College of Health Service Managers.

Meetings (formal)

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Organisation</th>
</tr>
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<tbody>
<tr>
<td>23rd February 2016</td>
<td>Canberra</td>
<td>Australian Indigenous Doctors Association</td>
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<tr>
<td>29th February</td>
<td>Melbourne</td>
<td>Health Strategy Consulting</td>
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<tr>
<td>29th February</td>
<td>Melbourne</td>
<td>AHPRA – teleconference</td>
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<td>9th March 2016</td>
<td>Canberra</td>
<td>Palliative Care Australia</td>
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<tr>
<td>14th March</td>
<td>teleconference</td>
<td>Obesity Working Group</td>
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<tr>
<td>14th March</td>
<td>teleconference</td>
<td>Prof Shaun Ewen regarding LIME funding</td>
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<tr>
<td>15th March</td>
<td>teleconference</td>
<td>College CEOs re Senate, Obesity + other</td>
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<tr>
<td>18th March</td>
<td>Canberra</td>
<td>ACT Health Directorate update on hospitals</td>
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<tr>
<td>31st March</td>
<td>Canberra</td>
<td>Policy adviser, Attorney-Generals (DD)</td>
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<tr>
<td>7th April</td>
<td>Canberra</td>
<td>National Rural Health Alliance</td>
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<tr>
<td>12th April</td>
<td>Canberra</td>
<td>FAS DoHA Compliance strategy</td>
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<tr>
<td>13th April</td>
<td>Cooma</td>
<td>RCS- CEO re SRSA</td>
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<tr>
<td>14th April</td>
<td>Canberra</td>
<td>Travel Managers Pty Ltd</td>
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<td>15th April</td>
<td>Canberra</td>
<td>DoHA</td>
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<tr>
<td>19th April</td>
<td>Melbourne</td>
<td>Chair CEOs group</td>
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<td>20th April</td>
<td>Melbourne</td>
<td>Ms Sarah Maguire RACGP</td>
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<td>20th April</td>
<td>Melbourne</td>
<td>AHPRA professions Reference Group</td>
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<td>27th April</td>
<td>Canberra</td>
<td>AMC progress reports working party</td>
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<td>2nd May</td>
<td>teleconference</td>
<td>CEOs meeting</td>
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<td>3rd May 2016</td>
<td>Canberra</td>
<td>Dept Health Federal Budget briefing</td>
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<td>4th May</td>
<td>Canberra</td>
<td>Universities Australia</td>
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<tr>
<td>5th May</td>
<td>Sydney</td>
<td>RACP – RHCE and Qantas</td>
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<tr>
<td>9th May</td>
<td>Canberra</td>
<td>National Rural Health Alliance CEO</td>
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<tr>
<td>10th May</td>
<td>Sydney</td>
<td>RACP- SRSA and RHCE meetings</td>
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<tr>
<td>10th May</td>
<td>teleconference</td>
<td>CPMC Executive</td>
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<td>11th May</td>
<td>Canberra</td>
<td>Department of Human Services SRG</td>
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<td>12th May</td>
<td>Canberra</td>
<td>Australian College of Nursing event</td>
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<td>12th May</td>
<td>Canberra</td>
<td>Jarrod Ball, Business Council of Australia</td>
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<tr>
<td>16-18 May</td>
<td>Adelaide</td>
<td>RACP annual conference</td>
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<tr>
<td>26th May</td>
<td>Canberra</td>
<td>Department of Health – rural health</td>
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</table>

END

Board-in-Confidence
4.4 CPMC Financial Statements

The CPMC financial statements provided to this meeting are for the end of April, 2016. It should be noted that the Executive reviews and has the opportunity to comment on monthly financial statements. For the February, March and May meetings the statements were accepted.

**Cash at Bank at the end of April 2016**

- Operating account: $58,743
- Maxi account: $147,139
- RHCE: $266,600 (these funds will need to be returned to the Cwth post audit)

Business, Associations Liability and corporate travel insurances were all renewed for 2016-17 on 30 May 2016 and therefore will be reflected in May 2016 statements.

On 10 May 2016 the Commonwealth deposited $800,000 as the first payment for the Support for Rural Specialists in Australia program. These funds go towards the management of the administrative processes and distribution of grant funds to rural specialists. The total funding commitment by the Commonwealth is $2.4M over three years. A separate paper supports this at item 5.2

April statements:
- Profit and Loss for the period July – April 2016 against budget
- Balance Sheet

CPMC is solvent and can pay its bills. Variances are in areas where additional travel has been required for meetings and to support the absence of any staff in the RHCE program management unit so I have been doing those functions transitioning RHCE to the new arrangement. CPMC will charge-back for the role of National Director occupied by the CEO, CPMC in a similar way it has occurred under the RHCE program. This income will add to the member subscriptions.

CPMC has made provision of approximately $25,000 to support the development and convening of the National Health Summit on Obesity.

The annual member subscription notices will be developed to support the preparation of the 2016-17 annual CPMC budget. College CEOs have been asked for the number of Fellows and were advised of the new funding model.

The interim audit will occur to support the process for lodgement through the Board and then to the regulator. To avoid incurring any ASIC fine, approval of the audited statements will go through the Executive for lodgement before 30 October 2016.

2016-17 CPMC Operating Budget has been populated with the known income and expenses for the forthcoming financial year.

**Recommendation:** That the Board notes the financial statements and approves the 2016-17 operating budget.

**Attachments**

Board-in-Confidence
## Balance Sheet

As of April 2016

This report includes Year-End Adjustments.

### Assets

<table>
<thead>
<tr>
<th>Current Assets</th>
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### Equity

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# Profit & Loss [Budget Analysis]

## July 2015 To April 2016

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<td><strong>$868,336.34</strong></td>
<td><strong>-$550,395.75</strong></td>
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</table>
## Profit & Loss [Budget Analysis]

**July 2015 To April 2016**

<table>
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<tr>
<th></th>
<th>Selected Period</th>
<th>Budgeted</th>
<th>$ Difference</th>
<th>% Difference</th>
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<tbody>
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<tr>
<td>Total Other Expenses</td>
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<td>Net Profit(Loss)</td>
<td>$317,940.59</td>
<td>$868,336.34</td>
<td>-$550,395.75</td>
<td>(63.4)%</td>
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| 5-0000 | total income | 383,000 |

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<th>November</th>
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<th>February</th>
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<td>6-2010</td>
<td>Accommodation</td>
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<td>6-2025</td>
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<td>6-2040</td>
<td>Other Travel Expenses</td>
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<td>150</td>
<td>1800</td>
<td></td>
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<tr>
<td>6-3000</td>
<td>Insurance Expenses</td>
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<td></td>
<td></td>
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<td>6-3100</td>
<td>Business Insurance</td>
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<td>150</td>
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<td>134</td>
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<td>1608</td>
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| TOTAL EXPENSES | 28585 | 36085 | 28085 | 28085 | 28085 | 28435 | 28085 | 28225 | 28085 | 28084 | 28084 | 346008 | |

Projected net profit/surplus 36,992
change by CPI noted
1 annual fees using rounded model
2 AMC 3 meetings per annum
3 new SRSA funding agreement
4 general interest from maxi account
5 book keeper charges $85 per hour and prepares IAS/BAS/tax forms plus advises on MYOB
6 support for the National Health Summit
7 Website via D Newman + support and changes for Summit
8 The Australian subscription for media monitoring purposes
9 CPMC Board meetings dinner and catering costs
10 CEO PD in contract
11 Rent and MOU revision to include IT email support
12 Salary at 0.8FTE as approved by the Board in February 2016 extending 2 years of contract.
13 Teleconference for Exec meetings
4.5 Changes in Directors

Since the February 2016 meeting of the Committee of Presidents of Medical Colleges the following changes in Directors has occurred.

<table>
<thead>
<tr>
<th>Name</th>
<th>College</th>
<th>Date of Appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Nicholas Talley</td>
<td>RACP</td>
<td>cessation 5 May 2016</td>
</tr>
<tr>
<td>Dr Catherine Yelland</td>
<td>RACP</td>
<td>5 May 2016</td>
</tr>
<tr>
<td>Professor David Watters</td>
<td>RACS</td>
<td>5 May 2016</td>
</tr>
<tr>
<td>Dr Phillip Truskett</td>
<td>RACS</td>
<td>5 May 2016</td>
</tr>
<tr>
<td>Professor Bala Venkatesh</td>
<td>CICM</td>
<td>1 June 2016</td>
</tr>
<tr>
<td>Dr Charles Corke</td>
<td>CICM</td>
<td>1 June 2016</td>
</tr>
</tbody>
</table>
5.1 Indigenous Update
CEOs, CPMC engaged with Dr Shawn Ewen in relation to a tender process for the LIME network.

CPMC has a Collaboration Agreement in place with the Australian Indigenous Doctors Association. The February Board meeting agreed to participate in a joint Collaborative Forum overseen by the AIDA. In that time the organisation has undergone some management changes and progress against the joint forum has stalled. A new CEO has been announced for AIDA: Mr Craig Dukes

Craig is currently the Chief Executive Officer of the National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) and will take up his appointment with AIDA on 24 May 2016. Craig is a descendant of the Mara and Jingili people from the Northern Territory. He has had a long involvement in the Aboriginal community and has worked at the local, state and national level and has also formed strategic international alliances.

Craig has been a leader in the Aboriginal and Torres Strait Islander health sector for over 12 years, having worked at Winnunga Nimmityjah Aboriginal Health Service, the Department of Health and Ageing, and as the inaugural Chief Executive Officer of Indigenous Allied Health Australia (IAHA).

Craig was the inaugural Co-Chair of Health Workforce Australia’s Aboriginal and Torres Strait Islander Stakeholder Advisory Committee, a position he held for three years. He was instrumental in driving the development of a national curriculum framework for the teaching of Indigenous health at Australian universities, which is currently being finalised.

In his role with IAHA he was an active participant in the development of the National Aboriginal and Torres Strait Islander Health Plan which was released by the Minister for Indigenous Health in July 2013. He chaired two round table discussions on Early Childhood and Mental Health that informed the Health Plan.

He also had input into the Mason Review of Australian Government Workforce Programs, in particular, Indigenous workforce programs. Craig was also the Director of the Ngunnawal Indigenous Higher Education Centre at the University of Canberra, where he supported Aboriginal and Torres Strait Islander students to achieve their tertiary aspirations.

Craig has a Bachelor of Applied Science in Conservation of Cultural Materials from Canberra University and his particular areas of expertise include the following:
• Capacity building within Indigenous organisations
• Working with Aboriginal and Torres Strait Islander people and communities
• Governance
• Stakeholder engagement
• Program management
• Organisational development.

Recommendation: The Board notes the appointment and intention by CEO, CPMC to pursue the continuation of the work undertaken to-date between the two organisations.

Board-in-Confidence
Dear Professor Talley

Re: Extension of AIDA - CPMC Collaboration Agreement for another year

The AIDA - CPMC Collaboration Agreement 2013 - 15 (the Agreement) articulates the strong commitment of AIDA and CPMC to work in partnership, to facilitate the shared objectives of increasing the Aboriginal and Torres Strait Islander medical specialist workforce and to promote and strengthen cultural competency and safety in the medical sector. In recognition of the importance and value of this Agreement, the AIDA - CPMC Indigenous Health Subcommittee meeting in February 2015 agreed on a one year extension of the Agreement.

As you would be aware, the AIDA - CPMC Agreement complements additional agreements between AIDA and Medical Deans Australia and New Zealand (Medical Deans) and the Confederation of Postgraduate Medical Education Councils (CPMEC).

Over the second half of 2015 and 2016 to date, AIDA has devised and pursued a proposal for a common collaboration forum to govern all three of these existing agreements through a Collaboration Agreement Forum, a proposal recently endorsed for support by the CPMC at its February 2016 meeting.

While work on the Collaboration Agreement Forum is progressing, it is likely to take some time for the governance and administrative structures of the new Forum to be finalised and agreed upon. We would therefore like to ask the CPMC to extend the current AIDA - CPMC Collaboration Agreement for another year to allow sufficient time for the Collaboration Agreement Forum to become operational.

Yours sincerely

Dr Kali Hayward
AIDA President

21 March 2016
**FOR DECISION**

### 5.2 Rural Health – Support for Rural Specialists in Australia

A proposal was lodged in December 2015 to government in relation to a new program under the title of Support for Rural Specialists in Australia (SRSA), however the government did not finalise any offer until May 2016.

CPMC signed Deed of Variation number 6 for the RHCE funding agreement in February 2016 in order to manage the continuation of the Program Management Unit until the end of March 2016 despite it having ceased on 30 June 2015 (with projects running until end of 2015). This DOV enabled the government and CPMC to continue to negotiate the arrangements for future funding of rural specialist grants and administer the reporting arrangements. CPMC drafted a transition plan and has been working against that plan.

A funding agreement to manage SRSA was executed on 4 May 2016. The only organisation to receive any new funding for rural CPD and upskilling was CPMC. All other organisations were de-funded. CPMC has thanked the Health Minister and Assistant Minister as well as Departmental staff accordingly.

A great deal of activity has occurred in relation to the new agreement as follows:
- Managing the RHCE program in absence of the National Program Manager
- Transitioning the existing staff from RHCE to the new SRSA at RACP
- Developing a new Service Agreement for CPMC and RACP to house the PMU
- Employing a new Program Manager for SRSA (via secondment within the RACP)
- Addressing website issues for both transition and new requirements
- Developing an activity plan for lodgement within 4 weeks of the execution of the new agreement
- Announcing the new arrangement
- Developing the budget
- Liaise with stakeholders

CEO, CPMC has also undertaken the National Director role for RHCE and now SRSA and has also worked closely with the RACP’s Fellows Learning and Support area to work through the requirements. The RACP has agreed to the new Service Agreement and the processes are being put in place to administer the new agreement.

It should be noted that the SRSA is not applicable for access by rural General Practitioners. SRSA is linked to the changes anticipated in STP. The program is for non-GP specialists who work in regional and rural areas and who require upskilling and being a part of the professional community.

**Governance requirements:** CPMC is required to implement a governance structure to support the SRSA. It is recommended that this occurs as a sub-committee of CPMC, chaired by a College with an interest in the area and capacity by the College President to undertake the duties which include overseeing the sub-committee, chairing meetings to determine funding allocations and also participate in any travel associated with the program. The PMU will support the governance arrangements.

**Recommendations:** That the Board notes the new funding agreement and the governance requirements and determines a new sub-committee to be called Rural Health and chaired by a College President.

Board-in-confidence
SCHEDULE: Support for Rural Specialists in Australia Programme

Schedule Commencement Date: 02/05/2016
Schedule Completion Date: 20/07/2019
Agreement Id: 4-34DZHJG
Schedule Id: 4-34DL7ZN

Item A  DEPARTMENT’S PROGRAM INFORMATION

A.1  Program Name: Support for Rural Specialists in Australia Programme

A.2  Program Description and Objectives:

The objective is to provide rural specialists with access to professional support and training opportunities.

Item B  YOUR ORGANISATION’S ACTIVITY INFORMATION

(see also clause 11.4 [Definitions] of the Terms & Conditions)

B.1  Name of Your Organisation: Committee of Presidents of Medical Colleges

B.2  ABN: 46 101 213 478

B.3  Activity Name: Support for Rural Specialists in Australia Programme
Activity Start Date: 02/05/2016
Activity End Date: 30/04/2019

Activity Details:

This Schedule must be read and interpreted in conjunction with the ‘Terms and Conditions For Standard Funding Agreement 2015’ The Schedule and the Terms and Conditions should not be read separately from each other.

AIMS OF THE PROGRAMME

The Aim of the project is to provide rural specialists with access to professional support and training opportunities.

This will be achieved by:
- Providing support and training via online learning programmes; and
- Individual grants to enable rural specialists to access training not available in their home town.
ACTIVITIES

1. Your Organisation will maintain and enhance the existing rural specialists website including:

1.1 Reviewing and where appropriate updating existing content and archiving materials no longer required.

1.2 Expanding the website as a platform for use as an ‘e-learning’ space and for the delivery of online training content.

1.3 Continuing professional development learning topics and themes to be addressed will include:
   - supervision skills;
   - cultural competency;
   - revalidation;
   - practitioners’ mental health; and
   - bullying and harassment.

2. Your Organisation will deliver an individual grant process for rural specialists including:

2.1 Develop and publish guidelines, which will include:
   - scope (types of training to be supported);
   - how to and who may apply;
   - amount of funding available; and
   - appeal process.

2.2 Develop and administer a funding process for grant recipients including:
   - promoting and marketing the project;
   - seeking and assessing applications for funding;
   - selecting grant recipients;
   - notifying successful and unsuccessful applicants;
   - advising and supporting grant recipients in relation to professional development training programme;
   - monitoring the progress of each grant recipient in completing the approved training programme;
   - ensuring grant recipients adhere to approved activities and budgets; and
   - providing opportunities for grant recipients to share experiences and encourage them to work collaboratively on similar projects and to use the rural specialist website for these purposes.

3. Your Organisation must maintain Governance arrangements within CPMC including:

   - providing overarching management and liaison with administrative processes conducted under a sub-contract with the Royal Australasian College of Physicians;
   - establishing a Governing Committee to assist with the formation of policies and documents.

Words or phrases defined in the Terms and Conditions carry the same meaning in this Schedule
Activity Performance Indicators:

<table>
<thead>
<tr>
<th>No</th>
<th>Performance Indicator description</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Support and training via online learning programmes delivered in accordance with the agreed Activity Work Plan.</td>
<td>100%</td>
</tr>
<tr>
<td>2</td>
<td>Individual rural medical specialist grants provided in accordance with the budget in the agreed Activity Work Plan.</td>
<td>100%</td>
</tr>
</tbody>
</table>

Additional Information:

B.4 Location Information:

Your Organisation has advised that all or part of the Activity will be delivered from the site location(s) specified below:

<table>
<thead>
<tr>
<th>Location Type</th>
<th>Location Sub-type</th>
<th>Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>None specified</td>
<td>Committee of Presidents of Medical Colleges</td>
<td>6/14 Napier Close, DEAKIN, ACT, 2600</td>
</tr>
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</table>

Service Area:

Your Organisation has advised that the Activity will service the service area(s) specified below:

<table>
<thead>
<tr>
<th>Type</th>
<th>Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>SA, NSW, QLD, WA, NT, TAS, ACT, VIC</td>
</tr>
</tbody>
</table>

Your Organisation must advise the Department of any change to the site location or service area information in writing within 30 days after that change.

If, however, the location or area is a Works Location for Capital Works or a site location for Real Property or information about the location or area was provided to the Department as part of a selection/agreement process, any such change must be agreed in advance in writing by the Department before Your Organisation may implement the change.
Standard Funding Agreement Schedule

**Item C**  
**FUNDING AND PAYMENT** (see also clause 3 [Financial provisions] of the Terms and Conditions)

**C.1**  
**Activity Name:** Support for Rural Specialists in Australia

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>Funding amount (GST Exclusive)</th>
<th>GST component (if applicable)</th>
<th>Total (GST Inclusive)</th>
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<td>2015-2016</td>
<td>$727,272.73</td>
<td>$72,727.27</td>
<td>$800,000.00</td>
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<td>2016-2017</td>
<td>$727,272.73</td>
<td>$72,727.27</td>
<td>$800,000.00</td>
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<td>2017-2018</td>
<td>$727,272.73</td>
<td>$72,727.27</td>
<td>$800,000.00</td>
</tr>
<tr>
<td>2018-2019</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
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**Bank Account Information:**
Your Organisation must notify the Department in writing of any changes to these account details:

- **BSB Number:** 032-102
- **Financial Institution:** Sydney level 14, 275 Kent Street WBC
- **Account Number:** 688 025
- **Account Name:** Committee of Presidents of Medical Colleges

**Item D**  
**BUDGET** (see also clause 3.5 [Budget] of the Terms and Conditions)

Expenditure of Project Funds must be in accordance with the Budget to be provided with the Activity Work Plan.

**Item E**  
**REPORTS** (see also clause 2.3 [Reports] of the Terms and Conditions)

**NOTE**
Your Organisation’s Reports must contain all the information specified below. All reports must be in English and in a form acceptable to the Department.

Words or phrases defined in the Terms and Conditions carry the same meaning in this Schedule
E.1 Performance Reports

Support for Rural Specialists in Australia Programme

Your Organisation is required to submit a Performance Report every six months by the dates specified at Item F. Each Performance Report must include the following information for the reporting period:

- report on any progress against the activities outlined in Item B.3, including:
- number of rural specialists, by college and specialty, provided with grants every six-months since execution of the agreement;
- number of rural specialists, by college and specialty, that completed the proposed training in the time specified by the grant;
- number of rural specialists, by college and specialty, that did not complete the proposed training in the time specified by the grant, including reasons for each non-completion.
- reports on feedback received from specialists receiving grants or accessing support and training via online learning programmes;
- a detailed statement of income and expenditure;
- a complete version of any Project Material developed or updated since the previous Performance Report, including a copy of any advertisements and a list of where the advertisements were placed;
- report on the Governing Committee, including but not necessarily limited to current membership, meetings held and advice provided; and
- an issues log containing a summary of appeals received and outcomes;
- what difficulties, if any, were encountered in performing the activities during the reporting period, and the action proposed or undertaken to overcome the difficulties.

The Performance Report must also include an update on any action undertaken in the current reporting period for difficulties encountered in a previous reporting period and also include:

- any potential issues that could impact on the timeliness and quality of deliverables;
- approaches or strategies for resolving any identified issues;
- variance between proposed budget and actual expenditure (subject to approval specified in the funding agreement);
- acquittals of individual grants to rural medical specialist; and
- recommendations for improving the performance of the activity against the performance indicators including how to better target resources to optimise their usefulness and delivery of the activity.
E.2 Activity Work Plan

Support for Rural Specialists in Australia Programme

Your Organisation is required to submit an Activity Work Plan within four weeks after the execution of this schedule with updates provided with each Performance Report. The Activity Work Plan must include the following information:

- an outline of how your organisation will complete the activities outlined at Item B; and
- Budget outlining Expenditure of Project Funds for the entire project period.

E.3 Annual Report

None specified.

E.4 Financial Acquittal Reports

Support for Rural Specialists in Australia Programme

None specified.

E.5 Other Reports

Support for Rural Specialists in Australia Programme

Statistical Reporting

Your Organisation must maintain a database that can be provided to the Department at any time. The statistics will include, but are not limited to:

1) grants to rural medical specialists:
   - Name
   - Primary location (full address and category in ASGC RA 1-5);
   - Estimate of full time equivalent of services provided at primary location;
   - Primary location is categorised as private or public facility;
   - Location of services provided other than at the primary location (ie town and ASGC RA 1-5 if different to primary location);
   - Specialty;
   - College; and
   - Number of years worked at the primary location.

2) online learning programmes:
   - number of web site visits by program or resource; and
   - number of specialists completing online learning programs by program.
E.6 Final Report

Support for Rural Specialists in Australia Programme

In addition to the information required under Item E.1 Performance Reports, the Final Report must include the following information for the reporting period:

The Final Report must include the following information for the entire reporting period as outlined in the Deliverable Table:

- an assessment on whether the Aims of the Project was achieved, and if not, an explanation of why this is the case; and
- an assessment of options for the future development of the Project.
Item F  **MILESTONES / REPORTING REQUIREMENTS / PAYMENT SCHEDULE**

The following table combines all of Your Organisation's Reporting and other Milestones for all Activities under this Agreement.

<table>
<thead>
<tr>
<th>Milestones and Reports</th>
<th>Activity</th>
<th>Information to be included and requirements</th>
<th>Due Date</th>
<th>Payment Amount (GST excl.)</th>
<th>GST</th>
</tr>
</thead>
<tbody>
<tr>
<td>F.1</td>
<td>Payment</td>
<td>Support for Rural Specialists in Australia</td>
<td>2 May 2016</td>
<td>$727,272.73</td>
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</tr>
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<td>F.2</td>
<td>Activity Work Plan</td>
<td>Support for Rural Specialists in Australia</td>
<td>Within 4 weeks of execution of the agreement.</td>
<td>$0.00</td>
<td>$0.00</td>
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<tr>
<td>F.3</td>
<td>Performance Report</td>
<td>Support for Rural Specialists in Australia Performance Report 1 including a Statement of Income and Expenditure for the period 2 May 2016 to 31 December 2016.</td>
<td>31 January 2017</td>
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<td>F.4</td>
<td>Progress Payment</td>
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<td>28 February 2017</td>
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<td>$72,727.27</td>
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<tr>
<td>F.5</td>
<td>Performance Report</td>
<td>Support for Rural Specialists in Australia Performance Report 2 including a Statement of Income and Expenditure for the period 1 January 2017 to 30 June 2017</td>
<td>31 July 2017</td>
<td>$0.00</td>
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<tr>
<td>F.6</td>
<td>Progress Payment</td>
<td>Support for Rural Specialists in Australia Progress Payment</td>
<td>15 August 2017</td>
<td>$363,636.37</td>
<td>$36,363.63</td>
</tr>
</tbody>
</table>

Words or phrases defined in the Terms and Conditions carry the same meaning in this Schedule

Department of Health SFA SCHEDULE Version March 2015
<table>
<thead>
<tr>
<th>Activity</th>
<th>Milestones and Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>F.7</td>
<td>Performance Report 3 including a Statement of Income and Expenditure for the period 1 July 2017 to 31 December 2017 and Audited Financial Statement 2016-2017</td>
</tr>
<tr>
<td>F.8</td>
<td>Progress Payment</td>
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<tr>
<td>F.9</td>
<td>Performance Report 5 including a Statement of Income and Expenditure for the period 1 January 2018 to 30 June 2018</td>
</tr>
<tr>
<td>F.10</td>
<td>Performance Report 4 including a Statement of Income and Expenditure for the period 1 January 2018 to 15 July 2018</td>
</tr>
<tr>
<td>F.11</td>
<td>Audited Financial Statement for the entire Project Period</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Due Date</th>
<th>Information to be included and requirements</th>
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</thead>
<tbody>
<tr>
<td>31 January 2018</td>
<td>Support for Rural Specialists in Australia</td>
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<tr>
<td>15 February 2018</td>
<td>Support for Rural Specialists in Australia</td>
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<tr>
<td>15 July 2018</td>
<td>Support for Rural Specialists in Australia</td>
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<tr>
<td>31 January 2019</td>
<td>Support for Rural Specialists in Australia</td>
</tr>
<tr>
<td>30 June 2019</td>
<td>Support for Rural Specialists in Australia</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>GST</th>
<th>Payment Amount (GST excl)</th>
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<tbody>
<tr>
<td>$0.00</td>
<td>$36,363.63</td>
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<tr>
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<tr>
<td>Item G</td>
<td>INSURANCE REQUIREMENTS (see also clause 9.3 [Insurance] of the Terms &amp; Conditions)</td>
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<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Your Organisation must have the following Activity specific insurance/s:</td>
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<td>Item H</td>
<td>ASSETS (see also clause 5 [Assets] of the Terms &amp; Conditions)</td>
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<td>None specified.</td>
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<tr>
<td>Item I</td>
<td>SUBCONTRACTORS (see also clause 4.2 [Subcontractors to be approved] of the Terms &amp; Conditions)</td>
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<tr>
<td></td>
<td>The following subcontractors are required to undertake the Activity as indicated:</td>
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<td></td>
<td>Support for Rural Specialists in Australia</td>
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<tr>
<td></td>
<td>&quot;None specified&quot;</td>
</tr>
<tr>
<td>Item J</td>
<td>SPECIFIED PERSONNEL (see also clause 4.3 [Your Organisation's Personnel and Specified Personnel] of the Terms &amp; Conditions)</td>
</tr>
<tr>
<td></td>
<td>The following Specified Personnel are required to undertake the Activity as indicated:</td>
</tr>
<tr>
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<td>Support for Rural Specialists in Australia</td>
</tr>
<tr>
<td></td>
<td>&quot;None specified&quot;</td>
</tr>
<tr>
<td>Item K</td>
<td>CONFIDENTIAL INFORMATION (see also Clause 8 [Confidentiality] of the Terms &amp; Conditions)</td>
</tr>
<tr>
<td></td>
<td>Support for Rural Specialists in Australia</td>
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Words or phrases defined in the Terms and Conditions carry the same meaning in this Schedule
Item J  SPECIFIED PERSONNEL (see also clause 4.3 [Your Organisation’s Personnel and Specified Personnel] of the Terms & Conditions)

None specified.

Your Organisation’s Confidential Information is:

None specified.

Item L  NOTICES (see also Clause 4.5 [Notices] of the Terms & Conditions)

The Commonwealth’s contact details and address for notices:

<table>
<thead>
<tr>
<th>Name or Position</th>
<th>Louise Anasson</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DoH Contract Manager</td>
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<tr>
<td>Phone</td>
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</tr>
<tr>
<td>Email</td>
<td><a href="mailto:louise.anasson@health.gov.au">louise.anasson@health.gov.au</a></td>
</tr>
<tr>
<td>Postal Address</td>
<td>GPO Box 9848 CANBERRA ACT 2601</td>
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<td>Facsimile</td>
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Your Organisation’s contact details and address for notices:

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<thead>
<tr>
<th>Name or Position</th>
<th>Ms Angela Magarry</th>
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<tbody>
<tr>
<td></td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>Phone</td>
<td>(02) 6282 8269</td>
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<tr>
<td>Email</td>
<td><a href="mailto:ceo@cpmc.edu.au">ceo@cpmc.edu.au</a></td>
</tr>
<tr>
<td>Postal Address</td>
<td>Suite 6, 14 Napier Close</td>
</tr>
<tr>
<td></td>
<td>Deakin ACT 2600</td>
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<tr>
<td>Facsimile</td>
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</table>
Support for Rural Specialists in Australia

Applies in full.
ANNEXURE A - Supplementary Conditions

Contact Grant Advice on (02) 6289 5921 to discuss the inclusion of Supplementary Conditions for your Schedule.

<Field> Activities _ Activity Title

Contact Grant Advice on (02) 6289 5921 to discuss the inclusion of Supplementary Conditions for your Activity.

Words or phrases defined in the Terms and Conditions carry the same meaning in this Schedule
Signatories to this Agreement

Parties
Commonwealth of Australia ("Commonwealth"), as represented by and acting through The Department of Health ABN 83 605 426 759, Sirius Building, Cnr Furzer and Worgan St, Phillip ACT 2600 ("Department")

Committee of Presidents of Medical Colleges ABN 46 101 213 478 of 6/14 Napier Close DEAKIN ACT 2600 ("Your Organisation").

Executed by the Parties as a DEED on the 4th day of May, Year 2016.

The Parties agree that by signing this Schedule they enter into the Agreement, which comprises this Schedule (including its Annexures and any Supplementary Conditions), the attached Cover Letter, the enclosed document entitled 'Terms and Conditions Standard Funding Agreement March 2016' and any other documents incorporated by reference.

This Agreement is deemed to have commenced on 2 May 2016

Signed, Sealed and Delivered for and on behalf of the Commonwealth of Australia by the relevant Delegate, represented by and acting through the Department of Health, ABN 83 605 426 759 in the presence of:

(NSignature of Departmental Representative) 4.5.2016

(Name of Departmental Representative)

(Signature of Witness) 4.5.2016

(Name of Witness in full)

Signed by Committee of Presidents of Medical Colleges, ABN: 46 101 213 478, in accordance with its Constitution:

(Signature of Director)

(Signature of other Director/Secretary)

Prof. David Watters OBE
(Name of Director in full)

(AngeLa MagArry
(Name of other Director/Secretary)

Words or phrases defined in the Terms and Conditions carry the same meaning in this Schedule

Department of Health SFA SCHEDULE Version 4.1 March 2015

William TONURI

3.5.16.
6.1 National Medical Training Advisory Network

CPMC members should note the communique from the NMTAN as outlined below with their permission. The meetings changed due to caretaker mode so that the next meeting is now scheduled for Thursday 1 September 2016 from 11am to 3pm at the Melbourne Airport Parkroyal. Professor Talley is CPMC representative.

10 March Communique

THE NATIONAL MEDICAL TRAINING ADVISORY NETWORK (NMTAN) EXECUTIVE COMMITTEE MET ON 10 MARCH 2016 IN MELBOURNE.

AS PART OF THE COMMITTEE’S CAPACITY AND DISTRIBUTION WORK, AUSTRALIA’S FUTURE HEALTH WORKFORCE (AFHW) REPORT – ANAESTHESIA WAS DISCUSSED. THE REPORT, WHICH IS SECOND IN THIS WORK SERIES, INCLUDES THE SUPPLY AND DEMAND PROJECTIONS FOR THE ANAESTHESIA WORKFORCE TO 2030 AND WAS DEVELOPED IN CONSULTATION WITH THE AUSTRALIAN AND NEW ZEALAND COLLEGE OF ANAESTHETISTS AS WELL AS THE PROFESSIONAL BODY, AUSTRALIAN SOCIETY OF ANAESTHETISTS. FOLLOWING DISCUSSION AT THE MEETING, THE REPORT IS EXPECTED TO BE UPDATED WITH SUGGESTED REVISIONS AND ENDORSED OUT OF SESSION.

NMTAN ALSO AGREED TO CONSIDER THE RECOMMENDATIONS RELEVANT TO ITS SCOPE OF WORK FROM THE SUPPLY AND DEMAND PROJECTION REPORTS FOR FURTHER ACTION.

INFORMATION WAS PROVIDED ON THE ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH CURRICULUM FRAMEWORK, WHICH HAS BEEN DEVELOPED TO ADDRESS THE VARIABLE NATURE AND EXTENT TO WHICH ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH CURRICULUM IS BEING IMPLEMENTED BY HEALTH PROFESSIONS AND HIGHER EDUCATION PROVIDERS. MEMBERS RECOGNISED THE NEED FOR NMTAN TO INCLUDE A GREATER FOCUSES ON THE ABORIGINAL AND TORRES STRAIT ISLANDER MEDICAL WORKFORCE AND AGREED TO UNDERTAKE FURTHER WORK IN THIS AREA.

NMTAN WAS BRIEFED ON NATIONAL INITIATIVES INCLUDING THE AUSTRALIAN GOVERNMENT RESPONSE TO THE REVIEW OF MENTAL HEALTH PROGRAMMES AND SERVICES, MY HEALTH RECORD, REVIEW OF THE SPECIALIST TRAINING PROGRAMME, THE INTEGRATED RURAL TRAINING PIPELINE AND THE REVIEW OF MEDICAL INTERN TRAINING.

THE NEXT MEETING OF NMTAN WILL BE HELD ON 21 JUNE 2016. THE NEWLY APPOINTED CHAIR OF THE NATIONAL NURSING AND MIDWIFERY EDUCATION ADVISORY NETWORK WILL BE INVITED TO ATTEND THIS MEETING, PROVIDING AN OPPORTUNITY IN FUTURE FOR COLLABORATIVE WORK ON HEALTH WORKFORCE BY THE TWO EXPERT GROUPS.

Recommendation: The Board notes the next meeting and Communique.
Laureate Professor Nicholas Talley  
Chair, Committee of Presidents of Medical Colleges  
6/14 Napier Close  
Deakin ACT 2600

Dear Professor Talley

Medical generalists in the Australian health system

I am writing to request a meeting with you to discuss the ongoing decline of the generalist medical practitioner workforce in Australia and potential initiatives to help promote and rejuvenate this essential component of the medical workforce.

The AMA uses the former Health Workforce Australia’s (HWA) definition of generalist medical practitioners – GPs, rural generalists and general specialists, such as general surgeons and physicians who retain a broad scope of practice.

Generalist medical practitioners have held a crucial role in delivering healthcare in Australia for generations and are particularly important for rural communities; however, as is widely recognised, the medical workforce has become increasingly specialised in recent decades driven by changes in knowledge, technology, health service delivery, and health care financing. This is not necessarily a positive development as there is evidence that centralised and sub-specialised care is not always in the best interests of the patient or cost effective for the health system.

The consequence of these developments is that public and private generalist medical practice has become less attractive and the number of medical graduates choosing a generalist career path has decreased significantly. Unfortunately, this is at a time when more generalist medical practitioners are required to meet the health care needs of both rural and metropolitan communities, and to address the growing burden of complex and chronic disease across the country.

The AMA is aware of some innovative programs underway that are attempting to address this issue such as the Royal Australasian College of Physicians’ dual physician training program. Advice we have received from the Health Workforce Principal Committee on initiatives at the federal and state level is encouraging, but if significant progress is to be achieved, it is important for the jurisdictions to work together with strong stakeholder engagement. The colleges have an important role in this area by developing generalist vocational training programs to facilitate the expansion of the generalist medical workforce.
While there is now much greater recognition of the need to boost generalism, the absence of a coherent and co-ordinated policy framework means the trend towards sub-specialisation continues.

I would be very grateful for an opportunity to discuss these matters with you and I will ask Mr Richard Boutchard from the AMA’s Federal Secretariat to contact your office to put arrangements in place for such a meeting.

Yours sincerely

Dr Stephen Parnis
Vice President

21 April 2016
6.3 Federal Budget

This item is For Noting.

Pre-Budget leaks included:

- Heath Minister Sussan Ley announced a $5 billion subsidised public dental scheme this year.
- The new Child and Adult Public Dental Scheme will replace the current Child Dental Benefits Scheme — introduced by Labor.
- The new plan will cover Australians under 18 years old, as well as the estimated five million people on low incomes who hold a Commonwealth concession card.
- The $5 billion will be spent over four years and is expected to provide treatment for more than 10 million citizens.
- Mr Turnbull also announced earlier this year that an extra $2.9 billion will be poured into state and territory hospitals between 2017 and 2020.
- The government is also expected to include $21 million for chronic conditions and to add more than 1000 new drugs to the Pharmaceutical Benefits Scheme.
- It has also hinted at an extra 17,400 aged care places.

On Tuesday 3 May, CEO, CPMC attended the Health Budget Lock-up and the briefing papers were reflective of a cautious budget for Health, with:

- $2.9B to public hospitals;
- Access to GP registrar training in rural and regional areas;
- Continuation on the pause on MBS indexation for a further 2 years;
- Removal/deletion of obsolete MBS items and adding access to new items;
- $66M towards enhanced compliance and fraud monitoring;
- A focus on aged care in rural and regional areas.

In the Australian Opposition Health spokesperson has accused the government of ripping health of $2.1Bn. This is because of the scrapping of the Child Dental benefits Scheme and the cuts to pathology and diagnostic imaging.

The papers are available at: http://www.health.gov.au/internet/budget/publishing.nsf/content/healthbudget1617-1

The above link was sent out on 3 May 2016 to all CPMC members.

Recommendation: The briefing be noted.

Board-in-Confidence
6.4 Submissions
At the dissolution of the Senate and the House of Representatives on 9 May 2016 for a general
election on 2 July 2016, the parliamentary committees of the 44th Parliament ceased to exist.
Therefore inquiries that were not completed have lapsed and submissions cannot be received.
However, information about the inquiries is still available but no submissions can be seen.

Senate Community Affairs References Committee Enquiry into Medical Complaints
CPMC drafted a submission to the above enquiry and passed it through the Colleges and then gained
input from the Executive where appropriate. The submission was lodged. While the enquiry would
cease it remains possible for a new enquiry to be launched into this (and Lyme Disease) in the
future.

Senate Enquiry into Health
This was a four year enquiry into Health. CPMC drafted a submission which reflected the election
statement and it was lodged.

Recommendation: The Board notes the submissions and related information.
6.5 End of Life Care Position Statement

CPMC position statement on End of Life care was drafted by secretariat following media coverage of this matter and the need to properly pace the views of specialist medicine on the record.

All Colleges were given the opportunity to provide comment on the draft up until 4 April, 2016.

The statement was approved and the timing of the release was agreed as best to be after the launch by the RACP on 16 May and during National Palliative Care week. Therefore it was launched 17 May 2016. It can be found at: [http://cpmc.edu.au/wp-content/uploads/2016/05/CPMC_Final_May-2016.pdf](http://cpmc.edu.au/wp-content/uploads/2016/05/CPMC_Final_May-2016.pdf)

**Recommendation:** The Board notes the Position Statement.
COMMITTEE OF PRESIDENTS OF MEDICAL COLLEGES

POSITION STATEMENT

End of Life Care

End of life care is health care for people with a terminal illness or terminal disease condition that has become advanced, is typically progressive and incurable.

The Committee of Presidents of Medical Colleges comprises members from across all aspects of medicine and College Presidents are committed to ensuring that all Australians have access to safe and appropriate care as they approach the end of their lives. Quality end of life care occurs when there is a partnership between the terminally ill person, their care team and their family, carers and loved ones.

Medical practitioners have an obligation to preserve life and where death is inevitable this should occur with dignity and comfort with adequate relief from pain and suffering. Good medical practice includes not initiating, or continuing life-prolonging measures when that treatment will not result in any benefit or will impose an unacceptable burden on the terminally ill person.

All medical practitioners have a responsibility to effectively, collaboratively and respectfully discuss choices regarding treatment escalation and de-escalation at the end-of-life with patients and their families. All physicians have a responsibility to document the summary and outcome of end of life discussions with patients and/or their families. Expert advice from a palliative care physician may be required.

CPMC strongly supports end of life care because it is patient-centred, coordinated and focused on rational investigation, symptom management and de-prescribing. It involves early identification, assessment and treatment of pain, dyspnoea and other problems (physical, psychosocial, cultural and spiritual)\(^1\). It enables patients nearing the end of life to live as well as possible, and then to die without unnecessary prolongation of the dying process. For families and loved ones it includes support through the bereavement phase.

CPMC recognises the issues associated with end of life care are complex and is working with the Australian government to address them, including through enhanced education and training for medical practitioners, and the promotion of advanced care directives.

Released 17 May 2016

\(^1\) World Health Organisation (WHO) website, Definition of Palliative Care – http://www.who.int/cancer/palliative/definition/en/
6.6 Update on the National Health Summit on Obesity

Background
CPCM is concerned that obesity is fast becoming Australia’s biggest health challenge with more than three quarters of the population overweight or obese. Overweight and obese people are at higher risk of cancer, type 2 diabetes, heart disease, and other life-threatening illnesses. It is however, a complex issue and designing a long term strategy across the life course involves a wide range of stakeholders from medical and nursing professionals, public health advocates, schools, food industry, advertising companies, town planners and insurers. CPCM has decided to take the lead on this important health issue by bringing the world and national leaders together to examine the issues, tackle the controversies, define potential interventions, and decide on a series of recommendations to expertly manage and reduce obesity in Australia.

A Working Party was convened to steer this concept, chaired by Professor Nicholas Talley and comprising representation from:

- Dr Catherine Yelland – President-elect, Royal Australasian College of Physicians
- Dr Frank Jones – President the Royal Australian College of General Practitioners
- Professor Michael Permezel, President, the Royal Australia and New Zealand College of Obstetricians and Gynaecologists
- Professor Malcolm Hopwood, President the Royal Australian and New Zealand College of Psychiatrists

A Scientific Advisory Committee has been developed to steer the program and ensure the outcomes are clearly defined.

A National Health Summit on Obesity has been convened for 9 November, 2016 at the Royal Australian College of General Practitioners, Melbourne on Wednesday 9 November 2016 at 10am.

The purpose of the CPMC Summit is to examine the evidence and develop documentation to assist in the clinical management of obesity. A facilitator has been engaged to support the day.

The Healthy Food Partnership is a government initiative and CPMC will invite representatives from the food industry to participate in the discussion. CPMC has also made a request for funding assistance from the Department of health. CPMC has also invited the Health Minister to launch the Summit.

A key outcome from the Summit is the development of a support document to assist the clinical management of obesity.

Further information on the Summit can be found at: http://cpmc.edu.au/our-members/national-health-summit-on-obesity/

Recommendation: This update be noted as progress against the development of the CPMC National Health Summit on Obesity.
Advocacy Meetings held on 9 March
The Executive Committee met with Hannah Cameron (Manager, Sector and Services Transformation Policy Team, Ministry of Health) and Angela Mansen who updated the Executive Committee members on the new regime for Therapeutic Regulation. A draft Bill will be completed by mid-2016 and circulated for consultation at that time. The Bill will be presented to the Select Committee at the end of 2016.

Direct to Patient Advertising (DTCA) can be commented on during the consultation process.

The Executive Committee also met with Julia Rowling and Jane Potiki, of the Electives and National Services, Ministry of Health. Julia and Jane spoke about National Patient Flow work and their move towards national consistency in systems and tools. Their work is trying to capture patient interaction in secondary services and the patient journey. An aspect of the work is tracking referrals and timeframes.

The group was joined by Alastair Kenworthy—who talked about SNOMED-CT. The Ministry of Health holds a license for use in New Zealand. The team is working towards a consistent system of diagnostic coding and is working with groups of clinicians to develop clinical codes. Ongoing feedback from clinicians is needed. The Executive Committee members noted that the system could help with tracking elective services however implementation could take several years.

CMC Council meeting
The CMC Best Practice Guide for Continuous Practice Improvement and Stocktake has been launched and encourages a move towards appraisals and practice review, including multi-source feedback for Colleges, in an effort to reduce duplication of assessments by senior medical staff.

The Chair encouraged members to consider that appraisals should attract points as part of Colleges’ Continuing Professional Development programme.

Ken Clarke has sent Best Practice to all Chief Medical Officers and the ED encourages Colleges provide a link to Best Practice on their websites.

Health Quality Safety Commission
The HQSC will release a Position Paper on the transparency of information related to health care interventions on Friday 11 March, in collaboration with ACC and the HDC.

Change in Secretariat provider for CMC
From 1 April ACEM will provider secretariat services to CMC.

Health Workforce New Zealand
The Chair welcomed Professor Des Gorman, Angela Foulkes, Margareth Atwood and Emmanuel Jo. Professor Gorman advised members that traditional flows of graduates out of the New Zealand workforce have changed with fewer now leaving New Zealand in the first 3 years from graduation. That said many still prefer to work in the main centres. There is a need to construct a sustainable workforce pipeline. This may require changing the way doctors are rewarded. If New Zealand has an oversupply of junior doctors this may enable correction of mal distribution. He also noted that it is important to reduce New Zealand’s reliance on overseas trained doctors. Currently this is approximately 40%, using the Medical Council of New Zealand definition, whereas an ideal would be 15%.
Professor Gorman advised that HWNZ was working on a modelling tool that allows querying of assumptions and changing them can also factor in models of care. The modelling may enable different Colleges to have different solutions in terms of vocational training funding.

HWNZ had developed a set of principles which will inform funding investment. HWNZ will work with DHBs and Colleges to understand the service and funding gaps. The aim is to determine how funding models would work to develop a better model of investment.

Emmanuel Jo demonstrated the model which allowed number variables to be changed at different points on a continuum (for example, numbers of trainee and age of retirement).

In the follow up session it was suggested that CMC would coordinate feedback on the principles and each College may like to contact HWNZ to discuss the modelling of data on their profession.

**Stakeholders session**

The **Medical Council of New Zealand** (MCNZ) discussed recertification programmes and the likelihood that it is likely these will be moving towards a more principle based system and it is likely that the mandated number of CPD hours will be removed. Colleges will be required to align to principles.

The Chair welcomed Stephen Child, Kate Baddock and Lesley Clarke of the **New Zealand Medical Association**. Dr Child initiated a discussion about professionalism and the charging of fees for service. In some areas of medicine there is a 5-13 fold difference in pricing. Dr Child asked if there was a role for CMC to act on this issue. Dr Child talked about the potential for justifiable and transparent pricing to be integrated in to codes of conduct. Dr Child noted that RACS has a position paper which contains principles about pricing. It talks about excessive pricing rather than setting prices.

The Chair welcomed Kieran Bunn of the **New Zealand Medical Students Association**.

The NZMSA has been involved with the TPP issue and is aligned with NZMA on this issue. The NZMSA annual medical conference is coming up. This year a focus for the association is discussion about euthanasia with the aim to generate discussion and provide information. Changes in TI prescribing is a change for NZMSA and members have been involved in discussions with universities on the parameters. NZMSA has held productive discussions with universities about bullying and sexual harassment as Universities have a role in teaching future teachers.

**Bullying and Sexual Harassment update**

The bullying and sexual harassment framework developed by the cross sector task force was noted by members.

**Direct to Consumer advertising (DTCA)**

The Chair asked members about their interest in working on a joint statement. There was general agreement that members should look at this issue.

**Choosing Wisely**

CMC is continuing with its commitment to the Choosing Wisely programme. The Steering Committee is functioning well and supports the implementation of Choosing Wisely. HQSC is providing non-financial support and the NHC may commit to funding for the development of a website. The Chair and ED are meeting with potential funders to garner support. The extent of the campaign reach on Choosing Wisely will depend of the amount of funding received. If funding is limited implementation will be based around ‘do not do’ lists and a small public campaign. More funding would enable a more comprehensive public campaign. Consumer New Zealand had made a commitment to be involved. CMC will be linking more strongly with Choosing Wisely Australia who will support NZ initiatives.
3.1 UNHCR Regional Representative

The United Nations High Commission on Refugees, Regional Representation is based in Canberra, and is responsible for the promotion and protection of refugee rights in the region which includes Australia, New Zealand, Papua New Guinea and the Pacific. The Regional Office focuses on three key areas: legal protection, resettlement, and public information.

The current UNHCR Regional Representative is Thomas Albrecht.

Correspondence from Mr Thomas Albrecht to brief the CPMC about the refugee health issues was received into secretariat and noted and agreed to on a no-commitment basis by the Executive at the 24 March meeting. It is attached.

Questions will be led by Professor Talley on this matter.

A biography taken from the UNSW via the Kaldor Centre [http://www.kaldorcentre.unsw.edu.au/authors/thomas-albrecht]

Mr. Thomas Albrecht is the Regional Representative of the United Nations High Commissioner for Refugees in Canberra, with geographical responsibility for 16 Pacific countries. Mr. Albrecht’s role is to work with governments and other partners to ensure all persons of concern to UNHCR, including refugees, asylum-seekers and stateless persons, receive protection, assistance and durable solutions to their plight. He is also keen to promote long-term cooperation on the protection of persons of concern in the region, and to increase understanding and support for refugees worldwide.

Prior to taking up this assignment in early 2014, Mr. Albrecht served as Head of the UNHCR Regional Support Hub in Nairobi, which, in close collaboration with the Organization’s Headquarters, works with offices in the East and Horn of Africa as well as the Great Lakes Region to ensure strategic coherence, programme quality and results, management effectiveness and financial due diligence and accountability for UNHCR’s operations. From 2005 to 2009, Mr. Albrecht served as Deputy Regional Representative at the UNHCR Regional Representation for the United States of America and the Caribbean, located in Washington. Before coming to Washington in October 2005, Mr. Albrecht was the UNHCR Representative in Ghana.

Mr. Albrecht was also posted at UNHCR’s Headquarters in Geneva, where he worked in the Department of International Protection. As part of his assignment he served as the principal editor of the UNHCR Resettlement Handbook, the authoritative guide to third country resettlement policy and practice. Mr. Albrecht was also involved in designing the new operations management system for the Organization. These assignments were complemented by missions throughout the world.
Dear Professor Talley,

Subject: UNHCR briefing at the next meeting hosted by
The Committee of Presidents of Medical Colleges

I am writing to you regarding the possibility of briefing the Committee of Presidents of Medical Colleges at your next meeting, which I understand is scheduled for 2 June 2016.

As you are no doubt aware, UNHCR has held and expressed longstanding concerns regarding the physical and mental health of refugees and asylum seekers in both Papua New Guinea and Nauru. Those concerns have been significantly heightened in recent months. I would be pleased to be able to share with you our most immediate concerns, as well as the medical opinion of doctors who will be accompanying missions planned in the coming months.

If you could please confirm your interest and availability, I would be happy to speak further regarding the details of what would be most useful for the Committee.

Yours sincerely,

Thomas Albrecht
Regional Representative

Laureate Professor Nicholas Talley
The Chairperson of The Committee of Presidents of Medical Colleges
Deakin ACT
Australia
3.2 Address by Health Secretary Mr Martin Bowles, PSM Secretary Department of Health at 12:15pm

Mr Martin Bowles, PSM is Secretary of the Department of Health. He commenced on 13 October 2014. He was previously Secretary of the Department of Immigration and Citizenship. He is a graduate of Griffith University. He has public hospital administration experience in having run Nepean Hospital. His deputy Secretary Mark Cormack worked with him there and also in Immigration.

Mr Bowles has previously addressed CPMC at a special meeting on workforce, also the Executive and via the Secretary’s breakfasts. His focus has been to lift the Department from a very ‘tactical thinking approach around programs’ to a service which thinks strategically about the health system. He has made a statement via the public service news about changing culture and wanting to make use of new technologies particularly around the area of big data analytics. (The compliance merger occurred in Nov 2015).

Secretary Bowles has publicly stated that the Medicare co-payment ‘crisis’ was difficult to manage however, the fact that rapid policy change occurred to reverse the decision, means that he believes the Department has the agility required to push boundaries and make real change around Medicare and primary healthcare. His vision for health via public servants is for them to be stewards of the system rather than own it.

Mr Bowles will address the Committee on health reform agenda while in caretaker mode.
3.3 Revalidation – Dr Michael Harrison RCPA President

The Royal College of Pathologists, Australasia represents the pathologists and senior scientists in Australasia.

Dr Michael Harrison is the President.

A medical graduate of the University of Queensland, Michael Harrison was admitted to the fellowship of the College in 1984 as a general pathologist. Since that time he has practised at Sullivan Nicolaides Pathology, principally in the fields of chemical pathology and microbiology. He became CEO/Managing Partner of SNP in 2002.

He has been a member of the Queensland State Council since 2003 and Queensland State Councillor 2008-2011. Other current roles include Chairman of the Quality Use of Pathology Committee from 1999, Chairman of the Medical Testing Accreditation Advisory Committee from 1999, Member National Pathology Accreditation Advisory Council 2008-9, currently a member of APC and Member, Diagnostics Expert Advisory Panel, National Prescribing Service. Past roles include PSTC and PCC member, Statistics Subcommittee of PCC/PSTC and Chairman of AAPP.

Michael has been on the RCPA Board of Directors as Vice President and was elected as President of the College in 2015. He has been a Director of CPMC since November 2015.
3.4 Revalidation RACP Professor Richard Doherty

Professor Richard Doherty Richard Doherty was appointed Dean of the Royal Australasian College of Physicians in March 2011. He trained initially in Paediatrics in Queensland, then undertook Fellowship training in Paediatric Infectious Diseases at the Children’s Hospital, Boston as a Harkness Fellow of the Commonwealth Fund, New York.

Following appointments as a consultant paediatrician at the Royal Children’s Hospital in Melbourne and Deputy Director of the Macfarlane Burnet Centre (the Burnet Institute) he was appointed Head of the Department of Paediatrics at Monash University in 1994.

His research interests have included basic and clinical virology, particularly of HIV, HTLV-I and Herpes Simplex virus as well as studies of immunological responses to viruses in vitro and in vaccine studies. He is a member of the Infectious Diseases Editorial Committee for the journal Paediatric Research. His university roles have included leadership in medical curriculum development and a period as Associate Dean for Teaching Hospitals. He has also served as Medical Director of the Children’s Program and as Head of the Department of Infectious Diseases, Monash Children’s (Southern Health, Victoria). He chairs the Board of Examiners of the Australian Medical Council and remains an Adjunct Professor in the Department of Paediatrics at Monash University.

Professor Richard Doherty will provide an overview of revalidation from the RACP perspective.
FOR DECISION

6.8 REVALIDATION
Members will receive presentations from two Colleges at this meeting: RCPA and RACP at items 3.3 and 3.4. Their presentations will be circulated after the meeting.

NOTE: CPMC Position on Revalidation
• CPMC convened a workshop in November 2014, to discuss the purpose of a revalidation process and to develop some guiding principles to take the lead in this important matter of public policy and safety.

• Discussion covered the concept of the benefits of reflective learning, maintenance of skills, quality improvement and assurance. It also included a discussion on the principles of maintaining competency; what a system would have to look like; how it would identify and manage the under-performer; what sort of connectivity is necessary with the other regulatory systems currently in place; and what type of data would be required.

• For a system of revalidation of medical practitioners to be adequate and worthwhile developing, it must be generally acceptable to all stakeholders; be defensible, feasible, and evidence-based; and reflect a formative, collegial and multi-sourced approach which is constructive and represents value-for-money. Any new system must inter-connect with existing regulatory systems and cover all doctors including those who are not college Fellows but use a college CPD program, as well as those who operate independently of the existing system.

FOR DECISION: Call for Nominations to the MBA Consultative Committee
Correspondence was received into secretariat for CPMC to nominate three representatives to participate in the Medical Board of Australia’s Consultative Committee on the revalidation of medical practitioners. This correspondence is attached.

Members will note the Board established an Expert Advisory Group chaired by Professor Liz Farmer in 2015, with members as follows:
• A member with experience in medical regulation
• A member with expertise in performance management – non medical practitioner
• One or more members with expertise in assessment of medical practitioners
• One or more members with expertise in medical education
• A member with expertise in safety and quality

The process was to then form the Consultative Committee, which will:
1. Provide a forum for discussion and exchange of views on what medical practitioners should do to demonstrate ongoing fitness and competence to practise;
2. Provide feedback to the Board on the proposals for revalidation and piloting;
3. Provide feedback to the Board about information and materials that are developed and
4. Advice on wider consultation regarding revalidation.

The Committee’s Terms of Reference note the frequency of meetings will be between quarterly and six-monthly in a variety of forms – face to face, teleconference and videoconference. The Board will pay for travel and accommodation arranged by AHRA. There are three spaces for CPMC. Nominations are due in to the MBA by 10 June, 2016.

Board-in-Confidence
Recommendations:
1. Note the CPMC position in relation to revalidation to support discussion at items 3.3 and 3.4
2. Note the correspondence from the MBA and
3. Decide on the 3 representatives giving consideration to the need to ensure appropriate spread of expertise across the specialties.

Attachment: Correspondence from Dr Joanna Flynn AM
FOR DISCUSSION

6.9 Medical Fees and Gaps

At the March meeting of the Executive, the former President of the RACS, Professor Watters requested the issue of medical fees and charges be discussed because it affects all medical specialty providers.

By way of background there has been some intense media scrutiny in recent months regarding the wide variation in fees charged. Public statements in relation to this matter have focussed in the main on supporting patient choice in selecting a treating doctor while also ensuring that full informed consent (including financial) has been established. The RACS position in relation to excessive fees where they are ‘manifestly excessive and bear little if any relationship to utilisation of skills, time or resources’ are unethical. The position paper can be located at: http://www.surgeons.org/media/20023066/2014-10-30_pos_fes pst-036_excessive_fees.pdf

RACS investigates complaints of overcharging and has also stated that while such cases are a minority, greater transparency is important. However, there is no fee schedule maintained by the College.

The CPMC public position on this matter has been reported to the Australian by Professor Talley as follows:

Nicholas Talley, the head of the Committee of Presidents of Medical Colleges, told The Australian he expected the problem of overcharging to become a formal agenda item. “My personal view is that we have a professional obligation to look after people effectively, and that includes ensuring they are only charged appropriately and fairly,” he said.


Mr Philip Truskett, President of the RACS since May 2016 will lead discussion on this topic from the perspective of professionalism.

Recommendation: The issue be noted for discussion by the Board, introduced by RACS President, Mr Truskett.

Board-in-Confidence
6.10 Strategic Planning Forum Report – FOR DISCUSSION

Background

- Since 2010 CPMC has had in place a formal strategic plan. CPMC members have moved to a platform of increased strategic engagement based on the UNITE strategic plan of 2011-13 which featured a greater emphasis on internal enhancement and then the current, Towards 2017 plan of 2014-17 which has a greater external focus.
- CPMC has always been responsive on important matters http://cpmc.edu.au/about-us/policy-statements reflects the core business of CPMC in so far as the issues of workforce (generalism and distribution) along with the role of a medical specialist are key to the mission of all Colleges; along with prescribing and the health of all Australians with the statement on tobacco.
- CPMC releases a Communique after each quarterly meeting which is widely distributed and on the website (hence public). Media statements are developed on contemporary broader sectoral issues such as BDSH, healthcare variation, education tax, sugary drinks, end of life.
- CPMC has also issued monthly general newsletters, which reflect information for members in between the quarterly meetings. These can be found at: www.cpmc.edu.au front page. CPMC also utilises the @CPMC_Aust twitter site to respond swiftly to general sectoral policy issues and commentary. The Chair also responds to tactical media arranged by the CEO.

In December 2015 the CPMC Executive agreed on an additional list of policy issues to be developed up for inclusion in the 4th February 2016 range of meetings with politicians and senior officials. The CEO developed background papers on the following issues:

- Health Care Reform
- The MBS review
- Australia’s health workforce including STP and regulation
- End of Life Care including an advanced care directive campaign
- Medicinal cannabis and current status.
- Private health insurance review and reforms affecting access to bulk billing incentives for pathology, access to PHI coverage for avoidable events and possible removal of incentives for coverage.
- Medical research expanding clinician led research opportunities

Attachment A reports against the current Business Plan.

In February 2016 following the change-over in Chairs for CPMC, a focus on better engagement with government, stakeholders, professions and politicians was anticipated and to assist with that process an Executive was formed and it was determined a half day strategic planning forum would be held on the day before the February 2016 CPMC meeting. A working group comprising Professor Watters (RACS President) and Professor Bala Venkatesh (CICM President) CPMC Chair, Professor Talley and Ms Magarry was convened which steered the process and presentations for the forum.

Some of the pre-discussion included giving consideration to whether CPMC should include in its strategic policy development over the next two to three years, developing campaign statements to align with those occurring in like-minded health care systems (UK, Canada, NZ). CPMC Chair raised the possibility of future policy development activity on the sustainability of Australia’s health care system and Obesity, because these two issues could fit with the usual advocacy, policy and government relations exercises as well as add value in areas where we know there are gaps in knowledge and CPMC could provide the expert advice it does well.

Board-in-Confidence
On 17 February 2016 the forum was held. Ms Magarry was tasked with providing a 20 minute presentation on the Australian health system reflecting the current economic environment and challenges for the system within which Colleges operated in. Dr Webber facilitated the proceedings. A report from that forum is at Attachment B. At the 24 March 2016 meeting of the Executive it was decided to put this report to the June meeting for discussion.

Board members are invited to discuss the report. Board may wish to note that current capacity of secretariat is constrained with one employee (covering both CEO and Company Secretary functions, in addition to National Director, Rural) and there is insufficient space within the secretariat to house any staff. Should any expansion occur then alternative premises would be a reasonable matter to consider.

Recommendation: For Discussion

Attachments
A: Report against current Business Plan
B: Report from Strategic Planning Forum
Reporting Against the CPMC Business Plan for 2015-17  

In 2015-17 CPMC will work towards achieving the Strategic Goals Towards 2017 according to the following objectives and actions. This plan builds upon the 2011-13 CPM Strategic Plan, and in particular that CPMC was a forum for dissemination of information and exchange of ideas among presidents and colleges, and between colleges and jurisdictional representatives.

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

<table>
<thead>
<tr>
<th>Actions</th>
<th>Performance Measures</th>
<th>Action taken</th>
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</table>
| 1.1 Maintain standing invitation to key health sector leaders and organisations to participate at CPMC meetings | Invitees will include: Secretary Department of Health Representatives of:  
  • Australian Medical Council  
  • National Health & Medical Research Council  
  • Medical Board of Australia  
  • Australian Indigenous Doctors’ Association  
  • Australian Commission on Safety & Quality in Healthcare  
  • Australian Medical Association  
  • Medical Deans of Australia and New Zealand  
  An may include:  
  • Other representatives  
  • Private Health organisations  
  • Public Health organisations | In Feb16 added the AAHMS  
Added CMC New Zealand  
Added CEO, RNZCGP |
| 1.2 CPMC will organise forums on sector issues of interest to members and intercollege discussions | Forums and discussion sessions organised as required (up to 2 per yr)  
Possible topics include:  
  • Workforce issues and innovative models of care.  
  • Regulatory policy and accreditation including Medicare and PBS | In Feb16 added workforce  
  • NPS  
  • Academy  
  • Address from the AMA.  
In June added  
  • Address from Health Secretary  
  • UNHCR  
  • revalidation |
| 1.3 Opportunity for members to share information and network with ‘Profession Observers’. | Sufficient time for members to raise topics, develop papers and ask questions to be scheduled for each meeting. | In Feb 16 added lead College President to items  
In June added time over dinner for governance |
**Objective 2:** CPMC will consolidate its influence by meeting with sector and political leaders and through representation at other meetings.

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<tr>
<th>Actions</th>
<th>Performance Measures</th>
<th>Action taken</th>
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<tbody>
<tr>
<td>2.1 Advocate on CPMC issues to political leaders</td>
<td>• Minister for Health to attend one CPMC meeting per annum&lt;br&gt;• Chair &amp; CEO to attend Ministerial Roundtable events&lt;br&gt;• Chair / Executive to meet with Ministers once every quarter as part of a government relations day with meetings to be including:&lt;br&gt;  • Minister Health&lt;br&gt;  • Opposition Health spokesperson&lt;br&gt;  • Education Minister&lt;br&gt;  • Opposition Education/VET&lt;br&gt;  • Foreign Minister&lt;br&gt;  • Others as required</td>
<td>In Feb 16 invited Minister to June meeting&lt;br&gt;In Feb 16 have met with Minister for Health, Opposition and Secretary.&lt;br&gt;Plan to meet with Senator Nash re rural health and related issues, post General Election&lt;br&gt;Govt Rels Day</td>
</tr>
<tr>
<td>2.2 Develop and maintain strong relationships with key sector agencies in medicine, and develop new contacts</td>
<td>• Participate in the regular Secretary’s meetings&lt;br&gt;• Conducts a strategic planning forum with key senior officials to steer workforce and other medicine issues&lt;br&gt;• Departments of Health in the areas of strategic policy, workforce, rural and population health&lt;br&gt;• Colleges CEOS forum &amp; communications</td>
<td>• Have done 3 breakfasts&lt;br&gt;• 17 Feb strategic planning forum&lt;br&gt;• Attend all CEOs forum&lt;br&gt;• Initiated the communications process with Department&lt;br• Local engagement</td>
</tr>
<tr>
<td>2.3 Chair or delegate to attend key health sector meetings including</td>
<td>• Attend all meetings as required and report to the quarterly CPMC meetings.</td>
<td>In Feb 16&lt;br&gt;• NMTAN attended&lt;br&gt;• DHS SRG&lt;br&gt;• S&amp;Q Forum abolished&lt;br&gt;In June&lt;br&gt;DHS&lt;br&gt;NMTAN postponed</td>
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Board-in-Confidence
**Objective 3:** CPMC will respond to sector issues and members’ requests according to CPMC’s goals and resources.

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<th>Actions</th>
<th>Performance Measures</th>
<th>Action taken</th>
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<tbody>
<tr>
<td>3.1 CPMC Secretariat to build support from sector Colleges</td>
<td>• CPMC has access to member Colleges for support to cover event logistics and coordination similar to CMC, NZ.</td>
<td>In Feb 16 part of strategic planning forum to determine support In June on agenda</td>
</tr>
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</table>
| 3.2 Responds proactively to issues | • CPMC conducts annual planning forum which determines principles of response to enable policy development  
• Responds within 7 days to internal requests and 10 days to external requests  
• CPMC develops quality submissions on issues of commonality delivered in a timely manner  
• CPMC participates in coordination of submissions on issues of commonality but where lead may be from member  
• Information provided to stakeholders via the communique after each quarterly meeting.  
• Twitter monitoring to enable topics of interest to be sent to members | All of these done |
| 3.3 Advocate for College issues within the sector | • Newsletters  
• College publications  
• CPMC website (load up some data) | Added newsletter in July 2015, monthly |
| 3.4 Establish inter-collegiate knowledge through dialogue at CPMC meetings or in separate forums | • Maintenance of strategic issues session at CPMC meetings for Members  
• Establish the specialist trainee inter-collegiate forum  
• Maintain the CPMC strategic liaison lunch | Need to decide on the specialist trainee inter-collegiate forum  
A post Fed Budget strategic luncheon TBC |
| 3.5 Research and forward projects | • Complete the Indigenous cultural competency curriculum project  
• Compete for special project work to build capabilities | Completed |

Board-in-Confidence
Dear Angela

Re: Facilitation of the Planning Session for the Committee of Presidents of Medical Colleges

Health Strategy Consulting was engaged by the Committee of Presidents of Medical Colleges (CPMC) to support the Board in forward planning of activity for the CPMC. I am pleased to provide the write-up of the planning session to you and I also include some practical advice and recommendations to support CPMC to make progress against its priorities in the near and medium term.

During the four hour meeting CPMC considered the drivers in the health system and honed down on three key themes of work for CPMC namely; obesity, workforce and end of life care.

While there was enthusiasm and interest from CPMC Board members, it was interesting that the College CEOs had little involvement in the day. This may be due to conventions where the CEOs are welcome to be present at meetings, but not participate, or this may reflect a lack of interest in the planning session by College CEOs.

Given CPMC’s small size and capacity, and the short tenure of the CPMC Chair and Board members, the CEOs are the core people who remain involved in CPMC over the medium to long term. It is difficult to see how CPMC can achieve its goals without their active support, even with the commitment and enthusiasm of College Presidents.

In order to engage the CEOs and Colleges more broadly in the work of the CPMC I recommend that the CPMC work with the Colleges to consider how to increase the capacity of CPMC to deliver on the priority areas of work identified. I have attached a draft paper for consideration ‘Building the Capacity of CPMC’.

Also, I recommend the CPMC, through the College CEOs, agree on some governance arrangements for policy development and advocacy. Discussion of such
arrangements, in the context of work that CPMC has agreed to pursue, will enhance engagement with College CEOs (though it takes constant work and a long time to build cooperate relationships within a membership body like CPMC). Obtaining agreement on these governance arrangements will also provide certainty to Colleges and CPMC on how policy and advocacy issues can be undertaken. I have included a drafts ‘Policy and Advocacy Network Governance Model’ for your consideration. This paper outlines the broad roles and responsibilities of CPMC and its member Colleges specifically in relation to issues which the CPMC has a mandate to progress. This document can form the basis of discussions with the Colleges as part of the process of progressing the priority items identified at the planning meeting.

Finally, I have attached the slides used in my presentation to the CPMC Board.

I applaud the vision that you and Nick have for CPMC and wish you all the best in supporting CPMC to be the agile, dynamic organisation that it has the potential to be. While it will be challenging, I believe there is a real opportunity to position CPMC as one of the leading voices supporting quality health care in Australia.

Please let me know any changes to the documents you would like prior to sending out to the Board. It has been a pleasure working with you Angela. I would be very pleased to continue consulting to CPMC at any time if there is a need for my services.

Yours sincerely

K. Webber
Principal Consultant
26 February 2016

Attachments:
Meeting Notes
Building the Capacity of CPMC
Policy and Advocacy Network Governance Model
Presentation Slides
Meeting Notes

Planning Session for the Board of the Committee of Presidents of Medical Colleges (CPMC)

1 pm to 5 pm
Offices of the Royal College of Pathologists of Australasia, Sydney.

1. The meeting commenced with Professor Nick Talley, Chair of CPMC welcoming participants and providing the rationale for the planning session. In particular Professor Talley stressed the unique nature of the organisations represented in the room – that they are all expert organisations with a collective potential to advice on and influence the health system as it relates to everyone.

Professor Talley reiterated that CPMC’s role is to do what individual colleges cannot do alone and that there is a opportunity to leverage off a good meeting held recently with the Minister Ley if CPMC can agree priority areas that they want to influence.

Professor Talley said he was keen to see CPMC be more and do more to inform and influence policy. He stressed the need for CPMC to move to become a more agile organisation.

Discussion turned to the appropriateness of the name of the organisation and that perhaps the term ‘Committee’ was part of the problem with the organisation and that perhaps ‘Council or an alternative would be better. It was agreed to discuss this in a future Board meeting.

2. The CEO of CPMC, Angela Magarry, set the scene by giving gave an overview of the contexts driving the health system now and over the coming years being:

- The international economy and the challenges to the Australian economy which will lead to an increasing focus on health service costs
- The increasing GDP being spent on health care in Australia
- The increasing out of pocket and private costs being contributed to health care
- The disproportionate investment in health treatments rather than preventative health measures.

There was discussion about the fact that despite all of the cost pressures, the health system is good and has good outcomes so why is there such a need for change. Other issues raised included the role of consumer expectations in treatments, contributing to increasing cost. Out of pocket expenses were also raised as an increasing issue as billing rates increased without concomitant increases in government reimbursement. The participants acknowledged that most of the focus of the Colleges is on hospital treatment despite the fact that there needed to be an investment into preventative strategies to address the disproportionate investment in treatments.

3. The planning session facilitator, Kim Webber introduced the format of the planning day being to:

- Revisit the CPMC vision;
• Determine priorities for CPMC;
• Consider how to make progress on actioning the priority areas.

**Revisiting the CPMC Vision**

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

There was robust discussion from the Board on the vision and general agreement that the wording was too long and that the statement needs to be revised to refer to scope (i.e. CPMC works on common issues across the Colleges).

It was agreed that for the purposes of this planning session the vision would stand if the phrase ‘Colleges will be the recognised and authoritative voice for the specialist Medical Colleges of Australia’ was removed.

**Determining Priorities for CPMC**

The Facilitator presented the results of a survey of College CEOs on the reported key drivers and priority areas (8 responses were received from the College CEOs).

The top 3 key drivers reported were:

- Cost and sustainability of health care (6 responses)
- Workforce maldistribution (across specialties) (4 responses)
- Workforce maldistribution (across geography) (3 responses).

The Board agreed that these drivers were significant and should influence the work of the CPMC. The Chair reinforced that workforce issues were on the Federal Government’s agenda and had been raised by Minister Ley during recent meetings with the CPMC Executive.

The Facilitator then presented the top 3 priority areas as reported from the College CEOs:

- Revalidation (4)
- Role in harmonising policies e.g. bullying, revalidation (2)
- Increase Specialist Training Places (2).

In addition to considering the feedback from CEOs, the Board considered the recent priorities that were set by the Board for discussion with Minister Ley which were:

- Health care reforms
- MBS review
- Australia’ health workforce including STP and regulation
- End of Life Care including an advanced care directive campaign
- Medicinal cannabis and current status
• Private health insurance reforms (e.g. refusal to pay for avoidable outcomes)
• Clinician led medical research.

The difficulty in aligning the Drivers and the Priorities was discussed.

The Board discussed the priority areas and considered the list of other medical peak bodies to determine where CPMC could and should have a unique role. Another key discussion point was the need to consider topics where the CPMC could get agreement on.

The CPMC determined that the priority areas for CPMC’s work should be:

• Obesity – from the perspective of ‘shining a light’ on obesity as an issue that is impacting the care able to be provided by Medical Specialists and leading to advocacy for a coordinated strategy to address obesity in the Australian population. It was discussed that there is no clinical College who members would not be impacted by this issue in their work.

• Workforce – this is a key theme of work for CPMC and a priority topic for engagement with Government as it an issue of great interest for them and the general public, particularly in rural and remote areas where access to medical specialists is difficult.

• End of Life Care – this topic is seen as important and where little progress is being made.

• Health care reform – this topic is of importance to CPMC as it requires a watching brief on issues and a proactive approach to develop policy perspectives on the health system as it operates as a whole.

Taking the Issues Forward

One of the historical issues that CPMC has grappled with is how to progress areas of work with little infrastructure and resourcing available within the very small CPMC.

The Board discussed the prospect of individual Colleges leading specific projects on behalf of CPMC and that members of the Board could ‘host’ joint projects.

It was agreed that the CPMC should take an approach of working for the public good in relation to its advocacy efforts and determine its positions within this context and the Medical Deans of Australia and New Zealand were cited as an example of where this has worked well.

• Obesity – Professor Nick Talley agreed to sponsor this area of work and offered to work with the CEO to provide an options paper on the topic to the Board. He indicated that a convention or conference of some kind would be a priority to raise the profile of the issue.

• Workforce – an options paper would be provided to the Board for decision on how this topic would be progressed.

• End of Life Care – this topic has been the focus of work for one or two of the Colleges and could be expanded and refined to develop into a CPMC wide area of work.

• Health care reform – it was suggested that a pre-election statement could be prepared as many Colleges would be issuing pre-election statements and
there would no doubt be some common elements which could form the basis of a CPMC statement.

The meeting ended positively with members requesting outcomes so that the enthusiasm of those at the meeting can be harnessed to take advantage of the excellent platform of support which the Board members have shown so far.
BUILDING THE CAPACITY OF CPMC

A DISCUSSION PAPER

This paper is provided to stimulate discussion amongst the College members of the CPMC.

Current Status

The CPMC is provided with funding from each of the College members and has historically focussed on providing a conduit for the Colleges to build relationships with each other and exchange information.

In recent times, CPMC has worked to provide a number of national submissions and national policy positions on behalf of the collective Colleges and has been successful in accessing Ministers in the Federal Government.

Within the current health system reform environment there is a need and an opportunity for CPMC to inform and influence decision making in government to support the goals of Colleges and Medical Specialists.

Building on Progress Made

There is potential for CPMC to lead the following activities at the national level on issues that impact all Medical Specialists and Colleges:

- Data and information
  Collect and use data to provide new knowledge on medical specialist issues.

- Research
  Analyse and interpret national medical specialist issues to inform the members and wider sector.

- Policy Development
  Develop policies and strategies on current and proposed reforms that impact on medical specialists.

- Advocacy
  Educate and communicate medical specialist issues to those of influence.

- Stakeholder relations
  Develop alliances and relationships with other national peak bodies in the medical and health sectors.

- Service provider/broker
  Implement and coordinate national programs which are aligned to the priorities of the members e.g. the RHCE program.
All of these areas are important to ensure that CPMC:

- has an evidence base to what it says (data and information, research, policy development)
- communicates those ideas effectively (stakeholder relations, advocacy)
- is able to implement solutions (service provider/broker).

Currently, CPMC is a small organisation with only one staff member. CPMC does not have the resources or the critical mass to be able to undertake all of its responsibilities on behalf of the membership. To make the CPMC work optimally, a model is required to build the capacity and sustainability of CPMC.

What Would be the Results for the CPMC and the Colleges?

CPMC would increase its capacity around nationally significant and relevant research and policy so that it is recognised as the holder of whole of medical specialist workforce expertise. CPMC would see more policies published, more articles in peer reviewed journals and more media engagement (with new ideas being communicated). CPMC would position itself as a ‘go to’ organisation for issues around medical specialists and offer an alternative voice. CPMC would market its College members and their achievements more (and to the right people) and position CPMC and the Colleges to be the trusted advisors on and implementers of national programs that support medical specialists.

The aim of these strategies is to support the CPMC and its College members. Some initiatives will have short term results and some will be longer term but in essence, signs of success will be:

- Increased profile and reputation of the CPMC
- Increased capacity and learnings of the CPMC
- Benefits for the Colleges’ and their members.

Solutions – How Can the Capacity of the Peak Body be Increased?

There are a number of strategies which could be utilised to increase CPMC’s capability – the strategies are not mutually exclusive and could be used simultaneously.

Strategy A

The CPMC, with support of its College members, can advocate to government for specific funding to develop advice and solutions for government on specific topics (e.g. how to address medical specialist workforce maldistribution and how to enhance generalism). This strategy will be very challenging in the current cost cutting climate and may lead to a conflict for CPMC between supporting its College members and delivering on contracts to government.
Strategy B

Individual Colleges can take the lead on projects on behalf of CPMC where they have the staffing and expertise to do so. However this has proven problematic in the past due to Colleges too heavily focussing on the perspective of their individual College.

Strategy C

The College members can invest their own staffing expertise to build the capacity of the CPMC. This could be done by identifying staff members who would benefit from a secondment to CPMC for either a specific timeframe or a specific project.

Strategy D

The Colleges can invest funding in CPMC through a temporary increase in member contributions. One of the critical success factors is that CPMC would need to have a reliable, consistent contribution to allow investment in the capacity and sustainability of CPMC. Therefore, it would need to be at least a two year investment.

The contribution would be a ‘reserves’ fund towards the additional activities. If the CPMC is able to generate the funding for these activities for other sources (though for example, Strategy A) then the contributions would not need to be used in full.

These options have been provided without prejudice as the basis for discussion.
It is proposed that a CPMC Network be recognised to consist of the Colleges and the Committee of Presidents of Medical Colleges (CPMC). The purpose of the network is to collaborate on national policy and advocacy matters with the aim of building intelligence at a national level about College wide issues to enable it to influence and evaluate policy directions.

Network policy and advocacy governance outlines the approach and communications processes within the network as a collaborative partnership for national policy and advocacy. The aim is to enable agreed positions and approaches to enable activity to be undertaken with the confidence of CPMC and its members.

Network Policy and Research Governance

The network policy and research governance approach is one of integrated governance as a principle for collaboration as a collective model. It does not replace existing governance structures. It acknowledges the interdependence of network partners and refers to the formal and informal systems, processes and behaviours across the network.

The Network will collaborate on the CPMC policy and research strategy which aims to address important strategic questions about issues facing all Colleges and Medical Specialists, using a solutions-based, public good approach and model and plan for the future.

The focus of the Network will be on strategic knowledge and information at the national level. Coordinated activities would include, for example, consolidation and development of national models for best practice policies and procedures (e.g. around bullying and workplace harassment) and developing positions on workforce distribution models.

The Network will aim to:
  • be agile, smart, credible
  • be beneficial to members
  • respect the independence of the Colleges.

The Network will not:
  • focus on problems only, but problems and solutions (i.e. take a positive approach)
  • do what a College could do alone (i.e. should not duplicate).
CPMC Network Roles and Responsibilities

**CPMC**

CPMC’s role as the body providing strategic advice to Government and advocacy for Colleges and Medical Specialists in Australia will be strengthened through the contributions and support of the Network.

CPMC will be the coordinator of the Network, the efforts of which will be focussed on national policy and advocacy. CPMC would be authorised to speak on behalf of the Colleges, as required, on national matters concerning issues that impact on all Colleges and may use College based intelligence, including information and data provided by the relevant College.

**Colleges**

The role of the Colleges in the context of the Network’s policy and advocacy function is to:

- Provide input and feedback on key policy questions and the overall policy agenda and
- Contribute intelligence (case studies), qualitative information and data, which it authorises for use by CPMC to enable it to fulfil its role in providing strategic advice to Government.

It is proposed that the operation and communication processes of the network be discussed by Colleges together with CPMC. It is intended that communication and decision-making processes and behaviours are discussed and agreed as overarching principles. For example:

- communication regarding national strategic advice to Government will be available for access by Colleges and
- communication regarding national policy issues by Colleges to be referred to CPMC.
1. Reconsider/affirm existing vision, strategy and focus

- **Vision:**
  - The Committee of Presidents of Medical Colleges will be the recognised and authoritative voice for the specialist Medical Colleges of Australia, acting to promote the highest quality of medical care and supporting the provision of well-trained and safe medical workforce serving the best interests of the Australian community by coordinated and collective advocacy and collaboration.
1. Reconsider/affirm existing vision, strategy and focus

- Objective 1: CPMC will provide a Morning Forum for discussion with the membership on issues and with external organisations who wish to liaise with the Colleges.
- Objective 2: CPMC will consolidate its influence by meeting with sector and political leaders and through representation at other meetings.
- Objective 3: CPMC will respond to sector issues and members' requests according to CPMC's goals and resources.

2. Consider priority areas of action for CPMC

a. What do you see as the main health system drivers for change over the next few years that will impact on Medical Specialists/Colleges collectively?

- What are the top 2 or 3 issues that CPMC should lead on behalf of the Members?
### Main Health System Drivers (CEOs, n = 8)

- Cost and sustainability of health care (6)
- Workforce maldistribution (specialties) (4)
- Workforce maldistribution (geography) (3)
- Technology inc personalised medicine (3)
- MBA proposal re revalidation (3)
- Ageing population (2)
- Encroaching scope of practice by non medical (2)
- Impact of PHNs on PHC services (2)
- Responding to chronic disease
- Quality and safety in practice
- Demand for public accountability
- Subspecialisation and narrow scope of practice
- Number of doctors graduating
- Regulation and compliance and red tape

### Top Issues for CPMC to Lead (CEOs, n = 8)

- Revalidation (4)
- Role in harmonising policies e.g. bullying, revalidation (2)
- Increase Specialist Training Places (2)
- Explain and promote role of Colleges
- Ensure AMC requirements for reaccreditation are reasonable
- Relationship with MBA
- Advocacy for chronic disease management funding
- Ensure PHNs have specialist involvement
- Advocate for welfare of trainees and IMGs in the workplace
- MBS review
- Workforce
- Quality of training
Priority Areas (Exec for APH meeting, Dec 2015)

- Health Care Reform
- MBS review
- Australia’s health workforce including STP and regulation
- End of Life Care including an advanced care directive campaign
- Medicinal cannabis and current status.
- Private health insurance reform (e.g. refusal to pay for avoidable outcomes)
- Clinician led medical research

Drivers

- Cost of health care (6)
- Workforce maldistribution (geography) (4)
- Workforce maldistribution (specialties) (3)
- Technology inc personalised medicine (3)
- MBA proposal re revalidation (3)
- Ageing population (2)
- Encroaching scope of practice by non medical (2)
- Impact of PHNs on PHC services (2)
- Responding to chronic disease
- Quality and safety in practice
- Demand for public accountability
- Subspecialisation and narrow scope of practice
- Number of doctors graduating
- Regulation and compliance and red tape
Priority Areas

- **Revalidation (4)**
- Role in harmonising policies e.g. bullying, revalidation (2)
- Increase Specialist Training Places (2)
- Explain and promote role of Colleges
- Ensure AMC requirements for reaccreditation are reasonable
- Relationship with MBA
- Advocacy for chronic disease management funding
- Ensure PHNs have specialist involvement
- Advocate for welfare of trainees and IMGs in the workplace
- MBS review

- **Workforce**
- Quality of training
- Health Care Reform (Exec)
- MBS review (Exec)
- Australia’s health workforce including STP and regulation (Exec)
- End of Life Care including advanced care directives (Exec)
- Medicinal cannabis and current status (Exec)
- Private health insurance reform (e.g., refusal to pay for avoidable outcomes) (Exec)
- Clinician led medical research (Exec)
- Obesity
- Medical training pathway

Medical Peak Bodies – where is CPMC unique role?

- All your individual member Colleges
- AMA
- AHPRA
- AMC
- CPMEC
- GPRA
- MBA
- AMC
- RFDS

- AIDA
- PHNs
- RDAA
- MDANZ
- MTRP
- AMSA
Opportunity to lead the debate on workforce

- A notable finding of this review has been the lack of objective, accessible and current data, for example, on the level of graduate preparedness; the quality of the intern learning experience and the extent to which learning outcomes are being achieved. We therefore recommend systematic data collection to provide ongoing performance feedback and to monitor the impact of changes (Intern review, 2015).

Taking Issues Forward?

- CPMC can... (the Value Proposition):
  - develop collective positions, leveraging knowledge and experience of Colleges
  - advocate on the basis of that knowledge

- Decision making and getting things done in membership organisations is based on persuasion, not authority.
- Because member organisations must use persuasion, not authority, to make decisions the process can be fraught with paralysis and micromanagement.

- Critical Success Factors
  - Cooperation and support of all member agencies and CEOs to support the ‘doing’ – continual process.
  - There has to be both a perception and a reality of unity for organisational credibility.
    - Firstly, there need to be mechanisms for achieving agreement on policy positions.
    - Secondly, there must be agreed positions for the media and well thought through questions and answers in order to handle questions.
Developing an Advocacy Strategy

Making Progress –

- Models for making it happen:
  - CPMC staff to work with Colleges to develop policy statements, suite of case studies etc
  - Individual Colleges to lead on behalf of CPMC
  - ...

- Role of Board, role of Colleges, role of CEO.
- Agreement on method for policy development, collective research and media and stakeholder engagement. Doing something is a great way to test your approach.

- In the end, the doing should reflect the vision of CPMC – to be the recognised and authoritative voice for the specialist Medical Colleges of Australia, acting to promote the highest quality of medical care and supporting the provision of well-trained and safe medical workforce serving the best interests of the Australian community by coordinated and collective advocacy and collaboration.