Australian College of
Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

19 February 2020

Dr Ann Tonkin
Chair, Medical Board of Australia
Australian Health Practitioner Regulation Agency

via email: performanceframework@ahpra.gov.au

Re: Public consultation on the draft revised registration standard*: Continuing Professional Development*

Dear Dr Tonkin

Thank you for the opportunity to provide feedback on the draft registration standard: *Continuing Professional Development.*

The College response and recommendations are documented in the attached submission.

I wish to particularly draw your attention to the issue of CPD Homes. The College regards this as vitally important not only to our members, but in the maintenance of the highest professional standards and quality and safety within the wider community.

ACRRM is firmly of the view that, as arbiters of recognised professional standards as they pertain both to training and ongoing professional development, the medical colleges should be the only organisations charged with the important responsibility of maintaining a CPD Home for their respective members.

In the case of ACRRM Fellows, the College is best placed to meet the full range of member requirements associated with maintaining CPD in the procedural and other advanced skills associated with generalist practice, avoiding the need to apply to multiple colleges for recognition of specific of specific clinical scopes of practice.

ACRRM remains committed to working with the Medical Board of Australia to achieve a final Standard which is appropriate in maintaining quality and safety and meets the needs and circumstances of our members and especially the rural and remote communities in which they live and work.

I look forward to ongoing discussion.

Yours sincerely

Dr Ewen McPhee
PRESIDENT

Australian College of Rural & Remote Medicine

WORLD LEADERS IN RURAL PRACTICE

COLLEGE SUBMISSION

Public consultation on the Draft revised *registration standard: Continuing professional development*

FEBRUARY 2020

ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the traditional owners of lands across Australia in which our members and staff work and live and pay respect to their elders past present and future.

Thank you for this opportunity to provide feedback on the revised draft of the Continuing Professional Development (CPD) Registration standard. The College remains committed to working with the Board toward a final standard which is appropriate for the needs and circumstances of our members and achieves healthcare quality and safety outcomes for their communities.

ACRRM Professional Development Program

ACRRM has revised its Professional Development Program (PDP) for the 2020-22 triennium, based on the MBA Professional Performance Framework (PPF). The Framework is based around the categories of Educational activities; Performance review; and Outcome measurement. The triennium model has been maintained and stipulates 150 hours of CPD to be completed over the 2020-22 period with 25% from each category and the remaining 25% from any category. The College has moved away from a weighted points system to an hour-based system for the sake of simplicity and transparency in measuring professional development activity for compliance purposes.

Although many of the performance review and outcome measurement activities already existed within our previous PDP framework, these changes have been made to give members a transition period in which to incrementally adjust to the evolving MBA requirements; report any program issues to the College; and enable refinements to program usability.

Key issues and recommendations

CPD Homes

The College seeks a clear statement from the Board within in the revised Registration Standard, that as the CPD Home for members and their AMC accredited medical college, ACRRM has the authority and capacity to fully manage and arbitrate their CPD needs.

As the arbiter of our members' AMC recognised professional standard as it pertains to both their professional training and ongoing professional development, ACRRM is the appropriate authority to determine what is required for maintaining the Fellowship standard and to ensure the highest standard of patient care across the profession.

ACRRM is unique in that many members have very broad scopes of practice, necessitating the maintenance of procedural and other advanced level qualifications in addition to those for the specialty of general practice. Our members have informed us that they are currently required, or are strongly influenced to, maintain multiple specialist college memberships for the purpose of having specific clinical scope of practice CPD recognised by other specialist colleges. ACRRM believes this is unreasonable, and that this compliance duplication is creating an unnecessary impost upon the healthcare system and upon time-poor rural doctors. These excessive burdens are leading to many rural doctors ceasing to provide their extended skilled services.

The College has established effective forums to discuss and share knowledge to ensure standards are congruent with other specialties' standards while still ensuring they are appropriate to the context of expanded generalist (Rural Generalist) practice in rural and remote areas. In particular, the Joint-Consultative Committees provide a governance framework to ensure all standards are subject to ongoing and robust cross-disciplinary input.

It should be noted that in the context or many rural and remote areas, the mix of specialised skills of ACRRM members is often vital to ensuring that their patients can have access to the healthcare services that they need, including in areas such as emergency, mental health and obstetric care.

The National Medical Workforce Strategy has specifically identified that general practitioners that can operate to the fullest scope of their practice to ensure provision of needed specialist care are vital to the local delivery of high-quality care in rural and remote contexts.[1]

You will be aware that the College is currently seeking specialist recognition of Rural Generalist Medicine within the speciality of general practice. We believe this will facilitate more formal recognition of this scope and further assist our members to navigate the complexities of meeting their compliance requirements. These matters are of the utmost importance to our membership and the viability of their practice in rural communities.

The College recommends that the revised Registration Standard includes some additional direction articulating that ACRRM members can complete the full scope of their CPD requirements through ACRRM as their CPD Home; and that the attainment of the appropriate standard should be recognised and accepted by any relevant specialist College or credentialing entity.

Additionally, in the interests of quality assurance in national professional standards and simplicity of process for practitioners, we would strongly recommend that only AMC accredited medical colleges be in a position to act as a CPD Home.

Recommendation 1:
That the revised Standard includes clarification that as their CPD Home and AMC accredited speciality college, ACRRM will be able to meet the full range of member CPD requirements associated with maintaining their Fellowship, including in procedural and other advanced skilled areas associated with their Fellowship qualification.

Recommendation 2:
That the revised Standard clarifies that medical colleges are the only appropriate bodies to act as CPD Homes.

Annual vs Triennium cycle

Feedback from members indicates that there is a clear need within the general practice CPD framework to maintain the triennium system (150 hours over three years) as opposed to a fixed annual minimum target of 50 hours.

Our members have strong concerns that the annual minimum target may be prohibitively difficult to achieve. As doctors in rural and remote locations, with many working in areas of severe workforce shortage, they face considerable difficulties taking time off to travel to attend CPD activities and in securing locums to back-fill and cover rosters during their absence. Planning for these absences often involves lead times of several months.

As many of our members maintain multiple MOPS (Maintenance of Professional Skills) reporting requirements, the added complication of coordinating these multiple reporting requirements with overall Fellowship reporting requirements within the constraints of a 12-month reporting cycle would be excessively complex and difficult to achieve.

[1] Aust Govt Dept of Health (2019) *National Medical Workforce Strategy: Scoping Framework July 2019*, Page 37

Currently ACRRM reports on compliance within the same timeframes as the RACGP (ie after the end of each triennial cycle), which then allows members to maintain access to Medicare A1 rebates. There is a cohort of Fellows of the RACGP who choose to participate in the ACRRM program to maintain their reporting requirements. A system that saw the two general practice colleges having different reporting cycles may not be workable, given the limitations of current legislation.

Recommendation 3:
That the revised Standard recognises that the triennium cycle is the appropriate framework for doctors in rural and remote locations and specifies that this continues for CPD purposes.

Category Definitions

ACRRM notes the Board's reassurance that there will be flexibility across the CPD categories. This flexibility must be sufficient to enable our College to include activities that suit the diverse clinical, operational and geographical scopes of rural doctors. ACRRM members generally cover a much broader clinical scope of practice across far more operational structures than the vast majority of their colleagues. There is also considerable diversity in their practice mix and associated CPD needs and circumstances, reflecting the diversity of communities and health services across rural, remote and regional Australia.

Currently the definitions of performance review and outcome measurement are generally quite broad and variable and while some guidance, examples, and information are provided on each of these categories, it is imperative that these do not become too prescriptive.

Recommendation 4:
That the revised Standard CPD categories definitions provide sufficient flexibility to enable the College to include a broad scope of activities within its CPD categories, reflective of the diversity of rural practice.

Logging Activities

As College members generally work long hours and are often called on to treat a wider range of complex conditions, it is imperative that they are able to record their CPD activities quickly and easily. The College continues to work with members to identify ways to satisfy the requirement to maintain a log of activities without creating onerous recording requirements.

Many ACRRM members are self-employed and already have a large administrative burden, often without any paid time to complete CPD. ACRRM accepts reflective notes as evidence of most CPD activities (with the exception of Life Support) and recognises the value that appropriate activities undertaken as a component of day to day professional practice can contribute to improved CPD.

The College is keen to ensure that in logging their reflective activities, members do not link CPD evidence back to individual patient records but rather that a general description of the time, topics and learnings is appropriate. Some members have expressed concern about the level of evidence required and the College is currently supporting members by providing detailed information regarding the manner in which they can attribute and record activities.

ACRRM will audit 10% of PD portfolios per annum and will continue to ensure that all members are meeting the requirements for maintaining CPD relevant to their individual scopes of practice.

Recommendation 5:
That the revised Standard provides sufficient flexibility to enable Colleges to adapt their CPD programs to make logging of activities as simple and easy as possible.

Outcome measurement

ACRRM members have wide and varied scopes of practice, thus traditional methods of outcome measurement such as formal or structured clinical audit will not suit everyone. Many members do not have access to large datasets with system wide clinical benchmarks with which to compare their individual practice. Locum doctors in particular have particular difficulty in accessing outcome data. Feedback indicates that this category appears most difficult to achieve.

ACRRM recommends that the outcome measurement category be flexible enough to encompass activities relevant to individual professional environments that can demonstrate improvements to patient care. It is our expectation that ACRRM will have the authority to, in line with the intent of the PPF, set the standards and appropriately accredit activities for this category.

Recommendation 6:
That the revised Standard ensures that the outcome measurement category is sufficiently flexible to encompass the broad scope of activities relevant to rural practice, and, that the revised Standard specifically recognises medical colleges' authority to set the standards and appropriately accredit activities for this category.

Additionally, that some specific advice be included on how locum practitioners might access outcome data.

Flexibility across categories

There are situations where some activities cross over between categories and it is desirable to be able to attribute some components to both performance review and outcome measurement. The College has responded by structuring its CPD program to enable members to allocate some time towards performance review and some for measuring outcomes for the same activity where there is a demonstrable relevance.

Recommendation 7:
That the revised Standard recognises that there are activities which may qualify under multiple categories and that in such situations these are able to be counted in more than one category.

Qualified privilege

Members have expressed significant concerns around the potential risk of CPD reflection being legally discoverable and used against the practitioner in the case of legal action. This is of particular relevance where a practitioner documents a gap in knowledge or identifies a situation where the outcome could have been better.

The College CPD Framework has been designed to enable members to record activities without providing information that would identify specific patient or event details. ACRRM awaits further clarification from the Board to ensure we can effectively support the need of our members in this important area. Some members have received advice that accessing patient records for the purpose of CPD and practice improvement may be considered illegal; in breach of health service policies; and/or could be seen to be accessing patient records 'without due cause'.

Recommendation 8:
That in association with the revised Standard, guidance be provided regarding CPD reporting to avoid adverse consequences with respect to qualified privilege.

Communication

Many of our members have serious concerns that they are being called upon to divert increasing amounts of their patient time toward CPD compliance and administration which they are not convinced will lead to improved patient safety. The College recommends that the Board focus its communications on demonstrating to doctors how incorporating these new measures into professional development can be practical and useful to improving patient outcomes.

Recommendation 9:
That the Board use the launch of the revised Standard to clearly communicate the benefits of the new approaches in terms of helping doctors to improve their quality services to their patients.

Responses to Consultation Questions:

1. Is the content and structure of the draft revised CPD registration standard helpful, clear, relevant and more workable than the current standard?

The content is clear and the structure is easy to understand. It is more relevant in that all medical practitioners need to meet the same overarching standard, though the structure is limited by a relative simplification arguably most appropriate for hospital-based clinicians.

2. Is there any content that needs to be changed or deleted in the draft revised standard?

The standard refers only to an annual cycle only and does not take triennial cycles into account. Noting previous College recommendations regarding the maintenance of a triennial rather than an annual cycle, this should be addressed.

In its 2020 -2022 CPD Program, ACRRM has maintained the traditional triennium system. The program strongly encourages members to achieve 50 hours per year as articulated in the PPF; however the College will accept the completion of 150 hours across all three years as meeting the requirement for the current triennium. As outlined above (see recommendation 3) we consider the maintenance of the triennium framework as very important to keeping CPD practicable for members and request that the revised Registration Standard make specific allowance for this.

3. Is there anything missing that needs to be added to the draft revised standard?

Additional information regarding the Board's expectations on reviewing performance and measuring outcomes activities would be appreciated. While it would not be appropriate for the MBA to mandate only specific types of activities, communication regarding examples beyond the more traditional large health service models would benefit rural doctors.

Additionally, ACRRM recommends the inclusion of more detailed information on the scope and accreditation process for CPD homes, noting that the College strongly recommends that this include the specification that they are AMC accredited medical colleges.

4. Do you have any other comments on the draft revised CPD registration standard?

As outlined previously, ACRRM requests a firm undertaking from the MBA to provide more information on CPD homes; acceptable CPD activities; and requirements for CPD recording in accordance with our recommendations below.

It would benefit our members if the CPD registration standard included more activity examples, particularly for those with non-standard types of practice. We note again however, that any examples should not be considered an exhaustive list.
There should always be scope for the College to design new activities without trepidation that they will not be viewed as acceptable by the Medical Board; if they meet the standards set out within the PPF.

Within the broad categories and hours specified, it should be up to the practitioner to determine the activities that will provide the most benefit to their individual scope of practice.

5. Who does the proposed registration standard apply to?

a. Should the CPD Registration standard apply to all practitioners except the following groups?

- ***medical students***
- ***interns in accredited intern training programs***
- ***medical practitioners who have limited registration in the public interest or limited registration for teaching or research (to demonstrate a procedure or participate in a workshop) and who have been granted registration for no more than four weeks***
- ***medical practitioners who are granted an exemption or variation from this standard by the Board in relation to absence from practice of less than 12 months***
- ***medical practitioners with non-practising registration.***

b. Are there any other groups that should be exempt from the registration standard?

The exceptions above are reasonable, however the colleges should appropriate grants exemptions for their members, rather than AHPRA. ACRRM does not consider that any other groups should be exempted.

6. Interns

a. Do you agree that interns should be exempted from undertaking CPD or should they be required to complete and record CPD activities in addition to or as part of their training program?
b. If CPD is included as a component of their training program/s, should interns have to comply with the same mix of CPD as other medical practitioners?
c. Should interns have to record what CPD they are doing or is completion of the program requirements sufficient to comply with the standard?

Interns should be exempt from the CPD registration standard and should not be required to record CPD activities in addition to their training program. ACRRM supports the inclusion of education and information regarding the PPF to be a component of training programs in order to support the transition into specialist practice requirements. However, it does not support a mandatory requirement for those on a specialist training pathway to demonstrate compliance to the CPD registration standard.

7. Specialist trainees

a. Do you agree specialist trainees should be required to complete CPD as part of their training program?
b. If CPD is included as a component of their training program, should specialist trainees have to comply with the same mix of CPD as other medical practitioners?
c. Should specialist trainees have to record what CPD they are doing or is completion of the program requirements sufficient to comply with the standard?

Specialist trainees should not be required to complete additional CPD as they already participate in a highly structured training program. While there is some value in ensuring that all training programs include some elements of educational activities, performance review and outcome measurement, they should not necessarily require the same proportion of these activities as the CPD standard.

8. International medical graduates

a. Should IMGs be required to complete CPD in addition to or as part of their training program or supervised practice?
b. If CPD is included as a component of their training program or supervised practice, should IMGs have to comply with the same mix of CPD as other medical practitioners?
c. Should IMGs have to record what CPD they are doing or is completion of the program requirements or supervised practice plan sufficient to comply with the standard?

IMGs should not need to complete additional CPD as they participate in a highly structured training program. While there is some value in ensuring that all training programs include some elements of educational activities, performance review and outcome measurement, they should not necessarily require the same proportion of these activities as the CPD standard.

9. Exemptions

a. Should exemptions be granted in relation to absence from practice of less than 12 months for parental leave, in addition to serious illness, bereavement or exceptional circumstances?
b. Is 12 months an appropriate threshold?
c. Should CPD homes grant these exemptions or should the Board?

These are valid grounds for exemption. ACRRM's position is that the College, as the CPD Home for its members, should continue to grant exemptions for members.

10. Practitioners with more than one scope of practice or more than one specialty

a. Do you agree with the Board's proposal that medical practitioners with more than one scope of practice or specialty are required to complete CPD for each of their scopes of practice/specialty and where possible this should occur within one CPD home? Do you have alternative suggestions?

ACRRM fully supports this proposal and regards it as critical to ensuring the framework is relevant and appropriate to the needs of our membership and its quality-assured practice.

As outlined above (see Recommendations 1-2), it is vital that our members with multiple scopes of practice can complete all of their requirements with one CPD home and that that home is their college which already has a system that is robust and flexible enough to include all of the required components to maintain safe practice.

As outlined, many ACRRM members have credentialing in multiple scopes of practice to maintain and having to fulfil the requirements of multiple programs would be cumbersome, time-consuming and have questionable benefit.

ACRRM's CPD Program has included MOPS (Maintenance of Professional Standards) requirements to accommodate these needs since the PDP's inception and is well placed to meet the needs of all members with multiple and extended skillsets through a single CPD Home.

11. CPD required

a. Are the types and amounts of CPD requirements clear and relevant?
b. Should all practitioners, including those in roles that do not include direct patient contact, be required to undertake activities focussed on measuring outcomes as well as activities focussed on reviewing performance and educational activities?
c. If practitioners in roles that do not include direct patient contact are exempted from doing some of the types of CPD, how would the Board and/or CPD homes identify which roles/scopes of practice should be exempt and which activities they would be exempt from?

The types and amounts are clear and relevant.

ACRRM supports the proposal that all doctors complete CPD appropriate to their individual clinical scope of practice; however it is our general view that practitioners in roles that do not include direct patient contact may still benefit from some type of performance review and outcome measurement activity.

Notwithstanding this view, the CPD standard must be flexible enough to enable our members to undertake activities that suit their specific professional role. The determination of the relevant suitability of these activities ought to be determined by the College as part of the overall CPD Framework. If these practitioners are exempted, communication from the Board that clearly articulates the specific requirements of the alternative types of activities that can be undertaken in non-clinical roles would be useful.

12. CPD homes

a. Is the requirement for all practitioners to participate in the CPD program of an accredited CPD home clear and workable?
b. Are the principles for CPD homes helpful, clear, relevant and workable?

As the Board is yet to advise on the circumstances and specifications for organisations acting as CPD Homes that are not AMC accredited specialist medical colleges, there continues to be considerable ambiguity and uncertainty regarding the principles for CPD Homes.

As outlined above, (see Recommendations 1-2), as the MBA is standardising the CPD requirements for all medical practitioners, these doctors should be able to have one CPD home rather than being required to pay for and undertake multiple programs across multiple specialist Colleges/CPD Homes.

The MBA should clearly articulate that doctors with more than one specialist clinical skill will be able to choose a single CPD home that best suits their broad scope of practice. In the case of ACRRM members, this will be the College.

The MBA should also provide the recommendation that the completion of a CPD Program that meets the clinical standards of any relevant specialist CPD requirements must be acceptable to all entities that determine said standards of specialist CPD maintenance including specialist colleges and credentialing committees.

a. Should the reporting of compliance be made by CPD homes on an annual basis or on another frequency?

For the reasons outlined in detail above (see Recommendations 1-2), the College considers it imperative that CPD homes are responsible for their members compliance and that these should be AMC accredited medical colleges.

Also as detailed above (see Recommendation 3), the College considers it imperative that the triennium structure that is currently well established is maintained for its members and that they encouraged to meet annual CPD targets wherever practicable.

c. Is six months after the year's end feasible for CPD homes to provide a report to the Board on the compliance of participants with their CPD program(s)?

This is a feasible time to finalise records and remediate where necessary.

d. Should the required minimum number of audits CPD homes must conduct each year be set at five percent or some other percentage?

The minimum audit should not be any lower than 5%. ACRRM will audit a minimum of 10% of CPD members annually.

e. What would be the appropriate action for CPD homes to take if participants failed to meet their program requirements?

It would be appropriate for CPD homes to provide all assistance to participants through a clear and workable remediation process. ACRRM's CPD Program includes a remediation policy that clearly identifies the process that will be undertaken by the College to support all members to meet the requirements of the CPD standard. The remediation program has a pathway for supporting members who may have completed the required CPD activities but have not adequately recorded them, as well as those that have not yet completed the amount of activity time required.

The appropriate action for CPD Homes should be that where at the conclusion of the remediation program, a CPD Home must report that the practitioner has failed to meet their requirements. This should then necessitate consideration of removal of access to Medicare billing rights and/or relevant clinical credentialing. The reporting of practitioners that have failed to meet their requirements should only occur subsequent a fair and reasonable process.

13. High level requirements for CPD programs

a. Should the high-level requirements for CPD in each scope of practice be set by the relevant specialist colleges?

ACRRM strongly supports the principle that the setting of high-level requirements within each scope of practice must be set by the relevant AMC accredited, specialist college. It should be noted however that most medical specialties span a range of areas of practice and there inevitably are points of intersection within the practice scopes of different specialty areas (for example ophthalmologists and emergency specialists provide surgical care). The principle should therefore be that all the scopes within the purview of each doctors' specialist profession are managed by the college associated with their profession.

As outlined above (see Recommendation 1), ACRRM members, many of whom are credentialled in areas such as obstetrics, surgery and anaesthetics, should have the benefit of having their College providing their single CPD Home which arbitrates a cohesive set of professional standards relevant to them and their practice context and which also takes responsibility for ensuring that other relevant specialties have input into their standards and processes as appropriate.

Within the new categories of educational activity, performance review and outcome measurement, the specialist colleges should determine the general framework of activities, exemption and extension processes, as well as acceptable evidence of CPD and audit arrangements for their members.

14. Transition arrangements

a. What is a reasonable period to enable transition to the new arrangements?

The College would be comfortable with 12 months as a reasonable timeframe for transition on the presumption that we will be able to continue with our triennium framework.

Submission and Recommendations Summary

The College is committed to working with the Board to ensure that the final draft revised Standards are appropriate to the needs and circumstances of our members in their practice. In addition to our responses to the questions above, the following recommendations are viewed as necessary steps toward achieving this.

Recommendation 1: *That the revised Standard includes clarification that as their CPD Home and AMC accredited speciality college, ACRRM will be able to meet the full range of member CPD requirements associated with maintaining their Fellowship, including in procedural and other advanced skilled areas associated with their Fellowship qualification.*

Recommendation 2: *That the revised Standard clarifies that only medical colleges are appropriate bodies to act as CPD Homes.*

Recommendation 3: *That the revised Standard recognises that the triennium cycle is the appropriate framework for doctors in rural and remote locations; and specifies that this continues for CPD purposes.*

Recommendation 4: *That the revised Standard CPD categories definitions provide sufficient flexibility to enable the College to include a broad scope of activities reflective of the diversity of rural practice.*

Recommendation 5: *That the revised Standard provides sufficient flexibility to enable colleges to adapt their CPD programs to make logging of activities as simple and easy as possible.*

Recommendation 6: *That the revised Standard ensures that the outcome measurement category is sufficiently flexible to encompass the broad scope of activities relevant to rural practice, and that the revised Standard specifically recognises medical colleges' authority to set the standards and appropriately accredit activities for this category.*
Additionally, that some specific advice be included on how locum practitioners might access outcome data.

Recommendation 7: *That the revised Standard recognises that there are activities which may quality under multiple categories and that in such situations these are able to be counted in more than one category.*

Recommendation 8: *That in association with the revised Standard, guidance be provided to Colleges regarding CPD reporting to assist our members to avoid adverse consequences with respect to qualified privilege.*

Recommendation 9: *That the Board use the launch of the revised Standard to communicate the benefits of the new approaches in terms of helping doctors to improve their quality services to their patients.*

ACRRM looks forward to ongoing consultation with the Board in order to ensure that we continue to provide an exceptional CPD Program that meets the unique needs of rural doctors, and also fulfills the requirements of the legislative authority.
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College Details

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Date: 14 February 2020