



# Building a **professional performance framework**

# Summary

The Medical Board of Australia (the Board) has designed a Professional Performance Framework to ensure that all registered medical practitioners in Australia practise competently and ethically throughout their working lives and provide safe care to patients. It is a continuation of what is already in place, not a departure from it.

The Professional Performance Framework is integrated, builds on existing initiatives and is evidence-based. It has five pillars:

1. Strengthened continuing professional development (CPD) requirements.
2. Active assurance of safe practice.
3. Strengthened assessment and management of medical practitioners with multiple substantiated complaints.
4. Guidance to support practitioners - regularly updated professional standards that support good medical practice.
5. Collaborations to foster a culture of medicine that is focused on patient safety, based on respect and encourages doctors to take care of their own health and well-being.

The Board has accepted the evidence provided by the Expert Advisory Group (EAG) on revalidation and their recommendations. The EAG's comprehensive report is available on the Board's website. A list of the Board's specific responses to each of the EAG's recommendations is included at Appendix A. However, the Board will not adopt the term revalidation, because it does not accurately describe its approach.

The Board's Professional Performance Framework is grounded in the evidence provided by the EAG and is practical, implementable and fair, without creating unreasonable new demands on doctors. It will be subject to ongoing review and evaluation.

The Professional Performance Framework is consistent with the Board's current regulatory approach and deliberately aligned to much of the work being done by agencies across the health sector to strengthen clinical governance and

quality assurance, and improve patient safety. It sets a direction and reflects progressive improvements that better assure patient safety and support more effective inter-agency collaboration and information sharing, in the public interest.

As it implements the Professional Performance Framework, the Board will:

1. consult on and propose to Ministers a revised registration standard for continuing professional development
2. consult on and propose to Ministers a new health related registration standard to provide assurance that doctors can continue to provide safe care to patients throughout their working lives
3. strengthen its assessment and management of notifications to better manage medical practitioners subject to multiple substantiated complaints
4. work with stakeholders to develop and implement models for peer review of performance
5. commission clinical advice on what constitutes a practical and effective health check for doctors aged 70 years and over
6. commission ongoing research and evaluation to ensure this work is effective, evidence based and fair
7. foster partnerships and collaborations to promote a culture of medicine that is focused on patient safety, based on respect and encourages doctors to take care of their own health and well-being.

Collaboration and partnerships are critical to our next steps. The Board will work with the profession and other stakeholders including the specialist medical colleges, employers, jurisdictions, professional associations, insurers and the community, as we develop and implement the Professional Performance Framework.

# Guiding principles

The Professional Performance Framework is practical, proportionate and fair. It is tailored to the Australian healthcare setting and will be strengthened by collaboration with the profession and the community.

It reflects the Board's responsibility to take regulatory action to promote the safety of the public, and respect for the roles and responsibilities of others in the health sector to lead different parts of the work needed to create and sustain long term change.

The Professional Performance Framework reflects the guiding principles proposed by the EAG:

- smarter not harder: strengthened CPD should increase value and effectiveness
- integration: all recommended approaches should be integrated with – and draw on – existing systems where possible to avoid duplication of effort, and
- relevant, practical and proportionate: all recommended improvements should be relevant to the Australian healthcare environment, feasible and practical to implement and proportionate to public risk.

## Core features of the Professional Performance Framework

### Strengthened continuing professional development

Under the Professional Performance Framework, the specialist medical colleges continue to have a significant role as standard setters, medical educators, supporters of individual medical practitioners and shapers of the culture of medicine. The direction in which the specialist medical colleges are now taking their CPD programs is consistent with these proposals to strengthen CPD.

Doctors are busy people. To maintain their registration, they must already undertake CPD. The Professional Performance Framework is not designed to increase the amount of CPD doctors undertake, but to make sure the CPD medical practitioners do is useful to them and shown by evidence to help them provide safe patient care.

Regular performance feedback, collaboration with peers and self-reflection are among the cornerstones of life-long learning. They reflect contemporary adult education principles and are becoming a routine feature of CPD programs undertaken by registered medical practitioners in Australia. They are prioritised under the Board's Professional Performance Framework.

### Implications of strengthened CPD for individual medical practitioners

Nothing is going to change tomorrow for individual registered medical practitioners under the Professional Performance Framework. The changes that will follow its implementation will be iterative and build on current specialist medical college CPD programs. They are designed to increase quality, effectiveness and choice.

In line with the EAG's advice, there are minimum requirements for the amount and type of CPD doctors will undertake. This CPD must be relevant to their scope of practice. Doctors will need to complete a minimum of 50 hours of CPD per year - a common current minimum requirement of specialist medical colleges – and choose activities from each of three types of CPD.

Under the changes designed to strengthen CPD, doctors will:

- choose an accredited 'CPD home' (specialist medical college or alternate provider) and participate in its CPD program
- develop a Professional Development Plan (PDP) for each CPD period, which outlines their current scope of practice and documents their individual professional development needs and the activities they plan to undertake
- undertake a minimum of 50 hours per year of CPD activities that meet the requirements of their chosen CPD program and the revised Board registration standard for CPD

- allocate their minimum CPD requirement proportionately across three types of activities:
  - at least 25 per cent of the minimum CPD undertaken annually should be educational activities to develop knowledge and skills
  - at least 25 per cent of the minimum CPD undertaken annually should be activities focussed on reviewing performance
  - at least 25 per cent of the minimum CPD undertaken annually should be activities focussed on measuring outcomes
  - the remaining 25 per cent of the minimum annual CPD can be distributed across any type of CPD
- complete and reflect on their CPD activities as they prepare their professional development plan for the next period.

### Implications of strengthened CPD for CPD programs and providers

Specialist medical colleges are Australia's existing experts in postgraduate medical education and CPD. Most colleges have already shaped their CPD programs in the directions the Board has set in the Professional Performance Framework.

There will be changes for CPD programs and providers introduced progressively in the years ahead as the Professional Performance Framework is implemented, including that CPD programs (specialist medical colleges or alternate providers) will:

- be responsible for an identified cohort of medical practitioners for whom they are the CPD home
- continue to revise their CPD program in line with a revised Board registration standard for CPD
- have a strengthened role in:
  - working with individual medical practitioners so that individual doctor's professional development plans reflect and support their scope of practice
  - ensuring doctors get more value from CPD activities, by requiring a mix of

performance review, outcome measurement and educational activities in their CPD programs

- supporting remediation of medical practitioners in their cohort with identified performance gaps
- sharing information with employers and other health sector agencies about medical practitioners who pose an identified risk to patients, within an established legal framework, and
- report to the Board medical practitioners in their CPD home who have not completed their CPD program requirements.

### Working with other stakeholders

Improved access to data will help improve safety and quality by giving doctors the tools to reflect on and review their practice routinely and measure outcomes.

Doctors currently have variable access to the data that helps them to measure the outcomes of their care and benchmark their performance with peers. Many procedural specialists contribute to, analyse and have access to performance data that is invaluable for practice improvement. Other medical practitioners have much more limited access to equivalent datasets that would enrich their practice by enabling them to better measure their outcomes and review their performance.

Under the Professional Performance Framework, the Board will work with other agencies so this challenge is addressed and urge governments and other holders of 'large data' to make data accessible to individual registered medical practitioners to improve safety and quality.

### Active assurance of safe practice

The community has a right to expect that the Board and the profession take reasonable steps to identify and manage predictable risks to patient safety. The EAG has identified a number of risk factors for poor performance. Targeted screening of medical practitioners with these risk factors is designed to ensure that all doctors providing clinical care continue to provide safe care throughout their working lives. Most medical practitioners who have these risk factors will be

practising safely. Screening will identify individuals who have markers of poor performance and will enable practical, proportionate and supportive interventions to be made to keep patients safe, when these are needed. The Board expects that the vast majority of doctors with identified risk factors will demonstrate their ability to provide safe care to patients and will remain in active clinical practice.

It is the regulator's job to identify predictable risks to patient safety and define the principles for screening for these risks. Designing and conducting the screening, and supporting and remediating medical practitioners back to safe practice whenever possible will require partnerships across the medical profession, involving the Board but led by specialist medical colleges, medical educators, employers, insurers and others.

### Age related risk of poor performance

The EAG has advised the Board that the evidence of age-related risk of poor performance is strong and must be addressed to keep patients safe. The Board accepts the evidence to support this contention that has been provided by the EAG in Part C of its report and believes this evidence base will continue to grow.

Doctors tend to retire later than many other professionals and often wish to continue to make important professional contributions as they age. Respecting and supporting this, the Board believes it is time to also assure their continuing ability to provide safe clinical care by requiring peer review and health checks for doctors aged 70 years and older who provide clinical care to patients.

As it develops the elements of the Professional Performance Framework, the Board will seek advice on issues, constraints and options for introducing formal peer review and health checks, including cognitive screening when this is indicated, of registered medical practitioners who are providing clinical care, at 70 years and three yearly thereafter. These checks will be designed to assure patients, individual practitioners, employers and regulators of doctors' continuing ability to continue to provide safe care.

The Board proposes to develop a new registration standard related to the health of medical

practitioners, which will be informed by legal and clinical advice and stakeholder feedback. It will be subject to extensive consultation and any other required regulatory processes, before it is proposed to Ministers.

### Peer review

The Board plans to require medical practitioners who are providing clinical care to have formal peer-review of their professional performance at 70 years of age and every three years thereafter.

This formal peer review will:

- be constructive and educative
- be integrated with and credited in CPD programs
- include three core elements:
  - practice observation
  - medical record review and
  - feedback and discussion
- align with peer review requirements of the specialist medical colleges, and
- be conducted at arms-length from the Board.

The Board will not be directly involved in peer review of the professional performance of these individuals and will only be advised of outcomes when there is a serious risk to patient safety. Most remediation to address identified performance issues and return practitioners to safe practice will be conducted at arms-length from the Board.

Clear thresholds for regulatory reporting will ensure that:

- practitioners aged 70 and over who are providing clinical care will be required to report to the Board their *participation* in formal professional peer review
- there is **no requirement** to report the *outcome* of peer reviews to the Board unless it reveals that the medical practitioner poses a serious risk to the public.

The Board will work with stakeholders to develop and implement models for peer review of performance that are practical, educationally valid and effective in identifying poor performance that unaddressed, may pose risks to patient safety.

This collaboration will draw on expertise from the profession, the specialist medical colleges and any other CPD providers, medical educators, professional associations, jurisdictions, insurers, the community and other relevant stakeholders.

### Health checks

Medicine can be both a satisfying and challenging profession. To provide good care to their patients, doctors need to take care of their own health and well-being. The World Medical Association's Declaration of Geneva<sup>1</sup> has been updated to include a commitment to this.

Through the Professional Performance Framework, the Board aims to support doctors to more actively and regularly monitor and manage their own health, as a commitment to their own well-being and to assure their ability to provide safe care to their patients over the long term.

To manage foreseeable risks to patient safety from doctors at age-related risk of poor performance, the Board plans to require health checks, including cognitive screening when this is indicated, for doctors aged 70 and over who provide clinical care.

The Board will not be directly involved in providing the health checks and will only be advised of outcomes when there is a serious risk to patient safety. Most action to address identified health issues and return medical practitioners to safe practice when this is possible, will be conducted at arms-length from the Board.

The Board will commission clinical advice on what constitutes a practical and effective health check for doctors aged 70 years and over, which types of medical practitioners should conduct these checks, what validated cognitive screening tools should be used and when these are indicated.

Clear thresholds for regulatory reporting will ensure that:

- medical practitioners aged 70 and over who are providing clinical care will be required to report to the Board *whether* they have undertaken the required health check

---

<sup>1</sup> <https://www.wma.net/policies-post/wma-declaration-of-geneva/>

- there is **no requirement** to report the *outcome* of the health check to the Board unless it reveals that the medical practitioner poses a serious risk to the public.

The Board will collaborate with stakeholders to ensure that there is support available for individual medical practitioners with age-related health issues that pose risks to patient safety.

### Risk from professional isolation

Practice context has significant potential to impact positively and negatively on the performance of medical practitioners. The EAG report states that supportive clinical governance frameworks, working with peers and in team environments all combine to improve performance. Equally, professional isolation can expose individuals to greater risks of poor performance. The Board accepts the EAG's finding that professional isolation can impact on performance and is a known risk factor. It also notes the EAG's advice that doctors working in rural and remote areas are not necessarily professionally isolated.

Through strengthened CPD arrangements and in consultation with specialist medical colleges and other stakeholders, the Board will provide guidance to the profession to help practitioners:

- identify the hallmarks of professional isolation, such as practice contexts removed from clinical governance structures (including being in solo private office-based practice); as locums or in deputising positions; in part-time positions with limited patient contact hours; or in very high volume practice, and
- manage the risk of professional isolation, including by increasing peer-based CPD for professionally isolated practitioners.

## Strengthened assessment and management of practitioners with multiple substantiated complaints

The EAG report states that three per cent of Australia's medical workforce accounts for nearly half of all complaints made to health practitioner regulators or complaints entities. It states that while it is not yet clear how, or at what point, multiple complaints indicate a performance issue

that increases public risk, failing to rule out or act on potential risk to patients from practitioners with multiple complaints is unjustified. The EAG states 'Action to improve the care being provided by a relatively small number of these 'high-risk' practitioners is economical, will improve safety and quality and quantifiably improve the current regulatory system'.

The community has a right to expect that the Board is doing all it can to protect patients by identifying and addressing any performance deficits of practitioners about whom multiple complaints have been substantiated.

The Board will:

- strengthen its assessment and management of medical practitioners with multiple substantiated complaints, by requiring them to participate in formal peer review
- require the results of this peer review, along with proposed remediation plans when performance deficits are found, to be reported to the Board to inform future regulatory action, and
- pilot this approach, with ongoing evaluation and structured review to determine its effectiveness and clarify the threshold for formal peer review for different areas of practice.

## Guidance to support practitioners

The Professional Performance Framework relies on clear, relevant and contemporary professional standards to guide the practice of doctors in Australia and improve patient safety.

The Board will continue to develop and publish clear, relevant and contemporary professional standards and will:

- revise *Good medical practice: A code of conduct for doctors in Australia*
- refine existing and develop new registration standards, and
- issue other guidance as required.

## Collaborations to foster a positive culture of medicine

The culture of medicine reflects the contribution and behaviour of Australia's 111,000 registered medical practitioners, the profession as a whole and the agencies that together provide the education, training, employment, standards and professional services that doctors engage with every day. The culture of medicine is strengthened by the contribution of patients and the community, and the interactions doctors have with them, each other and their colleagues across the health sector.

Patient safety, standards of practice and doctors' health and well-being are linked. All of these are affected by the culture of medicine. The Board supports the work being initiated across the health sector to build a positive culture that is better for doctors and safer for patients. Ongoing work in quality and safety and a continued focus on supporting doctors' health, including suicide prevention, are essential.

The Board has an important role in helping build a culture of respect, in partnership with many others. The Board's regulatory framework and approach, as much as the specific actions it takes to improve patient safety, will help re-set the culture of medicine. The Professional Performance Framework is an important part of this and by implementing it, the Board will:

- promote a culture of medicine that is focused on patient safety
- work in partnership with the profession to reshape the culture of medicine and build a culture of respect, and
- encourage doctors to:
  - commit to reflective practice and lifelong learning
  - take care of their own health and well-being and
  - support their colleagues.

*Good medical practice: A code of conduct for doctors in Australia* (the code) sets out the Board's expectations of all registered medical practitioners. Section nine of the code sets standards to help doctors maintain their health

and well-being, including by having a regular treating general practitioner. In implementing the Professional Performance Framework, the Board will review and strengthen the parts of the code that aim to encourage doctors to look after themselves and each other.

Specialist medical colleges commonly recommend their members have annual health checks and, under the Professional Performance Framework, will be encouraged to increase support for doctors' career transitions, including changes to scope of practice and towards retirement.

To support medical practitioners and students, the Board funds independently doctors' health services which are available to all doctors and medical students, no matter where they live. These services combine face-to-face health-related triage, advice and referral with a telephone help line and online tools and resources. They also support the education and training of doctors to give them the competencies and confidence to care for their colleagues.

There is a lot of work already underway that aims to build a more respectful culture of medicine. The Professional Performance Framework is designed to complement and encourage this work and enable greater collaboration, peer engagement and support in the interests of patient safety.

## Actions and timeframes

Implementing the Professional Performance Framework for doctors in Australia will take time. Collaborations to foster a culture of medicine that is focused on patient safety, based on respect and encourages doctors to take care of their own health and well-being will require long term commitment.

The elements of the Professional Performance Framework will be improved and refined by further consultation with the profession, the community and other health sector stakeholders. Some of the actions we propose to take will require support from Australia's health ministers and some will be subject to legal advice. It is unlikely that the proposed changes will require legislative change.

Our actions to implement the Professional Performance Framework span three phases.

## Phase one

**Over the next 12 months** the Board will:

1. Establish the legal basis for actively assuring that doctors can continue to provide safe care to patients throughout their working lives. This will involve seeking advice on issues, constraints and options for introducing formal peer review and health checks including cognitive screening when indicated of registered medical practitioners who provide clinical care from age 70 years and three yearly thereafter.
2. Commission clinical advice on what constitutes a practical and effective health check for doctors aged 70 years and over, which types of medical practitioners should conduct these checks, what validated cognitive screening tools should be used and when these are indicated.
3. Engage with Human Rights and Equal Opportunity Commissioners on these issues.
4. Work with the specialist medical colleges and employers to continue to strengthen CPD programs in line with the recommendations of the EAG and the Professional Performance Framework.
5. Urge governments and other holders of large data (such as Medicare) to make data accessible to individual registered medical practitioners to support performance review and outcome measurement.
6. Pilot formal peer review of practitioners with multiple substantiated notifications.
7. Explore actions (including possible Memoranda of Understanding) to enable information sharing between organisations with knowledge of individual medical practitioner's poor performance, potential risks or complaints, in the public interest.
8. Refer to the Australian Medical Council the challenge of poor professional behaviour in early career doctors, so its work on professionalism in medical students and the role of education providers can address this in a systematic way.



9. Alert Medical Deans, Universities Australia, specialist medical colleges, post-graduate training providers and employers to the future risk to patient safety from early poor professionalism among medical students, so they can better manage this risk.
10. Work with the Australian Health Practitioner Regulation Agency's Community Reference Group on how best to raise awareness of options for community engagement to strengthen the Professional Performance Framework for doctors in Australia.

## Phase two

**By 2020** the Board will:

1. Consult on a revised registration standard for continuing professional development and the proposed new health related registration standard, engage in any relevant approval processes and then propose these to Australia's health ministers.
2. Consult on changes to accreditation standards which will flow from the Professional Performance Framework.
3. Work with health sector stakeholders to consider:
  - how best to address under-developed and fragmented systems for the early identification and effective management of under-performance across the medical profession
  - responsibilities for remediation of underperformance, and
  - the best agencies to identify barriers and enable 'large data' sharing/ accessing patient outcome data to improve safety and quality.
4. Develop an evaluation plan for the framework

## Phase three

**Longer term** the Board will review and evaluate the effectiveness of the elements of the Professional Performance Framework, including by commissioning independent research as required and revising the relevant elements accordingly.

# Conclusion

The community expects that registered medical practitioners practise competently and ethically throughout their working lives and provide safe care to patients. The Board's role is to make sure these expectations are well founded. The Professional Performance Framework will support doctors to take responsibility for their own performance and encourage the profession collectively to raise professional standards and build a positive, respectful culture in medicine that benefits patients and doctors.

The Professional Performance Framework is based on five pillars – strengthened CPD, active assurance of safe practice, strengthened assessment and management of medical practitioners with multiple substantiated complaints, guidance to support medical practitioners and collaborations to foster a positive culture in medicine.

The Professional Performance Framework is deliberately aligned to other work being done across the health sector that is designed to progressively strengthen clinical governance and quality assurance and improve patient safety.

There is a lot to be done before the Professional Performance Framework is fully implemented. Many of the elements of it are in place already or only need fine-tuning. Others will require more substantial work. The Board is committed to working in partnership with the medical profession and others in the health sector as we implement the Professional Performance Framework. It is designed to justify and strengthen the trust that the Australian community has in their doctors.

# Appendix A

## Recommendations from the Expert Advisory Group and the Board's response

The Medical Board of Australia has accepted all of the recommendations made by the Expert Advisory Group on revalidation in its final report and has developed a proposed professional performance framework to implement the recommendations. The framework consists of five pillars:

1. Strengthened continuing professional development
2. Active assurance of safe practice
3. Strengthened assessment and management of medical practitioners with multiple substantiated complaints
4. Guidance to support practitioners
5. Collaborations to foster a positive culture

The following table indicates which of the pillars of the framework relate to each recommendation.

Recommendation	Response	Pillar
<b>1. Accreditation</b> a. The MBA should ensure a suitable accreditation body accredits all CPD programs for their educational functions to assure program quality, quality assurance and monitoring. b. All registered medical practitioners should undertake CPD within an accredited program relevant to their scope of practice.	Accept	1. Strengthened continuing professional development
<b>2. CPD home</b> a. Individual medical practitioners should choose an accredited CPD program to be their 'CPD home'. b. Accredited CPD homes, in partnership with their cohort of practitioners, should ensure that any CPD activities undertaken with other CPD providers are relevant to the practitioner's scope of practice. c. All CPD homes should report to the MBA any practitioners doing their program who have not fully complied with their CPD program requirements, no more than three months after the end of the CPD period.	Accept	1. Strengthened continuing professional development

Recommendation	Response	Pillar
<p><b>3. Professional development plans</b></p> <p>a. The MBA should require all registered medical practitioners to prepare a professional development plan (PDP) that is relevant to their scope of practice for each CPD period</p> <p>b. All CPD homes should assist their practitioners with the process of professional development planning as required</p> <p>c. The MBA should provide general guidance about professional development plans for CPD</p>	Accept	<p>1. Strengthened continuing professional development</p> <p>4. Guidance to support practitioners</p>
<p><b>4. Type and amount of CPD</b></p> <p>a. All registered medical practitioners must complete at least 50 hours of CPD per year.</p> <p>b. Practitioners must allocate their 50 hours of annual CPD proportionally across each of the three types of CPD, as follows:</p> <ul style="list-style-type: none"> <li>• at least 25% of the minimum CPD required annually should be 'validated educational activities'</li> <li>• at least 25% the minimum CPD required annually should 'review performance'</li> <li>• at least 25% of the minimum CPD required annually should 'measure outcomes and</li> <li>• the remaining 25% of the minimum CPD can be distributed across any types of CPD.</li> </ul> <p>c. The structure and content of CPD programs must be based on contemporary evidence and best practice.</p>	Accept	<p>1. Strengthened continuing professional development</p> <p>4. Guidance to support practitioners</p>
<p><b>5. Ensuring equitable access to diverse CPD programs relevant to practitioners' scope of practice</b></p> <p>a. The MBA should no longer recognise self-directed CPD undertaken outside an accredited CPD program.</p> <p>b. All accredited CPD programs (including those provided by specialist medical colleges) must provide access to their CPD standards and programs to all practitioners whose scope of practice is relevant (i.e. college programs should not be restricted to fellows of that college).</p> <p>c. The MBA should enable the establishment of new CPD programs in addition to those provided by specialist medical colleges.</p> <p>d. Accredited CPD programs should be sufficiently flexible to recognise legitimate workplace-based CPD activities.</p>	Accept	<p>1. Strengthened continuing professional development</p>

Recommendation	Response	Pillar
<p><b>6. Practitioners who do not provide direct patient care</b></p> <p>a. Accredited CPD programs should cater for practitioners who do not provide direct patient care, and include support for them to measure their outcomes and review their performance.</p>	Accept	1. Strengthened continuing professional development
<p><b>7. Supporting improved access to relevant data-sets</b></p> <p>a. To facilitate doctors' measuring outcomes, the MBA should lead the active engagement of stakeholders including the holders of 'large data' sources (such as Medicare, health departments, hospitals and clinical registries), primary health care networks and electronic medical records software companies to find ways to provide all doctors with ready access good quality individual, team and comparative data.</p>	Accept	5. Collaborations to foster a positive culture
<p><b>8. Improving career transition support</b></p> <p>a. Accredited CPD programs should offer general strategies and encourage or enable access to specific educational opportunities to help medical practitioners actively manage career transitions (when there is a change in their scope of practice) and their transition to retirement.</p>	Accept	1. Strengthened continuing professional development 4. Guidance to support practitioners
<p><b>9. The role of healthcare consumers</b></p> <p>a. The MBA should work with consumer groups to publicise and promote their processes for ensuring that doctors are up to date and fit to practise, and how their input is used to promote safety and quality of care.</p>	Accept	5. Collaborations to foster a positive culture
<p><b>10. Supporting system change: Implementation and transition</b></p> <p>a. The MBA should review and amend the Continuing professional development registration standard to reflect the recommendations in this report.</p> <p>b. The MBA should plan for a transition period to enable the implementation of these recommendations.</p> <p>c. Employers should support quality CPD by enabling in-house education, peer-review processes and in providing data-rich environments that support the assessment of performance and improvement of patient outcomes</p>	Accept	1. Strengthened continuing professional development 5. Collaborations to foster a positive culture

Recommendation	Response	Pillar
<p><b>Risk from individual characteristics</b></p> <p><b>11. Age related risk</b></p> <p>The Medical Board of Australia has the power to make changes that will strengthen public safety by better managing age-related risk.</p> <p>a. Subject to the provisions of the National Law and other relevant Commonwealth, state and territory laws, the MBA should:</p> <ul style="list-style-type: none"> <li>• require doctors at 70 years and every three years thereafter to undertake a confidential health check by a suitably qualified medical practitioner, including cognitive screening using a prescribed validated screening tool</li> <li>• require doctors at 70 years and every three years thereafter to undertake a formal managed performance review process with feedback, with credit for CPD, and</li> <li>• provide guidance on the requirements for the health and performance screenings, including the processes for dealing with the outcomes.</li> </ul> <p>b. CPD providers, indemnity insurers and employers should:</p> <ul style="list-style-type: none"> <li>• promote annual health checks for later career doctors</li> <li>• work closely and constructively with medical practitioners over the age of 70 <ul style="list-style-type: none"> <li>– to raise awareness of potential risks that may affect performance and improve supports for safe clinical practice, and</li> <li>– to increase supports for later career doctors considering and, where appropriate, managing changes to their scope of practice or transition to retirement, including providing written guidance, CPD education activities and the use of 'retirement ambassadors' to provide peer role models of successful retirement planning for doctors.</li> </ul> </li> </ul> <p>c. The MBA should:</p> <ul style="list-style-type: none"> <li>• commission an independent research group to receive, de-identify and analyse data on participant demographics (e.g. age, gender, practice environment, type and extent of patient care, notifications and complaints history and CPD) and outcomes of the health</li> </ul>	<p>11a. Accept in principle</p> <p>11b. Accept</p> <p>11c. Accept in principle</p> <p>11d. Accept</p>	<p>1. Strengthened continuing professional development</p> <p>2. Active assurance of safe practice</p> <p>4. Guidance to support practitioners</p> <p>5. Collaborations to foster a positive culture</p>

Recommendation	Response	Pillar
<p>and performance screening processes for doctors over 70 years.</p> <ul style="list-style-type: none"> <li>rigorously evaluate outcomes for the utility of this approach in detecting performance or health concerns that may influence fitness to practise (including seeking feedback from participating medical practitioners their CPD providers and any remediation providers), and undertake a cost-benefit analysis.</li> </ul> <p>d. If there are insurmountable legal obstacles to taking mandatory actions to investigate and address the potential risk from doctors over 70, as a minimum the MBA should commission further research to examine the risk of poor performance from doctors in this age group. This may include voluntary participation in appropriate pilot studies that reflect the above criteria and further collaborative research efforts investigating risks shown by notifications and complaints data for older doctors.</p>		
<p><b>12. Risk indicated by multiple complaints</b></p> <p>The MBA should:</p> <ul style="list-style-type: none"> <li>interrogate the notifications data it holds about doctors with multiple notifications, to identify patterns of potential underperformance and poor performance and clarify the points at which risk to the public is occurring, including investigating the number, type and frequency of performance complaints and the corresponding levels of risk</li> <li>increase system responses to practitioners with multiple complaints and or notifications by requiring practitioners with three or more substantiated notifications and/or complaints over a five-year period, to undertake additional assessments to investigate the potential risks to the public. This should include input from others involved in, or with knowledge of, the practitioners' performance to determine if there are specific performance issues and/or broader undetected performance risks that need to be addressed.</li> <li>develop MOUs with relevant organisations may assist in information sharing about complaints or potential risks.</li> <li>improve the coding systems in datasets held by AHPRA and health complaints entities to enable targeted research and greater insight, through</li> </ul>	<p>Accept</p>	<ul style="list-style-type: none"> <li>3. Strengthened assessment and management of practitioners with multiple complaints</li> <li>4. Guidance to support practitioners</li> <li>5. Collaborations to foster a positive culture</li> </ul>

Recommendation	Response	Pillar
<p>consistent and accurate categorisation of complaints and notifications.</p> <p>e. systematically evaluate the outcomes from these increased system responses to:</p> <ul style="list-style-type: none"> <li>• characterise the different types of performance-related complaints and their level of risk</li> <li>• identify hotspots of risk that need to be more fully or differently addressed, and</li> <li>• consider whether three substantiated complaints over a five-year period is the appropriate threshold for closer scrutiny or assessment.</li> </ul>		
<p><b>Risk from practice context</b></p> <p><b>13. Professionally isolated practitioners</b></p> <p>The MBA should work with providers of accredited CPD programs and other stakeholders to develop agreed indicators about the hallmarks and risks from practice context, including professional isolation and/or lack of collegial supports and:</p> <ul style="list-style-type: none"> <li>a. provide clear guidance to the profession about identifying and managing risk from professional isolation</li> <li>b. encourage doctors who meet the agreed indicators for professional isolation to direct the 25 per cent of unallocated CPD activities within their minimum CPD requirements towards managing identified risk from practice context. This should emphasise peer activities such as performance review, peer reviews, peer visits, formal and informal clinical networking, mentoring, other forms of increased collegial supports and outcomes measurement.</li> </ul>	Accept	<ol style="list-style-type: none"> <li>1. Strengthened continuing professional development</li> <li>4. Guidance to support practitioners</li> <li>5. Collaborations to foster a positive culture</li> </ol>

Recommendation	Response	Pillar
<p><b>Risk from health systems and culture</b></p> <p><b>14. Underdeveloped and fragmented systems for the early identification and effective management of underperformance</b></p> <p>The MBA should work with jurisdictions, employers, and medical indemnity insurers to address underdeveloped and fragmented systems for the early identification and effective local management of underperformance including:</p> <ul style="list-style-type: none"> <li>a. facilitating cross agency collaborations to encourage the existing and emerging champions of change in stepped early detection and performance improvement processes</li> <li>b. evaluating new programs to identify exemplar processes</li> <li>c. enabling further pilot projects to be trialled in systems likely to be successful. This is likely to initially include institutions with sufficient resources to implement pilots within existing robust clinical governance programs</li> <li>d. longer term diffusion of successfully developed models and trialling of models in smaller or different systems, and</li> <li>e. developing processes relevant to practitioners who do not work for employers or in larger group practice arrangements.</li> </ul>	Accept	5. Collaborations to foster a positive culture
<p><b>15. Barriers to inter-agency information sharing about risk</b></p> <ul style="list-style-type: none"> <li>a. The MBA should establish MOUs on processes to facilitate and strengthen robust information sharing about performance concerns/issues between relevant agencies and stakeholders to create a joined up system that facilitates early intervention for at risk practitioners.</li> </ul>	Accept in principle	5. Collaborations to foster a positive culture



Recommendation	Response	Pillar
<p><b>16. Poor professional behaviours of early career doctors are not fully addressed</b></p> <p>The MBA should:</p> <ol style="list-style-type: none"> <li>a. continue to alert stakeholders to the future risk to patient safety from early poor professionalism and remind: <ul style="list-style-type: none"> <li>• Medical Deans Australia and New Zealand and Universities Australia about the future risk to patient safety from graduating medical students with a proven and irremediable lack of professionalism and as needed, of their duty to strengthen teaching about professionalism and if necessary preclude entry to the profession of individuals who are unfit to practise.</li> <li>• colleges, post-graduate training providers and employers about the future risk to patient safety from trainees and early and established career doctors who demonstrate poor professionalism and do not respond to remediation or other educational interventions and as needed, of their duty to preclude from the profession individuals who are unfit to practise.</li> </ul> </li> <li>b. undertake further work to investigate the quality of professionalism education, supports for successful professional identity formation and the implications of underperformance in barrier examinations on the type and risk of future notifications and complaints.</li> </ol>	Accept	5. Collaborations to foster a positive culture
<p><b>17. Variable structures for remediation and patchy access for practitioners</b></p> <p>The MBA should:</p> <ol style="list-style-type: none"> <li>a. lead work, in partnership with other stakeholders, to develop a shared understanding of the roles and responsibilities of employers, colleges and other health sector stakeholders for identifying issues and managing remediation</li> <li>b. work with stakeholders to identify the best model for ensuring effective, supportive and equitably accessible remediation opportunities in Australia, including identifying the role of the MBA and examining the current model for the Doctors' Health Service Pty Ltd – which is funded by the MBA – as a national framework that is run at arms-length from the Board.</li> </ol>	Accept	5. Collaborations to foster a positive culture

Recommendation	Response	Pillar
<p><b>18. Barriers to accessing patient outcome data for improving safety and quality</b></p> <p>a. To assist in improving safety and quality, the MBA should lead the active engagement of a diverse group of stakeholders including the Australian Commission on Safety and Quality in Health Care (ACSQHC), holders of 'large data' sources (such as Medicare, health departments, hospitals and clinical registries), primary health care networks and electronic medical records software companies to find ways to create and share good quality individual, team and comparative data.</p>	Accept	5. Collaborations to foster a positive culture

---