The Royal Australasian College of Medical Administrators' Conference

Benefitting from the Boom

Challenges for the healthcare system

CONFERENCE HANDBOOK

RACMA
The Royal Australasian College of Medical Administrators

5 –7 September 2012 **Perth Convention + Exhibition Centre**

racmaconference.com.au

CONTENTS PAGE

For assistance or to discuss your next conference please contact

Leishman associates
conference and event management

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WELCOME FROM THE RACMA PRESIDENT

Dear Colleagues,

On behalf of the Royal Australasian College of Medical Administrators Board, I welcome you to the 2012 Annual Scientific Meeting "Benefitting from the boom – Challenges for the healthcare system".

RACMA's Annual Scientific Meeting provides a platform for College members and other interested parties to meet and discuss the major current topics impacting our industry. When you associate with RACMA you connect with many of Australia's leading health services decision makers. RACMA members are health care leaders of influence. They manage hospitals and consulting firms and advise governments at all levels. They work in the defence industries, immigration, tertiary education, health authorities, pharmaceuticals, IT and e-health.

This year's theme around boom times encompasses the sub themes of Rural and Remote Health, Indigenous and Advocacy Issues, Tele health and e-Health, National Health Reform, Strategic and Capital Planning, Workforce Planning, Quality and Safety, Medical Leadership in a climate of change, Public and Environmental health, Health Services Research and Junior Medical Staff workforce strategy.

Two of the concurrent sessions will be dedicated to showcasing health services research work in the free papers, selected from a diverse array of submitted abstracts and supported by poster presentations.

Our Candidates will battle it out for the Margaret Tobin Challenge Award with oral presentations from Hong Kong, Queensland, Victoria and New South Wales.

The inspiring program will include the prestigious Annual Langford Oration, this year delivered by Rear Admiral Robyn Walker, Surgeon General of the Australian Defence Force and FRACMA. This will directly follow our Conferment Ceremony when we welcome new Fellows, new Associate Fellows and commemorate achievements of our Fellows.

We are confident that you will enjoy your time with us in Perth.

Dr Lee Gruner
President, Board
The Royal Australasian College of Medical Administrators

MESSAGE FROM THE CONFERENCE CONVENOR

Dear Colleagues,

On behalf of the RACMA National Scientific Program Committee, I welcome you to the Royal Australasian College of Medical Administrators 2012 Annual Scientific Meeting.

RACMA 2012 is the major Australasian scientific event for Fellows, Associate Fellows, clinician managers and all doctors interested in medical management. The conference features many prominent international and local speakers focussed on the major theme of "Benefitting from the boom – Challenges for the healthcare system"

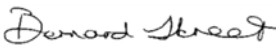
Other themes include:

- Rural and Remote Health with a particular emphasis on indigenous health
- Indigenous and Advocacy Issues
- Information Technology and e-Health
- National Health Reform
- Strategic and Capital Planning
- Workforce Planning and
- Quality and Safety
- Medical Leadership
- Public and Environmental health
- Health Services Research, and
- Junior Medical Staff workforce strategy

The abstracts in this booklet reflect the high quality of the papers and I thank all participants for their contributions.

I would also like to thank all who have contributed to the success of this conference, especially the National Scientific Program Committee, the RACMA Board, CEO and National Office. In particular Michelle Barrett, Curriculum and Training Coordinator and Paula Leishman, Leishman Associates, have played a superb role in putting together this outstanding program.

We hope you find the 2012 RACMA Conference an inspirational experience and one which helps you reach new heights as a leader and manager in the rapidly evolving field of medical management.



Dr Bernard Street
Chair, National Scientific Program Committee

The Royal Australasian College of Medical Administrators

CONFERENCE ORGANISING COMMITTEE

Dr Bernard Street	Chair
Ms Michelle Barrett	RACMA Curriculum & Training Coordinator
Dr Alison Dwyer	VIC
Prof Gavin Frost	WA
Dr John Gallichio	VIC
Dr Daniel Heredia	WA
Dr Stewart Jessamine	NZ
Dr Andrew Johnston	QLD
Dr Erwin Loh	VIC
Dr Donna O'Sullivan	QLD
Dr Andrew Robertson	WA
Dr Tony Sara	NSW
Dr Sally Tideman	SA
Dr Helen Tinsley	HK

GENERAL INFORMATION

REGISTRATION DESK OPENING TIMES

Wednesday 5 September 2012
8am – 6pm

Thursday 6 September 2012
8am – 6pm

Friday 7 September 2012
8am – 5pm

ACCOMMODATION

If you booked your accommodation through the conference registration and have any queries relating to your accommodation booking first speak to the staff at your hotel or alternatively Leishman Associates staff at the registration desk. Your credit card details were supplied to the hotel you have selected, as security for your booking. If you have arrived 24 hours later than your indicated arrival day you may find that you have been charged a fee. You will be responsible for all room and incidental charges on check out and may be asked for an impression of your credit card for security against these charges. This is standard policy in many hotels.

BANKING

Convention Centre ATM is located on Level 2 at the entrance to the Espresso Bar.

MOBILE PHONES

As a courtesy to other delegates, please ensure that all mobile phones are turned off or in a silent mode during all sessions and social functions.

PHOTOGRAPHS, VIDEOS, RECORDING OF SESSIONS

Delegates are not permitted to use any type of camera or recording device at any of the sessions unless written permission has been obtained from the relevant speaker.

SMOKING

All venues are non-smoking. No rooms are designated smoking rooms however guests are allowed to smoke outside the venue.

ENTRY TO CONFERENCE SESSIONS

It is suggested that delegates arrive at preferred sessions promptly to ensure a seat. If sessions become full then delegates will not be allowed entry. Please wear your name tag for entry to sessions.

SOCIAL PROGRAM ENTRY

The Welcome Reception and Conference Dinner are included in the cost of each full conference registration. Social events ARE NOT included in the cost of day registrations or for accompanying partners. Places for day registrants and additional guests for these events may still be available at an additional cost. Bookings can be made at the registration desk subject to availability.

All delegates who are registered to attend the dinner will receive a named sticker at registration. You MUST place your sticker on a table located on poster boards at the entrance to the Exhibition. You must allocate yourself to a table no later than 11.00 am on Thursday 6 September 2012.

SPECIAL DIETS

All catering venues have been advised of any special diet preferences you have indicated on your registration form. Please identify yourself to venue staff as they come to serve you and they will be pleased to provide you with all pre-ordered food. For day catering, there may be a specific area where special food is brought out, please check with catering or conference staff.

INFORMATION FOR PRESENTERS AND SESSION CHAIRS

All Speakers will be asked to report to the Speaker Preparation desk to load their presentations onto the conference network. This must be done AT LEAST four hours before you are due to present – this may mean the day before your presentation. An audio visual technician will be available throughout the conference.

Speakers Preparation is located in the Northern Foyer near Registration. Please see the staff at the Registration Desk for further assistance or directions.

ORAL PRESENTATIONS

Please refer to the program for the time allocated for each presentation, as these do vary. The chairperson for your session will give you a 3 minute warning, however you are asked to stick to your time allocation so that the program remains on schedule.

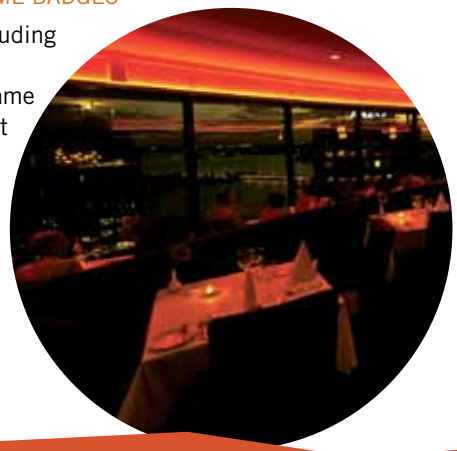
POSTER PRESENTATIONS

Posters will be displayed in the Northern Foyer of the Perth Convention & Exhibition Centre for the duration of the conference. There will be a poster session on Wednesday 5 September 2012 during the Welcome Reception.

Refreshments will be served during the Poster Presentation.

CONFERENCE NAME BADGES

All delegates, including presenters will be provided with a name badge, which must be worn at all times within the conference venue, as it is required for access to all sessions and workshops.



CONFERENCE PROCEEDINGS

Powerpoints, audio and abstracts will be available on the RACMA website following the conclusion of the conference. Speakers will be requested to sign a release form. This is not compulsory.

Disclaimer
The RACMA 2012 Conference reserves the right to amend or alter any advertised details relating to dates, program and speakers if necessary, without notice, as a result of circumstances beyond their control. All attempts have been made to keep any changes to an absolute minimum.

SOCIAL PROGRAM

There are two official functions included in the cost of full registration during the RACMA conference, together with an optional function for Candidates and an invitation only event.

WELCOME RECEPTION AND POSTER PRESENTATION

Date: Wednesday 5 September 2012
Location: Perth Convention & Exhibition Centre, Northern Foyer
Time: 6.00pm – 8.00pm
Dress: Business Attire

Join us for the official welcome to the RACMA 2012 Conference overlooking the beautiful Swan River, at the conference venue, Perth Convention & Exhibition Centre.

GALA DINNER

Date: Thursday 6 September 2012
Location: C Restaurant in the Sky, Level 33, 44 St George's Terrace Perth
Theme: Top Hats and Tiara's.
Delegates are welcome to dress to the theme
Time: 7.00pm – 11.30pm
Dress: After Five
Getting there: Delegates should make their own way there.

Join your colleagues and enjoy the Conference Dinner. C Restaurant in the Sky is 33 floors up, in the heart of Western Australia's sparkling capital city of Perth. There's something heady, something exclusive, and something special about being high up above a city like Perth.

OPTIONAL FUNCTION – CANDIDATES DINNER

Date: Wednesday 5 September 2012
Location: The Trustee Bar and Bistro, 113 St George's Terrace Perth
Time: 8.00pm
Price: $50
Dress: Business Attire
Getting there: Attending delegates depart after the Welcome Reception and either walk to the venue as a group or make their own way there.

INVITATION ONLY FUNCTION – RACMA BOARD AND HONG KONG GUESTS DINNER

Date: Wednesday 5 September 2012
Location: Frasers Restaurant, Kings Park
Time: 8.15pm
Dress: Business Attire
Getting there: Guests to make your own way to Frasers Restaurant via taxi.

PROGRAM

WEDNESDAY 5 SEPTEMBER 2012

0800–1800	REGISTRATION DESK OPEN			PCEC, NORTHERN FOYER
	MEETING ROOM 1	MEETING ROOM 2	SITE INSPECTION	MEETING ROOM 12
0900	**WORKSHOP SESSION 1** **System Level Change + Managing Up & Out** *Dr Andrew Johnson* Executive Director of Medical Services Townsville Health Service District *Dr Tony Austin, AM* Chairman, Remote Area Health Corps. Chairman, National Advisory Committee, Veterans and Veterans' Families Counselling Service	**MASTER CLASS SESSION 2** **CHAIR: DR DONNA O'SULLIVAN** **Clinician, or Leader? Or Both? How do You Become the Leader You Want to Be?** *Prof Graham Dickson* Founding Director of the Centre for Health Leadership and Research at Royal Roads University, Professor Emeritus of Leadership in the Faculty of Social and Applied Sciences Royal Roads University	**FULL DAY SITE INSPECTION** **CHAIR: DR ANDREW ROBERTSON** On this tour delegates will visit, The Fiona Stanley and Sir Charles Gairdner Hospitals for review of Capital Development, Royal Perth and Fremantle Hospitals to experience the four hour rule. Inclusive of lunch and coach transport.	10.00am – 4.00pm RACMA Board Meeting
1030–1045	MORNING REFRESHMENTS			PCEC, NORTHERN FOYER
1230–1330	LUNCH			PCEC, NORTHERN FOYER

1330	Sessions recommence as above	
1530–1545	AFTERNOON REFRESHMENTS	PCEC, NORTHERN FOYER
1700–1800	RACMA Annual General Meeting	PLENARY MR 1 & 2
1800–2000	Welcome Reception & Poster Display	PCEC, NORTHERN FOYER
2000	CANDIDATES SOCIAL FUNCTION The Trustee Bar and Bistro, 113 St George's Terrace Perth Attendees will depart after the welcome reception and walk to the venue as a group **Sponsored by Avant**	
2015	RACMA BOARD AND HONG KONG GUESTS DINNER Frasers at Kings Park *Invitation only* Guests to make their own way to dinner	

THURSDAY 6 SEPTEMBER 2012

0800–1800	REGISTRATION DESK OPEN	PCEC, NORTHERN FOYER
0830	**President's Welcome** *Dr Lee Gruner*	PLENARY MR 1 & 2
0840	**Welcome to Country** *Mr Cedric Jacobs* Indigenous Economic Solution, Western Australia	
	PLENARY SESSION 1 **BENEFITTING FROM THE BOOM**	**CHAIR: DR ROGER BOYD**
0855	**WELCOME ADDRESS + KEYNOTE PRESENTATION** **Statewide Perspective** *Mr Kim Snowball* Director General of Health, Western Australia	
0935	**The Mining Perspective** *Nicole Roocke* Director, The Chamber of Minerals and Energy of Western Australia	
1005	**The Effects of Boom Times – National Perspective** *Professor Philip Davies* Professor of Health Systems & Policy, The University of Queensland	
1045	MORNING REFRESHMENTS	PCEC, NORTHERN FOYER

1100–1220	**CONCURRENT SESSION 1** PLENARY MR 1 & 2 **CHAIR: DR DAVID SAGE** **INDIGENOUS AND ADVOCACY ISSUES**	**CONCURRENT SESSION 2** MR 3 **CHAIR: DR DAVID RANKIN** **CONTRIBUTED PAPERS** Presentations will be 15 minutes in duration, with 5 min Q&A and movement time
	1100–1120	1100–1120
	Seen but not heard: Tackling Health Status *Mr Ken Wyatt, AM, MP* Parliament of Australia	**Integrated Clinical Education Practice and Learning (ICEPaL) – breaking down the silos** *Dr Ian Graham* Director of Medical Services, Grampians Health Alliance
	1120–1140	1120–1140
	Lessons from NZ on Integrating Cultures *Dr Peter Jansen* Senior Medical Advisor Accident Compensation Corporation, New Zealand	**Primary Clinical Care Manual – Driving improvements in Safe Health Service Provision in Rural and Remote Settings** *Dr Jill Newland* Director of Clinical Support, Rural And Remote Health, Queensland Health
	1140–1200	1140–1200
	The Health of Aboriginal People is Everyone's Business *Jenni Collard* Director, Aboriginal Health, WA Health	**Easy Entry, Gracious Exit 10 years on – what are the lessons we have learned?** *Dr Ross Lamplugh* Chairman, Ochre Health Group
	1200–1220	1200–1220
	Facilitated discussion	**Fly In Fly Out (FIFO) and Drive in Drive out (DIDO) for Aged Care Services in rural and remote Western Australia (WA)** *Dr PK Loh* Head Of Department Geriatric Medicine, Royal Perth Hospital

1220–1320	**LUNCHTIME PRESENTATION: INTERNATIONAL PERSPECTIVE – LESSONS LEARNT FROM THE UK** *Sir Muir Gray* Director of the National Knowledge Service and Chief Knowledge Officer to the National Health Service and Public Health Director of the Campaign for Greener Healthcare *Pre-recorded presentation* RIVER VIEW ROOM		
1220–1320	Continuing Education Program Meeting MR 12		
	PLENARY SESSION 2 PLENARY MR 1 & 2 **HEALTH CARE REFORMS Q&A SESSION** **CHAIR: DR ANDREW ROBERTSON**		
1330	**National Health Care Reform – A summary of Key Commonwealth Measures** *Ms Jane Halton, PSM* Secretary of the Department of Health and Ageing		
1345	**IHPA & Activity Based Funding** *Dr Tony Sherbon* Chief Executive Officer, Independent Hospital Pricing Authority		
1400	**Are we there yet?** *Dr Christine Bennett* Professor and Dean, School of Medicine, Sydney, The University of Notre Dame Australia		
1415	Q&A session with panel		
1415–1515	Health Workforce Australia 2025 Workforce Census Meeting MR 12 *Invitation only*		
1445	AFTERNOON REFRESHMENTS PCEC, NORTHERN FOYER		
1515–1630	**CONCURRENT SESSION 3** MR 1 **CHAIR: DR JOHN GALLICHIO** **QUALITY & SAFETY**	**CONCURRENT SESSION 4** MR 2 **CHAIR: DR ANDREW JOHNSON** **MEDICAL WORKFORCE**	**CONCURRENT SESSION 5** MR 3 **CHAIR: PROF GAVIN FROST** **MARGARET TOBIN CHALLENGE AWARD**
	1515–1535	1515–1545	1515–1535
	Improving Care, Managing Resources, Delivering Quality *Dr Amanda Ling* Director – Office of Safety & Quality in Healthcare, Senior Medical Advisor, Performance, Activity and Quality Division Department of Health	**How do we provide a medical workforce in response to the changing needs of our rural and remote areas** *Mark Cormack* Chief Executive Officer Health Workforce Australia	**Doctors and Managers – never the twain shall meet?** *Dr Philip Reasbeck* Victoria
	1535–1555	1545–1615	1535–1555
	Complying with the new National Standards *Dr Liz Mullins* Principal, Mullins Health Consulting	**The Queensland perspective to providing a medical workforce to rural and remote communities**	**Interns and the private sector** *Dr June Song* New South Wales
	1555–1615	*Dr Denis Lennox* Executive Director & Senior Advisor Medical Services I Office of Rural & Remote Health Policy, Strategy & Resourcing Division Queensland Health	1555–1615
	Embracing the National Standards; the ACHS experience *Brian Johnston* Chief Executive The Australian Council on Healthcare Standards		**Right Doctor, Right Time, Right Pathology Result: Implementing Online Pathology Verification in the Tertiary Setting** *Dr Leah Barrett Beck* Queensland
	1615–1630	1615–1630	1615–1635
	Facilitated discussion	Facilitated discussion	**Paradigm shift in managing Non-communicable diseases: Moving beyond the health sector** *A/Prof Albert Lee* Hong Kong
1645–1730	**CONFERMENT CEREMONY, PROCESSION & AWARDS CEREMONY** RIVER VIEW ROOM Please note Robing Room available, MR 12 **CHAIR: DR LEE GRUNER**		
1730–1800	**LANGFORD ORATION** *Rear Admiral Robyn Walker, AM* Surgeon General, Australian Defence Force		
1800–1830	Photograph sessions		
1900–2330	**CONFERENCE DINNER AT C RESTAURANT – THEME: TOP OF THE TOWN: TOP HATS & TIARAS** Delegates to make their own way to C Restaurant, Level 33, 44 St Georges Terrace, Perth. Pre-dinner drinks commence at 7.00pm.		

FRIDAY 7 SEPTEMBER 2012

0730–0830	Training Committee Meeting *Invitation only*		MR 12
0800–1700	REGISTRATION DESK OPEN		PCEC, NORTHERN FOYER
	PLENARY SESSION 3 **RURAL & REMOTE MEDICINE**		PLENARY MR 1 & 2 **CHAIR: DR TONY AUSTIN, AM**
0845	**Rural and Remote Medicine – WA Country Health Service** *Dr Felicity Jefferies* Chief Executive of the Western Australian Country Health Service		
0915	**Servicing a Rural Community** *Tina Chinery* Chief Operating Officer, Southern Country Health Service, Western Australia		
0945	**The Royal Flying Doctor Service. A view from the cockpit** *Dr Stephen Langford* Medical Director, RFDS Western Operations		
1015	Facilitated discussion		
1030	MORNING REFRESHMENTS		
1030–1100	New Fellows Induction		MR 12
1100–1220	**CONCURRENT SESSION 6** MR 1 **CHAIR: DR TONY SARA** **TELEHEALTH & E-HEALTH**	**CONCURRENT SESSION 7** MR 2 **CHAIR: DR MICHAEL WALSH** **CAPITAL DEVELOPMENT & PLANNING** These presentations will be 30 mins duration	**CONCURRENT SESSION 8** MR 3 **CHAIR: DR SALLY TIDEMAN** **CONTRIBUTED PAPERS** Presentations will be 15 minutes in duration, with 5 min Q&A and movement time
	1100–1120	1100–1130	1100–1120
	eHealth in Australia 2012 *Dr Richard Ashby, AM* Executive Director Medical Services Princess Alexandra Hospital	**Private Hospital Providers and Capital Developments** *Dr Lachlan Henderson* CEO, St John of God Pathology Group Director Medical Services and Strategy St John of God Health Care	**A Clinical Training Network for Far North Queensland (Supporting Regionally Based Medical Training)** *Prof Geraldine MacCarrick* Clinical Dean Northern Clinical Training Network, Cairns Base Hospital
	1120–1140	1130–1200	1120–1140
	eHealth and the PCEHR *Dr Mukesh Haikerwal, AO* Head of Clinical Leadership and Engagement nehta – National E-Health Transition Authority *Via video conference*	**The New RCH – Project planning and implementation** *Prof Christine Kilpatrick* Chief Executive Melbourne Royal Children's Hospital	**In one person, many people; adaptive leadership** *A/Prof James Oldham* Chief Psychiatrist, Illawarra & Shoalhaven Local Health District
	1140–1200		1140–1200
	Tele-health & the Tertiary Sector – Why? *Prof Gavin Frost* Medical Dean, Notre Dame University Fremantle		**Can you send me an ISBAR on that? Embedding professional communication for patient safety across a large public health organisation in NSW, Australia** *A/Prof Rosemary Aldrich* Associate Director, Clinical Governance, Hunter New England Health
	1200–1220	1200–1220	1200–1220
	Facilitated discussion	Facilitated discussion	**Variety is the spice of life: improving staff morale by supporting placements in non-traditional roles** *Dr Tony Austin, AM* Chairman, Remote Area Health Corps
1215–1315	LUNCH WILL BE SERVED IN THE RIVER VIEW ROOM		
1215–1315	Education and Training Committee Meeting *By invitation only*		MR 12

	PLENARY SESSION 4 **MEDICAL LEADERSHIP IN A CLIMATE OF CHANGE**		PLENARY MR 1 & 2 **CHAIR: DR HONG FUNG**
1315	**Medical Leadership in a climate of change** *Prof Jeffrey Braithwaite* RACMA Board member, Director, Australian Institute of Health Innovation, University of NSW		
1345	**Leading in health** *Prof Graham Dickson* Founding Director of the Centre for Health Leadership and Research at Royal Roads University, Victoria, BC		
1415	Facilitated Panel Discussion		
1430	AFTERNOON REFRESHMENTS		
1445–1600	**CONCURRENT SESSION 9** MR 1 **CHAIR: DR S V LO** **PUBLIC & ENVIRONMENTAL HEALTH ISSUES** These presentations will be 30 mins duration	**CONCURRENT SESSION 10** MR 2 **CHAIR: DR DRAGINJA KASAP** **HEALTH SERVICES RESEARCH**	**CONCURRENT SESSION 11** MR 3 **CHAIR: DR LEE GRUNER** **INNOVATIONS IN THE MANAGEMENT OF JUNIOR MEDICAL STAFF**
	1445–1515	1445–1505	1445–1505
	The public health impact of Fly In Fly Out (FIFO) work in WA *Tarun Weeramanthri* Executive Director Public Health Division Department of Health Government of Western Australia	**The important role for RACMA and where we should head** *Prof Jeffrey Braithwaite* RACMA Board member, Director, Australian Institute of Health Innovation, University of NSW	**Managing medical workforce costs – a program of work at a large public tertiary health service** *A/Prof Erwin Loh* Executive Director, Medical Services & Quality for Southern Health
	1515–1545	1505–1525	1505–1525
	The Effect on health with the Mining Boom *Jim Dodds* Director Environmental Health at Health Department Western Australia	**What's new and what's coming** *Dr Simon Towler* Medical Advisor – Blood and Technology at WA Department of Health; Intensive Care Specialist at Royal Perth Hospital	**Work practice change and junior medical staffing** *A/Prof Colin Feekery* Executive Director Medical Services and Research Easternhealth
	1545–1600	1525–1545	1525–1545
	Discussion	**How to introduce new technology into your hospital** *Dr Alison Dwyer* Medical Director, Quality Safety and Risk Management Austin Hospital	**Junior Medical Staff feedback and strategy at Peter MacCallum cancer centre** *Dr Bennie Ng* Deputy Director of Medical Services Peter MacCallum Cancer Centre
		1545–1600	1545–1600
		Facilitated discussion	Facilitated discussion
1600–1645	**MEDICAL MANAGEMENT CONUNDRUMS** Panel: Graham Dickson, Jeffrey Braithwaite, Richard Ashby, Andrew Robertson, Lee Gruner, Michael Walsh, Christine Kilpatrick Delegates are encouraged to submit their medical management conundrum to the staff at the Registration Desk to go into the draw to win a prize		**CHAIR: DR BERNARD STREET** PLENARY MR 1 & 2
1645–1700	**Closing Remarks** *Dr Lee Gruner* President, Royal Australasian College of Medical Administrators		

MEDICAL MANAGEMENT CONUNDRUMS

Submit a medical management conundrum for your chance to win an Apple iPad.

A highlight of the conference will be closing plenary at 4pm on Friday 7 September. This will be a Medical Management Conundrums session, where eminent RACMA Fellows and Conference keynote speakers will put their minds to solving a range of health care administrative conundrums submitted by conference registrants.

The moderator is Dr Bernard Street, Chair of the RACMA National Scientific Program Committee, who has had a longstanding involvement in theatre and has conducted a number of panel discussions and "Hypotheticals" at national and international conferences. The Medical Management Conundrums Session will bring the magic of theatre to the conference, while exploring issues in an informative and entertaining way.

There will be a prize of an Apple iPad for the best conundrum submitted by a conference registrant.

Moderator, Dr Bernard Street
A/ Director of Clinical Services,
Shoalhaven District Memorial Hospital
Chair RACMA National Scientific Program Committee

Professor Graham Dickson
Founding Director of the Centre for Health Leadership and Research
Royal Roads University, Canada

Prof Christine Kilpatrick
Chief Executive Officer, Royal Children's Hospital, Melbourne, RACMA Fellow

Prof Jeffrey Braithwaite
Director Australian Institute of Health Innovation, University of NSW,
RACMA Board Member

Dr Andrew Robertson
Acting Chief Medical Officer, WA Health Department
Member RACMA National Scientific Program Committee

Dr Richard Ashby
Executive Director of Medical Services, Princess Alexandra Hospital, Qld,
RACMA Vice-President

Dr Lee Gruner
Consultant, Quality Directions,
RACMA President elect

Dr Michael Walsh
Chief Executive, Cabrini Health, Australia,
RACMA Board member

WORKSHOPS

WORKSHOP 1
SYSTEM LEVEL CHANGE + MANAGING UP AND OUT

Dr Andrew Johnston
Executive Director of Medical Services
Townsville Health Service District

Dr Tony Austin, AM
Chairman, Remote Area Health Corps,
Chairman, National Advisory Committee,
Veterans and Veterans' Families
Counselling Service

Dr Andrew Johnston

Dr Andrew Johnston is the Executive Director Medical Services at Townsville Hospital and the Eminent Staff Specialist for the Townsville Clinical School. He is also Associate Professor in Health Services and Head of Discipline in Medical Leadership and Management, at James Cook University.

He obtained his MBBS at the University of NSW in 1989, a Masters in Health Administration at the University of NSW in 1995 and his FRACMA in 1996. His career started in the Royal Australian Air Force, then branched into the NSW Public Hospital management, private sector in Cairns and then culminated with twelve years at Queensland Health.

Dr Johnson's main areas of interest include patient safety, medical decision making, medical workforce, emergency preparedness and disaster management, medical education and health technology assessment.

Dr Tony Austin, AM

Tony recently retired from the RAAF after a career spanning 28 years. During the early years of his career Tony gained considerable experience in Aeromedical retrieval (both fixed and rotary wing) throughout Australia, South-East Asia and the Pacific region.

Prior to his retirement, Tony spent six years in Canberra with the last three as Head of the Defence Health Services with the rank of Air Vice-Marshal. During this time he gained considerable experience dealing with Ministers, senior government executives and the media. He was also the ADF representative on the Australian Health Protection Committee – the peak body for organising Federal and State health responses to man-made and natural disasters, epidemics and pandemics.

He is currently the Chairman of the Board of the Remote Area Health Corps (RAHC) – a NFP company established to develop a pool of metropolitan health professionals who have the clinical and cultural skills needed to enable them to provide locum support to remote Indigenous health clinics in the NT.

Tony is also the Chairman of the National Advisory Committee (NAC) on the Veterans and Veterans Families Counselling Service (VVCS) answering directly to the Minister for Veterans Affairs and is a Member of the Administrative Appeals Tribunal where he sits on matters relating to veterans, social security or medical disability.

Finally, Tony holds an Adjunct Associate Professorial appointment with the University of Queensland and is a Fellowship examiner with the Royal Australasian College of Medical Administrators. He is the chairman of the RACMA Credentialling Committee and also a voluntary executive coach to several senior health professionals in Australia and New Zealand.

Einstein once said that the definition of insanity is doing the same things over and over again and expecting different results. For this reason the only way that we are going to improve the efficiency and effectiveness of our health care systems is to explore new ways of doing business. Health professionals are by nature a very conservative bunch and they are often loath to introduce new solutions to old problems. The successful introduction of system level change is thus a real challenge for medical administrators working at every level within an organisation. One of the key elements to achieving this success is the ability to manage staff at all levels – subordinates, peers and superiors. This requires clarity of vision, strong technical knowledge and robust leadership skills.

This workshop will use a series of short presentations, followed by interactive small groups, to explore the barriers to achieving successful systemic change. Using several realistic scenarios the groups will also explore the issues associated with managing staff both above and below and thus develop a range of possible solutions that they can take back to their workplaces.

Master Class 2
LEADERS ARE MADE, NOT BORN: ARE YOU THE LEADER YOU WANT TO BE?

Dr Graham Dickson (PhD)
Professor Emeritus, Royal Roads University

Dr Graham Dickson

Dr Dickson is Research Advisor to the Canadian Health Leadership Network, and a member of the Physician Assistants Certification Council of Canada.

Prior to leaving Royal Roads University, Graham was the founding Director of the Centre for Health Leadership and Research. Graham helped develop the Master of Arts in Leadership (Health specialization) at RRU.

Dr Dickson is the principal investigator on two participatory action research studies being conducted in Canada. The first is entitled, Evidence-Informed Change Management in Canadian Healthcare Organizations, a commissioned project for the Canadian Health Services Research Foundation. The second is entitled Leadership in Health Systems Redesign, a CIHR sponsored project, done in partnership with the Canadian Health Leadership Network, key Canadian decision makers and five universities across Canada Dr. Dickson has had a number of articles on leadership published in peer reviewed journals and professional magazines.

Dr Dickson was the principal investigator in the cross-Canada research project on the LEADS in a Caring Environment capabilities framework. This framework has been endorsed by Health Leaders Association of BC; the Canadian College of Health Leaders, and the Canadian Health Leadership Network. Recently, Graham oversaw the writing and publishing of five booklets dedicated to each of the capabilities of the LEADS framework. He co-authored the booklet on Systems Transformation. He has given numerous talks re LEADS across Canada and abroad in the past five years, including Uganda, Hong Kong, Whistler, and London (UK).

Dr Dickson teaches strategic planning for the Canadian Medical Association's Physician Management Institute (based on the LEADS framework). In the past two years he has designed and delivered LEADS programs for the Canadian Agency for Drugs and Technology in Health (CADTH); Eastern Health Region of Newfoundland, Health Canada; the Registered Nurses' Association of Saskatchewan, the Board of the Saskatchewan Medical Association; the Catholic Health Association of Manitoba, and the Atlantic Pharmacists' Association. He recently designed a program on effective teamwork for Accreditation Canada, and on public service leadership for the Tanzanian government. He teaches leadership in the International Foundation of Employee Benefits' Advanced Trustee Management Seminars for Canadian pension and health benefit trustees. Recently Graham presented at the World Federation of Medical Managers' meeting in San Francisco on competency assessment – conducted in partnership with the American College of Physician Executives.

Graham Dickson is a former teacher, administrator, and public servant in the BC civil service, before going out to Royal Roads in 1996.

Are leaders born? Or made? Or both? Leadership is like many other 'learned' attributes. It is both a function of the innate traits you are born with, but also what you do with those traits. As a science, there is a research base to what good leadership looks like in action. There is a 'craft' to leadership. But leadership is also an art. Like music, or art, mastery of the craft of leadership is not enough: it is how it is performed, in context, that determines its success. In this workshop, you will explore the craft of leadership, explore processes to measure your own personal leadership capability, be introduced to the discipline of personal mastery, and lay out an action plan to become the leader you would like to be.

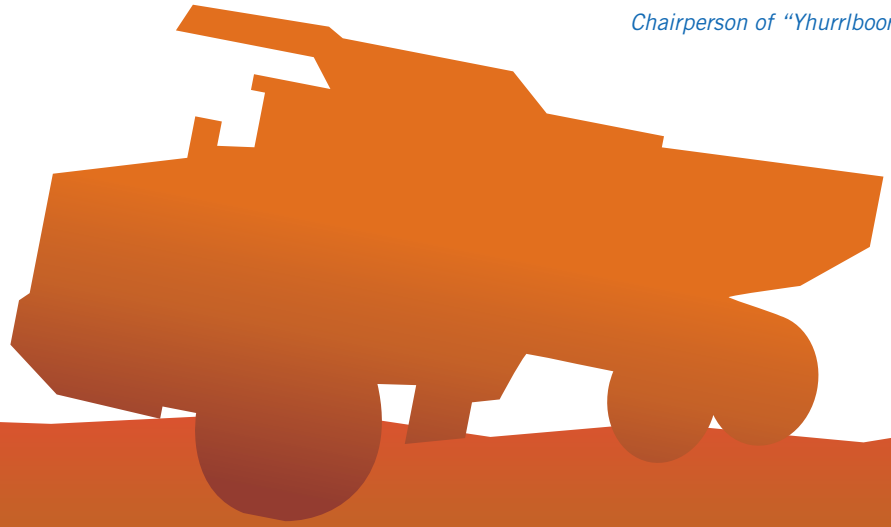
WELCOME TO COUNTRY

Cedric Jacobs

Cedric Jacobs is a highly respected Aboriginal man with over 40 years' experience in business and Aboriginal affairs and has qualifications including a diploma in Agriculture, diploma in Human Behaviour and tertiary qualifications in English. Cedric is formally a teacher and an ordained minister of the Anglican Church. He is the current Chairperson of the Perth Noongar Economic Foundation and Chairperson of the Sovereign Whadjuk Management Association Inc.

Cedric was a foundation Board Member of the Aboriginal Studies Unit at Edith Cowan and Curtin Universities and has held numerous positions including establishing the Aboriginal Housing Board in Western Australia, Chairperson of the "International Year of the Child" Aboriginal Child Committee, member of the Aboriginal representative to National Criminology Board, Chairperson of the Aboriginal Treaty Committee, elected Councillor of the Swan Shire Council, Regional Chairperson of the Aboriginal and Torres Strait Islander Commission, Chairperson of "Yhurrlboordah Land Aboriginal Corporation, Tribunal member on State Homeswest Housing panel, Executive Council member on Aboriginal Legal Service of Western Australia and Deputy- Chairperson of the Stolen Generation Perth Committee.

Cedric was leader of the Aboriginal delegations to the United States and Canada to study Native Americans and Canadians, New Zealand to study Parliamentary Representative system for Maori people, the Geneva International Forum on "Rights of Indigenous People" and State Government Committee to International Indigenous Conference on Education, Albuquerque, New Mexico. Cedric has been awarded the "Paul Harris Fellowship" in recognition for his contribution to humanitarian and educational programs and is a published author including his works "Healing a Divided Nation".



SPEAKER BIOGRAPHIES & ABSTRACTS

Plenary Session 1
BENEFITTING FROM THE BOOM

Kim Snowball
Director General, WA Health

BENEFITTING FROM THE BOOM – STATEWIDE PERSPECTIVE

As Director General of WA Health, Kim Snowball heads a staff of 40,000 and oversees the provision of Hospital and health services to almost 2.3 million Western Australians in a State covering 2.5 million square kilometres. He is also the current Chair of the Australian Health Ministers' Advisory Council.

Mr Snowball is a highly experienced public servant and certified practising accountant, and was previously the Chief Executive of the WA Country Health Service. This followed some fifteen years in senior management and policy development roles in Country Health.

Mr Snowball commenced as Director General in January 2010. He brings with him a wealth of experience in health, having worked in senior leadership roles in both the public and private health sectors, and as a consultant to Commonwealth, State and Territory Governments.

Mr Snowball is responsible for a total health budget of $6.7billion and is at the helm of WA Health during a period of major reform. These health system reforms have included the development of a system of Activity Based Funding and Management and the implementation of the Four Hour Rule Program across all major WA hospitals, both programs now adopted Nationally. He also provides key policy advice to the State Government on the national health and hospital reforms and the priority areas of Aboriginal Health, General Practice, Aged Care and remote service delivery to improve services for Western Australians.

More recently Mr Snowball has focussed on the required reform to the State's Health and Medical Research effort to underpin an investment strategy to improve health outcomes.

Mr Snowball has dedicated himself and the leadership team to improving health outcomes for Aboriginal Western Australians through employment initiatives, better targeted services, and partnerships with Aboriginal Community-Controlled Services to jointly plan and implement health improvement initiatives.

Nicole Roocke
Director, The Chamber of Minerals and Energy of Western Australia

THE MINING PERSPECTIVE

Having been appointed Director, in December 2007 Nicole Roocke has responsibility for the portfolios covering Occupational Safety and Health, Land Access, Environment, Education and Training, Immigration, Skill shortage initiatives, the Kimberley Region, Mine Security Services and internal services.

Prior to this Nicole was employed at CME as the Executive Officer, Safety and Health for a period of four and a half years where she was responsible for coordinating industry input on a variety of

government regulatory and policy issues and facilitating communication within the minerals and resources sector on safety and health in WA.

Prior to joining CME, Nicole was employed in a policy position at the Chamber of Commerce and Industry of WA as an adviser, health and had also worked extensively in the area of workers' compensation and injury management having undertaken policy and systems development.

Nicole is a registered psychologist and has completed a Masters of Science in Industrial and Organisational Psychology from UWA and a Masters in Risk Management from UNSW.

Prof Philip Davies
Professor of Health Systems & Policy,
The University of Queensland

THE EFFECTS OF BOOM TIMES ON HEALTHCARE: THE NATIONAL PERSPECTIVE

Philip Davies was appointed as Professor of Health Systems and Policy in the School of Population Health at the University of Queensland in 2009. Prior to taking up his current position he worked for 6½ years as a Deputy Secretary in the Australian (Federal) Government Department of Health and Ageing where he was responsible for several key areas of health policy including primary care, e-health, pharmaceuticals, pathology and diagnostic imaging services.

From November 2009 to June 2011 Professor Davies served as a Director of GPpartners, one of Australia's largest and longest-established Divisions of General Practice. He was subsequently selected to join the Board of Partners4Health Limited which operates the Metro North Brisbane Medicare Local, one of the 19 'first-wave' Medicare Locals established with effect from 1 July 2011. He is also a Director of Rural Health Workforce Victoria, a not-for-profit company that works to recruit, support and advocate for the health workforce in rural and regional areas of the State.

Professor Davies has undertaken numerous consultancy assignments for AusAID and the World Health Organisation in areas such as human resources for health and development of national health strategies and plans. In a health sector career spanning more than 30 years Professor Davies has also been a Deputy Director-General in the New Zealand Ministry of Health, a Senior Health Economist with the World Health Organization in Geneva and spent 14 years as a specialist health care management consultant with Coopers & Lybrand (now PricewaterhouseCoopers) in the UK and New Zealand. He became a Partner in the New Zealand firm in 1995. Professor Davies holds a first-class honours degree in Mathematics, a masters in Management Science & Operational Research and is a Fellow of the Australian Institute of Company Directors.

Conventional wisdom has it that coping with austerity and parsimony are more familiar than addressing the effects of 'boom times' in health systems. Yet evidence suggests that spending on health in Australia has grown, in real terms, by some 5.3% per year over the past decade despite what might be considered unfavourable macroeconomic conditions that prevailed for much of that period.

Now Australia faces the prospect of significant economic expansion as a result of a burgeoning minerals sector. Health care stands to be a major beneficiary from that growth.

The case of the USA, where health consumes more than 17% of GDP but average life expectancy is no better than in other less wealthy nations such as Chile and Costa Rica, is often cited as an example of wasteful health spending. Thus, 'boom times' may not always be beneficial for health.

This paper explores the relationship between national wealth and spending on health and seeks to consider the challenges of managing growth in health budgets. How can Australia ensure that more health spending delivers a better health system? And what does 'better' actually mean in this context anyway?

Concurrent Session 1
INDIGENOUS AND ADVOCACY ISSUES

1100 – 1120

Mr Ken Wyatt, AM, MP
Parliament of Australia

SEEN BUT NOT HEARD: TACKLING HEALTH STATUS

Ken Wyatt MP is the eldest child of Don and Mona Wyatt who raised ten children who have succeeded in their chosen paths. Ken grew up in Corrigin before moving to Perth to study and work.

Ken started out as a primary school teacher before moving into leadership roles in education, such as the District Director for the Swan Education District. Ken has also held important positions in health. Ken's career has allowed him to stay in contact with our community at many levels. Ken's experiences have shown him the importance that education plays in our community and the need for a health system which has enough doctors, nurses and beds.

Ken has a history of fighting for important programmes in education and health. Ken was part of the team that secured $6.7m for Western Australia out of $13m available from the Federal Government for ongoing Aboriginal education funding. Ken was also on a Council of Australian Governments (COAG) sub-committee which fought and received a record $1.5b from the Federal Government for indigenous health.

Since his election to the seat of Hasluck, Ken has worked tirelessly to advocate for his electorate at a local, state and federal level and has been vocal in raising the wants and needs of his constituents in Parliament.

1120 – 1140

Dr Peter Jansen
Senior Medical Advisor
Accident Compensation Corporation,
New Zealand

LESSONS FROM NZ ON INTEGRATING CULTURES

Dr Jansen (Ngati Raukawa) is a Senior Medical Advisor to the New Zealand Accident Compensation Corporation. ACC has provided comprehensive no-fault cover for personal injuries caused by accident since 1974. Peter has extensive experience as a GP, then as a teacher, researcher and health management advisor for Mauri Ora Associates, and also in pharmaceutical medicine.

He has published a number of papers relating to cultural competence in health care, and led the development of guidelines on Cultural Competence for health related organisations in New Zealand. He received the award of Distinguished Fellow of the Royal New Zealand College of General Practitioners and the Marire Goodall award from the Maori Medical Practitioners Association for this work.

Dr Jansen is also a board member of the New Zealand Health Quality and Safety Commission.

Successive government policies have aimed to assimilate or integrate Maori with other New Zealanders. However despite improved access to services, the health status of Maori stills lags behind Europeans. Government responses to this have included the requirement for health professionals to address cultural competence and a new focus on Maori approaches to health well-being (Whanau Ora). The presentation will highlight key points along the pathway from assimilation to biculturalism and note challenges that lay ahead.

1140 – 1200

Jenni Collard
Director, Aboriginal Health, WA Health

THE HEALTH OF ABORIGINAL BUSINESS IS EVERYONE'S BUSINESS

Jenni Collard is an Aboriginal woman originally from Darwin, Northern Territory. Jenni has cultural connections to both the Jawoyn-Wadaman groups in the Northern Territory, the Inginoo group in Cape York Queensland and the Torres Strait Islands.

Jenni has worked in the State Government of Western Australia for the past 25 years in various agencies. These agencies include the Department of the Premier & Cabinet, Public Sector Standards, Education, Indigenous Affairs and Child Protection.

Jenni has a Bachelor of Business (Accounting) qualification and has been the Director of the Aboriginal Health Division since February 2011. Jenni is married to a Noongar man from the Wheatbelt area of Western Australia and has four daughters.

In the past, funding provided for Aboriginal programs has marginally improved the disparity in health outcomes between Aboriginal and non-Aboriginal people. Over the past few years, there has been significant investment in Aboriginal health, thereby raising the profile across all service delivery areas. The current challenge for WA Health is to implement programs in new and innovative ways to ensure the past is not repeated. How will WA Health achieve this?

This presentation will explore how WA Health is committed to system wide improvements by focusing on three key areas: Aboriginal Cultural Learning, Aboriginal Workforce and Aboriginal Leadership. The innovation in this approach is the underlying principle that Aboriginal and non-Aboriginal people share a responsibility to implement these priorities.

Concurrent Session 2 CONTRIBUTED PAPERS

1100 – 1120

Dr Ian Graham
Director of Medical Services,
Grampians Health Alliance

INTEGRATED CLINICAL EDUCATION PRACTICE AND LEARNING (ICEPAL) – BREAKING DOWN THE SILOS

Dr Ian Graham is a specialist medical administrator (FRACMA) with 25 years' experience in medical management, postgraduate medical education and informatics. He works as a visiting Director of Medical Services for a network of four health services comprising 14 hospital campuses in the Grampians Region of western Victoria. He also runs a consulting practice in medical governance and management, clinician engagement, medical education and informatics. In this capacity he has worked for medical colleges (RACS, RACP, ANZCA); Ernst & Young Health and Risk Advisory practices; and numerous hospitals and health services in Australia and overseas.

The ICEPaL (Integrated Clinical Education Practice and Learning) Project is developing a health professional integrated 'dashboard' to support clinical practice, health professional clinical education and training and Continuing Professional Development for medical, nursing and allied health staff in the Grampians Region of Western and Central Victoria.

The project is utilising 'enterprise wiki' technology, cloud computing, international standards for interoperability of health and educational information systems (MedBiquitous) and the evolving National Broadband Network.

The integration of healthcare education, management and practice in rural Australia has been limited by the siloed nature of the Australian healthcare system. Despite its small population and vast land area, Australia has more than 16 medical schools, 14 medical colleges and hundreds of health services and healthcare facilities. These organisations compete for scarce funds, patients, trainees and information resources. Every organisation and practice has its own clinical data, information and knowledge management systems and websites, few of which connect or integrate in any way.

The rural practitioner or trainee has neither the time nor the inclination to search through these various websites and systems while busy with their own clinical caseload. Good patient care and efficient management of patients is compromised by time wasted with multiple telephone calls, searching unresponsive and poorly laid out websites or dealing with e-learning management systems designed for the classroom or home rather than the clinical workplace.

The enterprise wiki provides tools that allow for easy access and updating of online content. In many ways, it is similar to the Facebook social networking site but it is designed to work in a secure corporate environment and, in this implementation, will support orientation, collaboration, communication, clinical engagement and evidence-based healthcare in small rural practice and hospital settings. It provides a simplified, responsive and easily managed alternative to conventional websites, paper-based documentation and email communication. Users familiar with word processors are able to enter and update information quickly, so that content owners have direct control of their documents rather than having to pass them on to other administrative or technical staff.

Wikis, like Wikipedia, are collaborative tools which grow in usefulness as the community of contributors grows. Like a website, an enterprise wiki comprises a large number of 'pages'. These can be arranged in a hierarchical manner or tree structure so there can be 'parent' and 'child' pages. Each page can contain text, tables, images, links to other pages or websites, video or audio content, and gadgets or widgets such as calendars and search tools. However, unlike conventional static websites, the enterprise wiki is very dynamic, allowing authorised users to create, edit or comment on individual pages. The pages are grouped into discrete areas of the system with users only authorised to enter, view and edit specific 'spaces'.

This presentation will outline the development of the ICEPaL approach and demonstrate key aspects of the evolving health professional 'dashboard'.

1120 – 1140

Presenter: Dr Jill Newland
Director Of Clinical Support, Rural And Remote Health, Queensland Health
Authors: Jill Newland and Rosemary Schmidt

PRIMARY CLINICAL CARE MANUAL – DRIVING IMPROVEMENTS IN SAFE HEALTH SERVICE PROVISION IN RURAL AND REMOTE SETTINGS

Dr Jill Newland is the Director of Clinical Support in the Office of Rural and Remote Health, Queensland Health. Staff of the Clinical Support Unit provide clinical governance advice to staff in rural and remote health facilities throughout Queensland. The unit also manages the credentialing and scope of practice services for all rural locum general practitioners throughout Queensland. Jill has previously held positions as Director of Clinical Support in the Northern Area Health Service and Executive Director of Medical Services at Cairns Base Hospital. She has worked in administrative positions within Queensland Health since 1983.

Queensland Health, through the Office of Rural and Remote Health (Cairns) partners with government and non government primary healthcare providers to produce the Primary Clinical Care Manual (PCCM), an evidence based clinical practice manual for use in primary care settings. Designed for multidisciplinary teams, including nurses, nurse practitioners, midwives, health workers, medical officers and Queensland Ambulance Isolated Practice Area Paramedics, use of the PCCM improves the standard of health care delivery in rural and remote settings. As the manual becomes better known, it is increasingly being used in outer metropolitan/outer urban area locations. The manual is published as a partnership collaboration between Queensland Health and the Royal Flying Doctor Service (Queensland Section).

As well as in Queensland, the PCCM is used by Health Departments in Victoria, New South Wales, Western Australia, non government healthcare providers including the Royal Flying Doctor Service, Aboriginal and Torres Strait Islander Health Services, mining companies, correctional institutions, James Cook University, University of Southern Queensland and the Armed Forces of Australia – Army, Navy and Airforce. The PCCM is available in electronic and print versions.

Published every two years, it is written to comply with the principles for clinical guidelines as set out by the National Health and Medical Research Council1. It contains Health Management Protocols and Drug Therapy Protocols, which require updating every two years, as per the Queensland Health (Drugs and Poisons) Regulation 1996.

The manual is peer reviewed and endorsed by Queensland Statewide Clinical Networks. Contributors include Apunipima Cape York Health Council, Royal Flying Doctor Service – Queensland Section, Queensland Ambulance, New South Wales Health Service (Greater

Western Health Service); James Cook University, Queensland Aboriginal and Torres Strait Island Health Council, Queensland Poisons Information Centre, Royal Australian Navy – Fleet Health Support Unit and Queensland Health. Incorporating relevant Coroners' recommendations and clinical incident analyses, it provides the rural and remote workforce with information to drive quality improvement and enhance patient safety.

Clinical audit against the PCCM standards will provide evidence for primary centres of their progress towards meeting the relevant Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards 2.

Multidisciplinary rural and remote health care providers benefit through use of the PCCM by providing safer primary care, in turn helping reduce patient referral for hospitalisation and presentations to Emergency Departments.

From a medical administrator's perspective, knowledge of and support for the PCCM's use in smaller facilities can help facilitate good clinical governance and improve patient care. Many medical administrators have overall responsibility for smaller facilities and use of tools such as the PCCM can improve standards of care and provide some reassurance to the medical administrator.

1140 – 1200

Dr Ross Lamplugh
Chairman, Ochre Health Group

EASY ENTRY, GRACIOUS EXIT 10 YEARS ON – WHAT ARE THE LESSONS WE HAVE LEARNED?

Ross graduated in 1991. After basic surgical training he briefly left clinical medicine to pursue other business interests and also worked in Medical Administration for the Tasmanian Health Department. Following his return to clinical medicine and a stint as Medical Superintendent on Palm Island he spent 8 years in Bourke as a GP Anaesthetist.

In 2002 Ross and a colleague founded Ochre Health which operates in 14 rural Australian towns as well as urban areas of Canberra, providing medical centre and hospital staffing services. In many of these communities Ochre Health has re-established services to chronically understaffed remote towns.

The Ochre Health Group is a for profit entity established in 2002 which manages general practice and hospital services in 14 disadvantaged communities in rural Australia. It also contains Australia's largest rural medical recruitment agency – Ochre Recruitment.

Rural and Remote Medical Services (RaRMS) is a not for profit entity established in 2001 to provide practice management support to rural medical practices. RaRMS currently manages services in 4 rural and remote communities in NSW.

Although both organisations were developed independently they employ a similar 'easy entry, gracious exit' model to attract and retain doctors and to expand nursing and allied health services in rural communities. This similarity is perhaps not unexpected given that founding members of both organisations are experienced rural and remote practitioners who intimately understand the challenges and opportunities of rural and remote medicine, and are passionate about the provision of quality medical services to these communities.

The 'easy entry, gracious exit' model provides communities with greater continuity of service while freeing doctors to work as clinicians and removing the emotional, business and financial complexities of owning a practice.

Ten years on, and both Ochre Health and RaRMS, continue to use and develop the 'easy entry, gracious exit' model to deliver services to rural Australia. The experience of both organisations has been that this model, when used in a flexible manner and adapted to the needs of individual communities and doctors, is successful in increasing doctor numbers and stabilising the medical workforce.

This presentation explores the similarities and differences between Ochre's private and RaRMS' not for profit version of the 'easy entry, gracious exit' model, and the issues that each organisation has faced over the past ten years. The paper will discuss key learnings on how to maintain medical services in rural and remote communities in Australia.

1200 – 1220

Dr PK Loh
Head of Department Geriatric Medicine, Royal Perth Hospital

FLY IN FLY OUT(FIFO) AND DRIVE IN DRIVE OUT(DIDO) FOR AGED CARE SERVICES IN RURAL AND REMOTE WESTERN AUSTRALIA (WA)

Dr PK Loh is head of department of Geriatric Medicine at the Royal Perth Hospital, Perth, Western Australia. He is a fellow of the Royal Australian College of Physicians and Royal Australian College of Medical Administrators.

The Department of Geriatric Medicine (DGM) in Royal Perth Hospital provides a Fly in Fly out (FIFO) clinical service to the Pilbara and Kimberly Regions of Western Australia. Whereas it provides a Drive in Drive out (DIDO) service to the town of Northam and the Wheatbelt region. In the past DGM also provided DIDO service to the south west region and town of Bunbury. Staff Specialist and Advance Trainees from DGM travel to these regions to provide a clinical service to the aged and disabled populations of those communities. The logistics of providing FIFO and DIDO in aged care will be presented. FIFO and DIDO may be provided as a public hospital or a private practice arrangement. The increased use of FIFO in the WA mining sector has provided logistic challenges for FIFO services in aged care. These challenges impinge on both the providers and recipients of the geriatric medicine or aged care services. The demands of providing a FIFO service in the current environment, human resource issues and the option of moving away from a FIFO or DIDO service will be presented. These options include Telehealth and the challenges of recruiting local geriatric medicine specialist in the rural and remote areas of Western Australia.

1245–1315

THE EFFECTS OF BOOM TIMES ON HEALTHCARE: THE INTERNATIONAL PERSPECTIVE

Lunchtime Presentation
pre-recorded presentation

Sir Muir Gray
Director of the National Knowledge Service and Chief Knowledge Officer to the National Health Service and Public Health Director of the Campaign for Greener Healthcare

Sir Muir Gray is Director of the National Knowledge Service. The National Library for Health, a core service of the National Knowledge Service, will organise the best current knowledge and the National Knowledge service will deliver it to staff and patients wherever and whenever they need it. He has recently been given the role of Chief Knowledge Officer for the NHS and is closely involved in the provision of knowledge not only to clinicians but also to patients and those who manage healthcare.

In his previous post as Director of Research and Development for Anglia and Oxford Region, he was in a position to support the UK Cochrane Centre in its early days, and to set up the Centre for Evidence-Based Medicine. For 10 years he was Programmes Director for the UK National Screening Committee.

Sir Muir Gray is the author of Evidence-Based Healthcare, the third edition of which is in preparation, and joint author of The Oxford Handbook of Public Health Practice. His most recent books are The Resourceful Patient, Evidence-Based Surgery and How To Get Better Value Healthcare.

Sir Muir Gray's most recent venture in 2008 has been to set up a charity called Knowledge Into Action. This is separate from his NHS work but is based on the same fundamental belief that we can improve health by the application of the best knowledge through the best systems. The charity has several programmes, including The Campaign for Greener Healthcare, The National Walking Campaign, and Oxford Health Systems. He has also started using digital broadcasting to share his experience.

Plenary Session 2
HEALTH CARE REFORMS

Ms Jane Halton
Secretary of the Department of Health and Ageing

NATIONAL HEALTH CARE REFORM – A SUMMARY OF KEY COMMONWEALTH MEASURES

Jane Halton is Secretary of the Australian Department of Health and Ageing. She is responsible for all aspects of the operation of the Department including the provision of advice on and administration of Medicare, the Pharmaceutical Benefits Scheme, Aged and Community Care, Population Health, regulation of Therapeutic Goods, plus hospital financing and Private Health Insurance. She also has responsibility for leadership on health security issues, including matters related to bioterrorism.

Jane is a member of the board of the Australian Institute of Health and Welfare, a board member of the National E-Health Transition Authority and a Commissioner of the Australian Commission on Safety and Quality in Health Care. She is also on the executive board of the Institute for Health Metrics and Evaluation at the University of Washington and on the Advisory Boards of the Centre for Applied Philosophy and Public Ethics (CAPPE), and the Melbourne Institute Advisory Board.

Jane is the chair of the OECD's Health Committee. She was an Executive Board Member on the World Health Organisation (WHO) 2004–2007 and President of the World Health Assembly (2007), and was Vice-Chair of the Executive Board 2005–2006 and Chair of the WHO Program, Budget and Administration Committee 2005–2007. She is currently Chair of the WHO Intergovernmental Meeting on Pandemic Influenza Preparedness.

Jane was a Commissioner of the Health Insurance Commission from 2002 to 2005 and was Chair of the Australian Obesity Taskforce (2003–2006). She also chaired the National Aboriginal and Torres Strait Islander Health Council between 2002–2008. She was co-chair of the Organisation for Economic Cooperation and Development (OECD) Group on Health between 2002–2007. Jane was also a Commissioner of the Australian Sports Commission between 2008–2010.

Prior to her appointment in January 2002 as Secretary of the Department of Health and Ageing, Jane Halton was Executive Co-ordinator, Department of the Prime Minister and Cabinet (PM&C) and was responsible for advising on all aspects of Australian Government Social Policy including the Status of Women.

Prior to joining PM&C, Jane Halton was national program manager of the Australian Government's Aged and Community Care Program with responsibilities for long term care. Jane holds an honours degree in Psychology from the Australian National University, is a fellow of the Australian Institute of Management and an honorary fellow of the Australian College of Health Service Executives. She was awarded the Public Service Medal in 2002, and the Centenary Medal in 2003. Jane is married with two sons.

Australia's health system is amongst the best in the world. However, demands on the system are increasing due to an ageing population, increased rates of chronic and preventable disease, new treatments becoming available and rising health care costs.

The Commonwealth Government has taken action to address these challenges, working with states and territories to secure a truly national agreement on health reform. The Commonwealth, states and territories have agreed to major reforms to the organisation, funding and delivery of health and aged care. These reforms will provide better access to services, improved local accountability and transparency, greater responsiveness to local communities and a stronger financial basis for the health system into the future.

Ms Halton will give an overview of key reform measures that have been implemented to improve the health system for all Australians.

Dr Tony Sherbon
Chief Executive Officer of Independent Hospital Pricing Authority

IHPA AND ACTIVITY BASED FUNDING

Before taking up the position of Acting Chief Executive Officer in the Independent Hospital Pricing Authority in September 2011, Dr Tony Sherbon had 21 years' experience in clinical and administrative management within the NSW, ACT and South Australian health systems. Dr Sherbon is currently working on the establishment of the Independent Hospital Pricing Authority agreed at the Council of Australian Governments meetings held in April 2010 and February 2011. Dr Sherbon previously oversaw the design and implementation of the SA Government's Health Care Plan in his previous role as Chief Executive of SA Health as well as being a former chair of the Australian Health Ministers Advisory Council, and has previously been a Board member of the South Australian Health and Medical Research Institute, National E-Health Transition Authority and Health Workforce Australia.

The Independent Hospital Pricing Authority (IHPA) commenced operations in December 2011 and is charged with the responsibility of introducing some key elements of activity based funding for public hospitals in Australia. The Commonwealth legislation that created the IHPA was based on the National Health Reform Agreement signed by all first ministers in August 2011.

In June 2012, IHPA published its Pricing Framework and the National Efficient Price for the 2012/13 financial year which will provide a firm basis for hospital managers to plan for the uncapped introduction of activity based Commonwealth funding from 1 July 2014. Commonwealth payments to Local Hospital Networks will be based on this National Efficient Price from 1 July 2012 although a guarantee of funding will apply at jurisdictional level for the 2012/13 and 2013/14 financial years which are transitionary years under the Agreement.

IHPA has also drafted criteria that will be used to determine which public hospitals are activity base funded and which will be block funded. This has important implications for all small hospitals in Australia.

IHPA is also responsible for designing and implementing new activity based funding systems for mental health, subacute care and teaching, training and research in all Australian public hospitals and has commenced work on these issues.

Dr Christine Bennett
Professor and Dean, School of Medicine
The University of Notre Dame Sydney

ARE WE THERE YET?

Dr Christine Bennett was appointed to the role of Professor and Dean, School of Medicine, Sydney, The University of Notre Dame Australia in May 2011. Prior to this appointment, Dr Bennett was the Chief Medical Officer for Bupa Australia Group.

Dr Bennett is a specialist paediatrician and has over 25 years of health industry experience in clinical care, strategic planning and senior management in the public, private and not-for-profit sectors. She is a Fellow of the Royal Australasian College of Physicians and has an active commitment to and involvement in medical professional issues, social policy and medical research.

In February 2008, Dr Bennett was appointed by the then Prime Minister Kevin Rudd to be Chair of the National Health and Hospitals Reform Commission that provided advice to governments on a long term blue print for the future of the Australian health system. The report was presented to the Government in June 2009.

Dr Bennett's experience has included being Partner in Health and Life Sciences for KPMG Australia, CEO of Research Australia, CEO of Westmead Hospital, General Manager for the Royal Hospital for Women and Head of Planning in NSW Health. She has held many Non-executive Director roles for private and publicly listed companies, as well as government and charitable organisations. Dr Bennett is currently of the board of Obesity Australia.

Dr Bennett is also the Chair of:

- *Research Australia promoting health and medical research in Australia;*
- *The Sydney Children's Hospitals Network;*
- *The Australian National Preventive Health Agency Advisory Council;*
- *The Bupa Health Foundation Steering Committee.*
- *Dr Bennett is a Non-Executive Director of Bupa Health Dialog.*

This presentation will look at the current state of health reform in Australia. It will ask 'Are we there yet?' when it comes to the journey of health reform that was started under Prime Minister Rudd and continued by Prime Minister Gillard. Professor Bennett will draw on her experience as Chair of the National Health and Hospitals Reform Commission to look at reform of the financing and governance arrangements of the health system. She will draw explore the strengths and weaknesses of the reform

to date in discussing the need for further reform to put healthcare on a sustainable footing. She will also examine progress towards significant action on public health challenges, and the infrastructure to enable better sharing and use of data by clinicians and to give patients access to their own health information through the Person Controlled Electronic Health Record (PCEHR).

Concurrent Session 3
QUALITY AND SAFETY

1515 – 1535

Dr Amanda Ling
Director – Office of Safety & Quality in Healthcare, Senior Medical Advisor, Performance, Activity and Quality Division Department of Health

IMPROVING CARE, MANAGING RESOURCES, DELIVERING QUALITY

Dr Amanda Ling is the Clinical Lead for the ABF/ABM Program and Director of the Office of Safety and Quality in Healthcare at the Department of Health.

Amanda has worked using an activity based approach (casemix) across a range of healthcare settings. These include paediatric and adult services, and across tertiary and secondary care as well as integrating a casemix approach across secondary, primary and community based care.

She has been actively involved in patient safety and quality improvement in both public and private sectors, and is committed to ensuring patient safety is a core component of ABM.

Amanda trained as a GP and biostatistician. Prior to joining the Department of Health in 2010 she was an Executive at the Sir Charles Gairdner Group for five years.

WA Health has taken an integrated approach to performance, activity and quality since the introduction of Activity Based Funding and Management (ABF/ABM) in 2010. The stated aim of ABF/ABM is "to deliver safe care of the highest quality in a timely manner, to citizens and patients who need it, at an agreed price". Dr Ling will share how WA Health is building on strong foundations of clinical engagement and reform, evidence based care and safety and quality programs to make local and national health reform meaningful for patients and staff in WA.

1535 – 1555

Dr Liz Mullins
Principal, Mullins Health Consulting

COMPLYING WITH THE NEW NATIONAL STANDARDS

Liz is a medical and sciences graduate of the University of Melbourne with twenty-five years experience in clinical and management aspects of health care.

Following work in the public hospital system in Victoria, in both general medicine and management, she worked in the UK and the US from 1992–1997. During this time, she was responsible for developing teaching materials on clinical pathways and clinical risk management, facilitating their implementation in many major and diverse health organisations. In early 1997, Liz returned to Victoria and assisted in establishing Healthcare Risk Resources International (HRRI) Australia, a national clinical risk management consultancy.

In July 2007, HRRI came under the umbrella of the Avant Mutual group of companies. Avant is Australia's largest medical defence organisation, supporting a significant membership base. As National Manager of Risk Management Resources, Liz led a team who develop tools and strategies to assist in reducing risk in individual practitioner practice and hospital settings.

Liz has worked with most state governments, most private hospital groups and a wide range of medical colleges. She seeks to assist clients to bring out the very best out of their people and from their clinical risk management systems.

In March 2010, Liz and colleagues established Mullins Health Consulting. This group aims to build on their regarded reputation to work in both the public and private healthcare sector to reduce clinical risk and improve safety by better engagement with clinicians, managers and the system. They work in a broad range of organisations, always focusing on optimising structures and processes to optimise outcomes for the patients and the organisation.

Liz is a Fellow of the Royal Australasian College of Medical Administrators (RACMA) and is a member of the Australian College of Health Service Executives (ACHSE). Liz is a clinical tutor at the University of Melbourne St Vincent's Hospital Clinical School and is a member of the Victorian Health Services Review Council.

The challenge of implementation of the new national standards is, in part, the challenge of implementing new terms, new phrases, new colours, new symbols but old problems to an often overworked, tired and somewhat disillusioned workforce.

This paper outline an approach which harnesses existing structures , roles and processes within an organisation – regardless of size – to embrace the opportunity that the National Standards bring to clinicians, managers and patients.

Areas to be discussed include:

- New or re-vamped committees
- Role of clinician leaders
- Role of quality and risk personnel
- Engagement of medical staff
- Use of data in terms of standards
- Role of Executive.
- Value of the Board in leading this process and understanding their role in meeting the Standards.

Contemporary small, rural and larger public hospital experiences will be discussed.

1555 – 1615

Brian Johnston
Chief Executive, The Australian Council on Healthcare Standards

EMBRACING THE NATIONAL STANDARDS; THE ACHS EXPERIENCE

Brian has been Chief Executive of The Australian Council on Healthcare Standards since November 2000 and its international business entity, ACHS International, since its establishment in 2005. His professional career has been spent in the health industry. Established in 1974, the ACHS is the leading independent authority on the development, implementation and assessment of quality improvement systems for Australian health care organisations. ACHS activities include standards development, performance assessment, education, information dissemination and research. He has been a member of the International Society for Quality in Health Care's Accreditation Program Council since 2001 and was its elected Chair from 2006 to 2009. He was awarded Life Membership of the Society in 2010. He is a Fellow of the Australasian College of Health Service Management, a Fellow of the Australian Institute of Company Directors and a Fellow of the Australian Institute of Management. He holds an appointment as Visiting Fellow in the Australian Institute for Health Innovation, at the Faculty of Medicine, University of New South Wales.

The only constant is change. The implementation of the National Safety and Quality Health Service Standards brings with it an interesting array of changes and challenges. The Standards are a key component of the new model for accreditation that arose from the Patterson Review in 2005. They move the fulcrum on the safety and quality continuum towards compliance and, in the minds of some, lessen the emphasis on continuous quality improvement.

There are two perspectives worth exploring as to the ACHS experience so far. Firstly, the changes made by ACHS to its programs as it embraces the National Standards and, secondly what the experiences have been of our member organisations as they alter their internal quality and safety systems during

the implementation phase. Information collected from gap analyses of progress towards implementation of the National Standards by member organisations will be discussed; it provides useful pointers for establishing 'deep and meaningful relationships' with the National Standards.

Concurrent Session 4
MEDICAL WORKFORCE

1515 – 1545

Mark Cormack
Chief Executive Officer Health Workforce Australia

HOW DO WE PROVIDE A MEDICAL WORKFORCE IN RESPONSE TO THE CHANGING NEEDS OF OUR RURAL AND REMOTE AREAS?

Mark Cormack was appointed as the first Chief Executive Officer of Health Workforce Australia (HWA) in January 2010.

HWA is Commonwealth statutory authority, established by COAG as the national workforce agency to plan, fund, research and deliver programs for the enhancement and development of Australia's health workforce.

Prior to this Mark was Chief Executive of ACT Health from July 2006 to January 2010. ACT Health is the ACT Government agency responsible for the provision of public health, hospital and healthcare services to the ACT and region.

Mark has also filled a number of national roles in the public health care system:

- *Australian Health Ministers Advisory Council (AHMAC) – member*
- *Chair of the Health Policy Priorities Principal Committee (HPPPC), the National Health Policy Standing Committee of the Australian Health Ministers Advisory Council (AHMAC).*
- *Board director of the National E Health Transition Authority (NEHTA)*

Mark Cormack has a Bachelor of Applied Science (University of Sydney) and Master of Health Management (University of Wollongong). Mark has worked in and for the public health care sector in various capacities as a health professional, senior manager, policy maker, planner and industry advocate for 30 years.

The primary tenet of any change is that you know what you have now and what you need in the future. This is as true for the rural and remote medical workforce as it is for any other significant change.

Health Workforce (HWA) is the national body tasked with reforming Australia's health workforce.

In bringing about change, HWA is building the evidence base on the current and future workforce, undertaking workforce planning, and putting in place targeted responses (usually in partnership and collaboration) that meet the aims of that planning.

Introduction to HWA – Our key role in COAG health reforms.

The rural and remote health workforce – What we know from HWA's landmark study Health Workforce 2025 (released in April 2012). A key finding is that the distribution of doctors in rural and remote Australia will continue to be a significant issue over the next decades.

A strategy to respond to rural and remote health workforce issues – The context in which HWA works is the National Strategic Framework for Rural and Remote Health and the 'Close the Gap' program to achieve better outcomes in Indigenous health. In this context, HWA has developed the national Rural and Remote Health Workforce Innovation and Reform Strategy, which will be considered by Australia's Health Ministers in November this year. The strategy will provide national guidance on future needs and reforms to improve the health and aged care services in rural and remote communities.

Examples of targeted initiatives we have already commenced – HWA supports and manages a number of initiatives already targeted at the rural and remote medical workforce, including:

- Rural medical generalists – HWA is looking at how to grow the number of rural medical generalists to provide general practice as well as hospital or specialist services in rural and remote areas.
- Rural dual-trained physicians – HWA is working with the Royal Australian College of Physicians to explore a dual-trained physician model for rural communities.
- International health professional recruitment to rural and remote areas – HWA in 2012–13 will review the pathways that allow international health professionals to practise in Australia, with the aim of streamlining pathways and looking at how best to deploy professionals across Australia.

1545 – 1615

Denis Lennox
Executive Director & Senior Advisor Medical Services; Office of Rural & Remote Health Policy, Strategy & Resourcing Division, Queensland Health

THE QUEENSLAND PERSPECTIVE TO PROVIDE A MEDICAL WORKFORCE TO RURAL & REMOTE COMMUNITIES

Dr Denis Lennox is Queensland Health's Executive Director of Rural and Remote Medical Services in the Office of Rural and Remote Health and an advisor to the Deputy Director General, Policy, Strategy and Resourcing. He chairs the Department's Medical Advisory Panel and State Recognised Practice Committee.

Denis received primary and secondary education in Bundaberg, a medical degree from the University of Queensland and a degree in health administration from the University of New South Wales. Upon graduation in medicine he commenced hospital-based clinical practice. An unexpected opportunity of medical management experience in Bundaberg prompted a vocational medical career in management commencing with appointment at the Royal Brisbane Hospital as Queensland's first registrar in Medical Administration. He has subsequently served in various management, policy and strategy roles in the Corporate Office of Queensland Health and in the Toowoomba Health Services. He resides in Toowoomba with a pastoral ministry in a small community church.

Innovation in medical service, education and workforce and community engagement are the contributions Denis brings to health in Queensland over a thirty-five year career, with a regional and rural focus for the last twenty-four.

With the acknowledged generous support of colleagues, Denis established rural medical training at the Toowoomba Hospital in the late 80's and the Cunningham Centre as a multidisciplinary rural training unit. The early years in the current position were focused on the rural international medical graduate (IMG) workforce.

For the last nine years, the focus of his attention shifted to systematic reform of the status of rural medical practice and of supply of Australian graduates to the rural medical workforce. During the proceedings of the Bundaberg Hospital Commission of Inquiry which he was invited to assist, the then Minister for Health announced the Government's intent to recognise rural generalist doctors as "specialists" so initiating Queensland's planned rural generalist reform. This reform has now gained recognition of the discipline in professional and industrial terms and established an integrated vocational pathway to practice in Rural Generalist Medicine from secondary school.

In both his past and current endeavours, Denis acknowledges the inestimable support of his wife Shirley, family and colleagues in health service and education.

A "tops and tails" report by two rural generalist trainees performing their first Caesarean Section "solo" in Longreach is exemplary evidence: Evidence of a supply line delivering quality and passionate Australian graduates into Rural Generalist Medicine for at least the prime portion of their career.

The twentieth century closed with grim prospect of a new century succession to the rural medical generalists whose huge personalities are remembered with fondness and exploits recounted with reverential awe. Many pronounced the end of an era of practitioners equally competent in general practice as in secondary practice e.g., in obstetrics or anaesthetics. Some seriously proffered a fleet of retrieval helicopters as the likely medical service alternative for most rural residents.

A 2001/02 workforce survey offered a glimmer of hope. Closure of an international graduate supply line option in 2003 forced the question of prospect for a designed renaissance in Australian graduate supply.

The design of key pillars of rural medical generalist supply line reform emerged from consultation during 2003/04: The first a mechanism of State recognition of rural generalist practice (accomplished in 2008) and the second a vocational pathway joining up medical school to early, safe entry into such practice requiring minimal relocation.

A landmark industrial agreement in 2005 provided key pillar three – a mechanism to value rural generalist practice for its true worth – and political endorsement of the whole program. The new supply line opened in 2007 with heartening interest.

Concurrent Session 5
MARGARET TOBIN CHALLENGE AWARD

The Margaret Tobin Challenge award is the College's prestigious oral presentation competition where Candidates showcase their health services research work in a dynamic and entertaining forum. Presentations are judged on their relevance to the conference theme and sub themes, content, flow, handling of questions and presentation style. The judging panel this year will comprise the RACMA President, RACMA Vice President, Chair, Continuing Education Program Committee and Past President, Hong Kong College of Community Medicine. The session will be chaired by the Chair, Education and Training Committee and the award winner will be presented with a cheque for $1500 and a medallion at the Conferment Ceremony and Langford Oration.

1515–1535

Dr Philip Reasbeck
Victoria

DOCTORS AND MANAGERS – NEVER THE TWAIN SHALL MEET?

1535–1555

Dr June Song
New South Wales

INTERNS AND THE PRIVATE SECTOR

1555–1615

Dr Leah Barrett Beck
Queensland

RIGHT DOCTOR, RIGHT TIME, RIGHT PATHOLOGY RESULT: IMPLEMENTING ONLINE PATHOLOGY VERIFICATION IN THE TERTIARY SETTING

1615–1635

A/Prof Albert Lee
Hong Kong

PARADIGM SHIFT IN MANAGING NON-COMMUNICABLE DISEASES: MOVING BEYOND THE HEALTH SECTOR

LANGFORD ORATION

1730–1800

Rear Admiral Robyn Walker, AM
Surgeon General, Australian Defence Force

CHALLENGES FOR THE MILITARY HEALTH CARE SYSTEM

Robyn Walker qualified as a medical practitioner in 1982 and worked in the public health system in Queensland, Australia until 1990. Rear Admiral Walker joined the RAN as a direct entry medical graduate in 1991 with the intent to continue her career in diving medicine.

Early postings in the Royal Australian Navy included HMAS ALBATROSS (the Naval Air Station), the Submarine Escape Training Facility at HMAS STIRLING, the Submarine & Underwater Medicine Unit at HMAS PENGUIN and HMAS WESTRALIA.

In January 1996 Lieutenant Commander Walker assumed the position of Officer in Charge of the Submarine & Underwater Medicine Unit and remained there until her promotion to CMDR in July 2000. On promotion she posted to Maritime Headquarters as the Deputy Fleet Medical Officer which included significant Sea Training Group responsibilities.

In July 2002 Commander Walker posted to Defence Health Service Branch in Canberra as Director of Preventive Health prior to her posting on promotion in January 2003 to CAPT as Chief Staff Officer Health (J07) at Headquarters Joint Operations Command in 2004. In this position she was responsible for coordinating the health care to ADF operations in Iraq, Solomon Islands, East Timor and for the Banda Aceh tsunami response.

On 04 July 2005 she took up, on promotion, the position of Director General Strategic Health Policy and Plans in the Defence Health Services Division. Commodore Walker was posted to the position of Director General Garrison Health Support within Joint Health Command on 11 August 2008 and to Director General Health Capability on 01 February 2010. Commodore Walker has also been dual hatted as the Director General Navy Health Service since August 2008.

Commodore Walker was appointed as a member in the Military Division of The Order of Australia on 26 January 2010 for exceptional service as a medical officer in the ADF. She was named as the ACT Telstra White Pages Community and Government Business Woman and overall Telstra ACT Business Woman of the Year in September 2011.

Rear Admiral Walker assumed the position of Commander Joint Health and Surgeon General Australian Defence Force in December 2011.

Rear Admiral Walker is a qualified medical practitioner, a specialist medical administrator, has a Diploma in Diving and Hyperbaric Medicine and is a Graduate of the Australian Institute of Company Directors. She is the author of a number of scientific publications relating to diving medicine and is co-author of a major international diving medicine textbook. She remains an avid recreational diver.

The Australian Defence health care system is designed to prevent and minimise the impact of operational, environmental and occupational health threats and to treat ill and injured members. These actions conserve the combat strength of the ADF and maximise its operational preparedness to undertake the duties required by Government. Defence has a commitment to managing the health consequences of operational service as well as providing health treatment to ill and injured personnel. ADF personnel are entitled to comprehensive health care that is related to Defence service or clinically necessary for the management of non-compensable illnesses and injuries.

The Australian Defence Force health care system must provide this care both within Australia and in the deployed environment and there is an expectation that the care provided in all locations will meet the contemporary standards enjoyed by all Australians within the civilian health care sector. Whilst there are many similarities between the military and the civilian health care system (such as financial and workforce pressures) there are also different challenges faced by medical administrators in the provision of this care. Maintenance of clinical governance in a deployed environment, the ethics of health support to combatants, detainees and local populations, provision of health care to colleagues and working in an organisation where health care is not the primary role of the organisation are just some of these challenges. This presentation will address both these similarities and differences from a medical administrator perspective.

Plenary Session 3
RURAL & REMOTE MEDICINE

0845 – 0915

Dr Felicity Jeffries
Chief Executive of the Western Australian Country Health Service

RURAL AND REMOTE MEDICINE – WA COUNTRY HEALTH SERVICE

As the current Executive Director of Clinical Reform at WA Country Health Service & previous Director of Western Australian Centre for Rural and Remote Medicine, Dr Jefferies has extensive knowledge of rural recruitment and workforce issues.

Also included in her portfolio are Aboriginal Health, Postgraduate Medical Education, Telehealth and the Southern Inland Health Initiative (SIHI) – a $565 million package to improve health care for the people of the southern inland region. Dr Jefferies was a member of the Medical Board of WA and now represents WA on the Health Workforce Australia board. As a General Practitioner with extensive rural experience and as an administrator she brings with her crucial knowledge in providing innovative solutions to rural and remote workforce challenges.

The WA Country Health Service employs 9,000 employees, has 70 hospitals and services approximately 25% of the WA population. The country health service regions cover 2.5 million square kilometres and 80% of trauma originates in country WA. Health service delivery is managed by a generalist model and requires proactive management of rural medicine opportunities and training to attract and retain the rural medical workforce. The Rural Practice Pathway is a collaborative training pathway for all stages of training from medical student through to internship, prevocational and vocational training. Growing the number of rural junior doctor training places in WA has been made possible with the support of Royalties for Regions funds and the collaboration of WA Country Health Services with the Rural Clinical School of WA, WA General Practice Education and Training, AMA Doctors in Training and Rural Health West. This initiative provides a definitive pathway for doctors with an interest in rural medicine, supporting the development of the future rural medical workforce for WA.

0915 – 0945

Tina Chinery
Chief Operating Officer Southern Country Health Service, Western Australia

SERVICING A RURAL COMMUNITY

Tina Chinery is the Chief Operating Officer Southern Country Health Service. The Southern Country catchment area covers more than 227 000 km2 with a population of over 300 000, of whom 3.1 per cent are Aboriginal. The population represents 13 per cent of Western Australia's total and is projected to grow to more than 350 000 by 2020. The health service she leads includes acute and primary health care services ranging from hospitals through to aged care and employs approximately 3400 staff. Prior to this role Tina was the Regional Director for country health in the Pilbara Region.

Tina has been working in rural health for over 20 years starting her career as a registered nurse in the late 1980's and completing a post graduate diploma education in 1996. Tina commenced working in health leadership roles in early 2000 and her leadership skills were recognised when she was nominated by the Director General to undertake leadership development. She completed the Delivering the Future Program WA Health in 2010 and is currently studying her Executive Masters of Public Administration through ANZSOG. Tina is an active member of the Country Health Services (CHS) Leadership Group and a member of CHS Executive.

The presentation provides an overview of a health administrators experience in managing state and federal funded health services in the Pilbara Region Western Australia during the period 2007 through to 2012. The Pilbara Region covers a total area of 507,896 square kilometres extending from the Indian Ocean to the Northern Territory border (including offshore islands).

The Pilbara Health region is divided operationally into Inland, East and West Pilbara health districts. The region is one of seven regions that make up the largest country health service in Australia called WA Country Health Service.

The presentation describes a health administrator's challenges of providing health services in a region where there is a mining boom. As well as highlight some of the challenges the presentation will also highlight opportunities and lessons learnt.

0945 – 1015

Dr Stephen Langford
Medical Director, RFDS Western Operations

THE ROYAL FLYING DOCTOR SERVICE. A VIEW FROM THE COCKPIT

Dr Stephen Langford is Director of Medical Services for the Royal Flying Doctor Service in Western Australia. He commenced working as a flying doctor in 1983 in northwest WA, and has subsequently spent almost 30 years involved in rural health, telehealth and retrieval medicine.

His responsibilities include clinical policies, recruitment and credentialing of medical staff, the strategic direction of emergency retrieval services, and clinical standards. He instigated a Statewide telehealth number for the RFDS in the early 1990s and the single point coordination system for air medical transport across WA in 1995. Dr Langford was instrumental in the introduction of the Rio Tinto LifeFlight jet, the first RFDS jet aircraft, into Western Australia in 2009.

The RFDS in WA employs approximately 40 full-time and 20 part-time doctors, including GPs, career doctors, specialist anaesthetists, emergency physicians and retrieval registrars. They utilize 14 turboprop aircraft, jets, helicopters and road vehicles. Standardized retrieval aircraft, medical equipment, training, clinical guidelines and governance pervades all RFDS aeromedical services across WA.

The Royal Flying Doctor Service in Western Australia provides a range of niche health services across the State which include telehealth, flying clinics and emergency aeromedical transport. In 2011, over 41,000 telehealth calls were managed, giving remote callers direct contact with experienced primary care and retrieval doctors, 24 hours a day, using telephone or web-based video. Many patients are treated remotely using a cache of pharmaceuticals, the classic RFDS medical chest, supplied to 550 remote locations across the State.

Flying clinics using RFDS, AMS and hospital-based doctors from a number of regional centres, provide regular General Practice services to Australians who otherwise would have access to none. Additional female GP services, primary health care nurses, health promotion teams and a visiting Dental service are also offered. Last year 32,000 patients were seen at 2,400 remote clinics in WA.

The RFDS operates a truly Statewide aeromedical retrieval service handling more than 9,500 calls p.a. through a single Clinical Coordination Centre in Perth. Fourteen turboprop aircraft, based at five centres, plus charter aircraft and helicopters, fly over 22,000 hours and transport more than 8,600 patients to definitive care, 75% of which is in Perth. Critically ill patients regularly undergo some of the longest retrieval flights in Australia, if not the world. Our recently established Rio Tinto LifeFlight jet service conducts long distance flights within WA, neonatal transfers to Eastern State capitals, as well as retrieving patients from our Indian Ocean Territories.

There are many challenges from the 'Boom'. Demand for aeromedical retrieval has grown by nearly 37% in 4 years as have calls for medical advice and requests for pharmaceutical supplies. The sheer increase in numbers of people in regional areas seriously challenges the capabilities of our existing health infrastructure, in both primary care and hospital services. Despite long established systems, new ad hoc medical and aeromedical providers, lured by lucrative contracts, are also appearing and challenging the previously well coordinated models of referral and patient transport.

Costs have risen extraordinarily, with rental costs for staff in some remote locations of $2,500 per week. Air travel, hotels, building and maintenance costs and the lure of exceptional salaries makes operating a health business extremely expensive. There is fierce competition for employees across all occupational groups.

Significant numbers of itinerant workers, poorly screened for medical problems are entering hot and remote rural areas and then adding to the workload of routine and emergency services. The increase in the effective population travelling and working in previously remote locations is unprecedented. All health providers are being challenged to meet the needs of the expanded population, whilst at the same time addressing the longstanding health needs of indigenous Australians and traditional populations in remote areas.

Concurrent Session 6
TELEHEALTH AND E-HEALTH

1100 – 1120

Dr Richard Ashby, AM
Executive Director Medical Services,
Princess Alexandra Hospital

E-HEALTH IN AUSTRALIA 2012

Dr Ashby has a past history as Director of Emergency Medicine at the Royal Brisbane and Women's Hospital before his appointment as Director of Medical Services at the RBWH from 2000–2006. He is currently the Executive Director of Medical Services at the Princess Alexandra Hospital in Brisbane. Dr Ashby was appointed to the Board of RACMA (Council) in 2005, having been a Fellow since 1986.

Despite Federal Government expenditure of over one billion dollars on the National E Health Transition Authority and the Personally Controlled Electronic Health Record, (PCEHR) and a similar amount by state governments on various e-Health projects, clinicians in Australian hospitals could be forgiven for feeling "short changed" as electronic health record projects are seriously delayed or are delivering suboptimal functionality.

Some would blame the relative immaturity of E-Health solutions whilst others blame Clinicians for their alleged change aversion.

This paper will examine the current state of e-Health in Australia and why results of so much effort and expenditure remain patchy. The role of classic government procurement models and ICT project management in these outcomes will be examined, and options going forward will be canvassed.

1120 – 1140

Dr Mukesh Haikerwal, AO
Head of Clinical Leadership and Engagement
nehta – National E-Health Transition Authority

E-HEALTH AND THE PCEHR

Dr Mukesh Haikerwal is a General Medical Practitioner in Melbourne's Western Suburbs where he has practised since 1991.

He is currently working with the National e-Health Transition Authority (NEHTA) as its National Clinical Lead and Head of the Clinical Leadership Safety & Engagement Unit. His role is in apprising the Australian community of the benefits of the vital role of IT in health care an enabler of reform and sustainability. This includes drawing together the four corners of the health world: Consumers, Clinicians, Policy Makers and Vendors to synthesise an approach that is beneficial, understood and agreed.

He is the Chair of Council of the World Medical Association and was elected unopposed in May 2011 following 3 years as the Chair of the Finance and planning committee.

He was the 19th Federal President of the Australian Medical Association, its Federal Vice President and, prior to that AMA Victorian State President. This saw him responsible for national policy development, lobbying with federal parliamentarians, co-ordinating activity across the AMA State entities and representing the AMA and its members nationally and internationally In particular this role included developing and finalising the reform of the Law of Tort in Victoria and the Federal response to the Medical Indemnity crisis to 2007.

He was awarded Honorary Fellowships by both the Australian Medical Association (2005) and the Royal Australian College of General Practice (2007) as well as being presented with the Australian Medical Association President's Award in May 2009. In October 2009 he was made an Honorary Life Member of the Royal Australian College of General Practitioners.

He is a Professor in the School of Medicine in the Faculty of Health Sciences at Flinders University in Adelaide, South Australia and was appointed to the NH&MRC Health Care Committee.

Mukesh is a Broadband champion with the Department of Broadband, Communications and the Digital Economy, Chair of the beyondblue National Doctors' Mental Health Program, the General Practice Data Governance Committee and a Co-Chair of the Australian Asian Medical Federation. He also sits on the Advisory Board of Brain Injury Australia.

1140 – 1200

Prof Gavin Frost
Medical Dean, Notre Dame University Fremantle

CREATING A VISION FOR TELE-HEALTH IN ACADEMIA

Prior to his appointment as Dean, School of Medicine Fremantle, was Domain Head in Population and Public Health in the new Notre Dame University School of Medicine Sydney.

Before this he was the inaugural Chief Medical Officer with MBF Australia, the nation's largest private health insurance company for 7 years.

Dr Frost is a medical graduate of Sydney University and the Sydney Hospital Clinical School, and holds a Masters degree in Public Health. He is a Fellow of the Royal Australasian College of Medical Administrators. He is also a Fellow of the Faculty of Public Health Medicine of the Royal Australasian College of Physicians.

In 1997–98 he was the CEO of Royal North Shore Hospital, a 750 bed teaching hospital of Sydney University.

For 2 ½ years prior to that he was a Senior Medical Advisor in the Australian Commonwealth Department of Health. Before this secondment, he was the Deputy Chief Health Officer in the NSW Health Department for 4 years, acting as Chief Health Officer for part of that time.

In his Government roles, he has made numerous visits to China, and to Indonesia. He has also undertaken

consultancies in Papua New Guinea, Romania, Qatar, Bahrain, United Arab Emirates, Uzbekistan, Libya and the Indian Ocean Territories of Cocos (Keeling) Islands, and Christmas Island.

The recent decision by the Federal Government to provide remuneration to medical practitioners and others who offer telehealth services has triggered two immediate responses from the University sector.

The first is to undertake teaching and research to ensure that this mode of delivery is effective and efficient, and that procedures are established to measure these outcomes. Delivery to, and utilisation by, rural and remote communities presents its own set of challenges.

The second is to assess the cost and benefit of this process to ensure that expenditure provides outcomes better than current health care delivery mechanisms in these difficult-to-reach locations.

The hardware/software and connections are not part of this study, as broadband, the NBN and satellites represent technology not content.

Two staff have already been appointed to develop and deliver the curriculum and the next stage, based at the University's Broome campus will undertake the research and evaluation through the Kimberley and Pilbara regions of WA and in rural locations of the University's Rural School sites in NSW.

Concurrent Session 7
CAPITAL DEVELOPMENT & PLANNING

1100 – 1130

Dr Lachlan Henderson
CEO, St John of God Pathology, Group Director Medical Services and Strategy, St John of God Health Care

PRIVATE HOSPITAL PROVIDERS AND CAPITAL DEVELOPMENTS

Dr Lachlan Henderson, a former GP, is the current CEO of the SJGHC Pathology Division. He has been a Hospital and Group Medical Director for SJGHC as well as a private hospital CEO (Mount Hospital, Perth). From 2009–11, he was also the SJGHC Group Director of Strategy, playing a key role in the Group's successful Midland Hospital bid – a 367 bed health campus that will be designed, built and operated as a public/private partnership.

St John of God Health Care (SJGHC) is a private hospital and pathology operator with facilities in Western Australia, Victoria and New South Wales (as well as New Zealand). The Group operates 13 private hospitals (2030 beds); a large Pathology Division ($120M revenue); as well as Home Services and Social Outreach Divisions. The Group's annual revenue is $943M and it employs close to 10,000 people.

The presentation will focus on the role of doctors as administrators in the private health care system with particular reference to engaging in financial decisions, strategy and capital developments. It will include a review of his recent experience in the Group's successful Midland hospital tender, as well as insights into medical administrators expanding their horizons beyond DMS roles.

1130 – 1200

Prof Christine Kilpatrick
Chief Executive, Melbourne Royal Children's Hospital

PROJECT PLANNING AND IMPLEMENTATION

Christine Kilpatrick is Chief Executive Officer of The Royal Children's Hospital Melbourne. Christine graduated from medical school, University of Melbourne and went on to pursue a career in neurology specialising in epilepsy. She worked in both public and private practice as well as pursuing an academic career at the Royal Melbourne Hospital where she established and led the Epilepsy Program.

In the early 2000s Christine moved from neurological practice into hospital administration and was appointed Executive Director Medical Services, Melbourne Health and later Executive Director Royal Melbourne Hospital, Melbourne Health. In addition to an undergraduate medical degree Christine has a Doctor of Medicine (MD) and a Master of Business Administration (MBA) both from University of Melbourne.

She is a Fellow of The Royal Australasian College of Physicians and The Royal Australasian College of Medical Administrators. Christine is also a Graduate of the Australian Institute of Company Directors. Christine has held several external appointments including Chair Victorian Quality Council in Healthcare and Chair Methodist Ladies College Board. She was awarded a Centenary medal in 2003.

The new Royal Children's Hospital (RCH) officially opened on the 26th October 2011, with patients transferred to the facility on the 30th November 2011. The new hospital campus, brings together not only the clinical services, but also the research partners, Murdoch Childrens Research Institute and The University of Melbourne, Department of Paediatrics. The campus includes over 200,000 square metres within the 4.1 hectare site, built adjacent to the old hospital.

The new Royal Children's Hospital has been delivered as a public/private partnership (PPP) under the State Government's Partnerships Victoria Model. The partnership will see the public sector, RCH, continue to operate the hospital and provide all core clinical services, staffing, teaching, training and research, while the private sector (Children's Health Partnership – CHP) will finance, design, construct and maintain the new hospital building.

The project was six years in the making, beginning with service planning, development of the functional brief, design phase and construction phase. This presentation will discuss the multiple phases, as well as principles used in guiding the project, governance arrangements, internal and external communication strategy and the extensive change program implemented by The RCH to support the transition to the new facility.

Concurrent Session 8
CONTRIBUTED PAPERS

1100 – 1120

Prof Geraldine MacCarrick
Clinical Dean, Northern Clinical Training Network, Cairns Base Hospital

A CLINICAL TRAINING NETWORK FOR FAR NORTH QUEENSLAND (SUPPORTING REGIONALLY BASED MEDICAL TRAINING)

Professor MacCarrick is a graduate of the University of Tasmania. She holds Fellowships of the Royal Australasian College of Medical Administrators and the Royal Australian College of General Practitioners and is a member of the Australian College of Rural and Remote Medicine. Her PhD is in Medical Education. Professor MacCarrick has filled leadership roles in education and management in a range of medical organizations: hospitals, medical schools and post graduate training programs. Prof MacCarrick is currently Clinical Dean with James Cook University. The role is to facilitate the development of a self-sustaining and research-focussed medical workforce for northern Queensland.

There is currently a maldistribution of the medical workforce in Australia, particularly felt in Queensland. This is contributing to inequalities in health service access and poorer health outcomes for regional populations.

We know that regionally based health professional education works. Interventions such as James Cook University Medical School, has seen a doubling in the number of junior resident staff in the region. However in Queensland alone it is estimated we need over 1000 additional accredited vocational training positions to accommodate the bulge that has been created by the increased domestic graduate numbers. Although increasing the number of regionally trained medical graduates has played a significant part of the solution towards alleviating medical workforce maldistribution, this now needs to be urgently matched with expanded postgraduate training opportunities situated in regional areas.

Of particular concern are the known inefficiencies in the medical 'training pipeline'. Undergraduate, junior doctor and vocational training tend to act as silos with lack of engagement with the private and community sectors.

The Northern Clinical Training Network (NCTN) is a collaboration between James Cook University School of Medicine and Dentistry and Queensland Health. The NCTN vision is an integrated pipeline of clinical education the primary purpose of which is to help address the inefficiencies in the 'training pipeline' and improve engagement with the private and community sectors.

The role and governance of the NCTN will be described with a particular focus on support of medical workforce training in Far North Queensland.

1120 – 1140

A/Prof James Oldham
Chief Psychiatrist, Illawarra & Shoalhaven Local Health District

James Oldham worked in the UK as the Medical Director of a private hospital group. He returned to Australia to take up the position as Chief Psychiatrist of the Illawarra and Shoalhaven LHD.

He is interested in training doctors to develop their leadership skills using self reflection, feedback and new ways of communication.

IN ONE PERSON, MANY PEOPLE; ADAPTIVE LEADERSHIP

Adaptive leaders are in living relationships with those they lead. There is no universal recipe for success and any solution to an adaptive challenge is just a temporary resting place. Aristotle called patterns of adaptive behaviour virtues and maladaptive behaviours vices.

Recent developments in neuroscience support the contention that we could be more complex than the organisations we drive. The new models of brain and behaviour support the use of ancient methods of reflective practice, deep listening and the need for dialogue with those around us. Plato asked: "Isn't it quite necessary for us to agree that the very same forms and dispositions as are in the city are in each of us?"

By taking account the complexity of our workplace and the mysterious intricacy within, we may engage in a state of active "not knowing" where we might delay an intervention until the chance of success is higher. As a result we progress forward at the same time as we move the organisation; we and the target are both in motion.

"Thus play I in one person, many people, and none are content."
WILLIAM SHAKESPEARE

1140 – 1200

Presenter: A/Prof Rosemary Aldrich
Associate Director, Clinical Governance, Hunter New England Health
Authors: Rosemary Aldrich, Kim Hill, Juliana Ford, Anne Duggan

CAN YOU SEND ME AN ISBAR ON THAT? EMBEDDING PROFESSIONAL COMMUNICATION FOR PATIENT SAFETY ACROSS A LARGE PUBLIC HEALTH ORGANISATION IN NSW, AUSTRALIA

A journalist for eight years in electronic and print media before becoming a doctor and subsequently a public health physician, Conjoint Associate Professor Rosemary Aldrich is, in 2012, a RACMA Accelerated Pathway candidate. Her key interests include health system strengthening in Australia and in the Asia Pacific region through attention to equity considerations and governance structures and processes for policy, appropriate healthcare communication, quality systems, and workforce management (including skills development and sustainability). Rosemary is the Chair of the Workforce Committee of the Australasian Faculty of Public Health

Medicine (Royal Australasian College of Physicians), and a member of its Council, and teaches undergraduate and post-graduate public health and health system improvement at the University of Newcastle, NSW.

Hunter New England Health (HNE Health) is a public health organisation in NSW Australia where 15,000+ staff provide primary, secondary and tertiary services to approximately 850,000 people resident in metropolitan, regional, rural and remote centres across an area the size of England. With 45 inpatient facilities, 40 emergency departments (with 1,000–65,000 presentations annually), and networked care effected through inter-hospital transfers where necessary, opportunities for healthcare communication-related incidents are limitless. For this reason in 2006 the HNE Health Director of Clinical Governance initiated a long-term strategy to enhance professional communication across all staff. Baseline evaluation of 2006 data showed that 75% of severe adverse events had communication failure as a root cause (Hill et al 2007). Funded by the Australian Commission on Safety and Quality in Health Care in 2008–2009 we identified, adapted (in consultation with local clinicians), trained staff to use, and piloted the use of the ISBAR (introduction, situation, background, assessment, recommendation) tool, aiming to improve the quality of clinical handover in inter-hospital transfer. Training staff in ISBAR enhanced their confidence to communicate, enhanced patient and carer perceptions of the quality of healthcare communication, and showed potential to reduce adverse incidents (Aldrich et al 2009). Based on this evidence, in 2010 and 2011 the ISBAR in Our Communication program team (comprising the Director Clinical Governance, the Program Leader, and Program Implementation Manager) used a seven-element approach to promote ISBAR across our organisation, aiming to prevent communication-related adverse events. The program team did not act alone: implementation was effected through strong Executive Team leadership, support from champions who formed our Communication Coalition, and many managers and clinician leaders who shaped the uptake of ISBAR.

Simultaneous attention to Leadership and governance, Engaging with people and processes, Training and education, Tools and resources, Evaluation and audit, Reporting and communication, and Sustainability (our LETTERS model) resulted in more than 9,200 staff documented as having trained to use ISBAR in the year to end November 2011, at which time the Clinical Governance ISBAR Implementation manager concluded their role. The number of staff documented as trained in the previous year had increased to nearly 10,000 by April 2012.

A deliberate and broad strategy for sustaining staff training and embedding use of ISBAR (including making annual training mandatory, having an e-learning module, training 400 managers and supervisors as trainers, and having an ISBAR email icon on every desktop) has turned ISBAR into a noun and a verb in our organisation. The format is used widely in many settings and forms of communication, and for recording information, which in turn has informed other quality activities. Using our original methods for incident evaluation, and compared with 2006 data, in 2011 there was a 50% reduction in the proportion of severe adverse events which implicated communication-failure as a root cause (from 76% to 38%), and a 75% reduction in the absolute number (from 96 to 23). Reductions in the number and severity of adverse events have resulted from a range of initiatives in our organisation, of which the ISBAR in our Communication program is one. We have applied the LETTERS model to other quality improvement initiatives.

1200 – 1220

Dr Tony Austin, AM
Chairman, Remote Area Health Corps

VARIETY IS THE SPICE OF LIFE: IMPROVING STAFF MORALE BY SUPPORTING PLACEMENTS IN NON-TRADITIONAL ROLES

Tony retired from the RAAF in 2008. His last years were spent in Canberra as Head of the Defence Health Services. Since retiring Tony has been the chairman of the Remote Area Health Corps – a federally funded Not For Profit company established to address workforce issues in the remote Indigenous clinics of the Northern Territory. He is chairman of a National Advisory Committee to the Minister for Veterans Affairs on mental health in veterans and their families. He also sits on the Administrative Appeals Tribunal in Sydney. Tony is also a censor with RACMA and chairs the Credentialling Committee.

As the delivery of health care becomes more specialised, clinicians find that their routine scope of practice narrows, often with the loss of their more generalist skills. Often they will

be working in facilities with a wide range of highly sophisticated diagnostic services and rapid access to equally specialised colleagues. While this all improves the quality of care delivered to our patients, it can lead to a sense of frustration or a diminishing sense of professional satisfaction. Many clinicians will seek to counter this by either undertaking voluntary work in developing countries supported by non-government organisations such as Medecins Sans Frontieres (MSF) or Rotary or by involvement with challenging recreational activities such as adventure sports. Others may join a military Reserve unit.

My experience with military Reserve health professionals is that they are an eclectic group of people who seek personal and professional opportunities to help others, who thrive on working in challenging environments and who truly value cultural diversity. In my experience people who volunteer to work in remote Indigenous communities throughout Australia share these same characteristics.

It is my belief that organisations that employ health professionals can enhance staff morale, improve basic clinical skills and lift cultural competency by encouraging staff to take short-term placements in these remote communities. By supporting these placements the organisation is demonstrating that it values its staff and it values equity and diversity. In this paper I will outline some ways in which health organisations can develop partnerships to achieve these goals.

Plenary Session 4
MEDICAL LEADERSHIP IN A CLIMATE OF CHANGE

1315 – 1345

Professor Jeffrey Braithwaite
RACMA Board member, Director, Australian Institute of Health Innovation, University of NSW

MEDICAL LEADERSHIP IN A CLIMATE OF CHANGE

Professor Jeffrey Braithwaite is Foundation Director, Australian Institute of Health Innovation, Director, Centre for Clinical Governance Research and Professor, Faculty of Medicine, University of New South Wales, Australia. His research examines the changing nature of health systems, particularly patient safety, leadership and management, the structure and culture of organisations and their network characteristics, attracting funding of more than AUD$36 million, chiefly from researcher-initiated National Health and Medical Research Council and Australian Research Council grants.

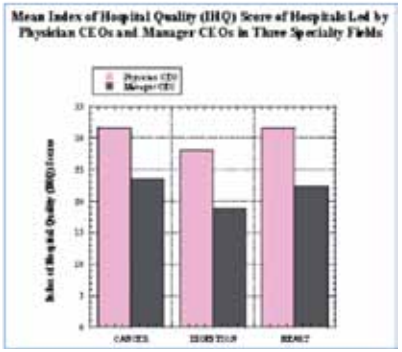
Professor Braithwaite has published extensively (more than 300 refereed contributions, and 500 total publications). He has presented at or chaired international and national conferences, workshops, symposia and meetings on more than 500 occasions, including over 60 keynote addresses. He has contributed several times each to the British Medical Journal and The Lancet. His research appears in journals such as Social Science & Medicine, BMJ Quality and Safety, International Journal of Quality in Health Care, Journal of Managerial Psychology, Journal of the American Medical Informatics Association and many other prestigious journals. Professor Braithwaite has received numerous national and international awards including a Vice-Chancellor's award for teaching from UNSW, a Gold Medal of the Uniting Church of Australia for services to older people and six separate awards for research papers in 2007 and 2008.

In this address we will tease out two thorny constructs: how does medical leadership contribute to improved health systems? And how can it continue to contribute in an environment which itself is altering, perhaps quite radically, over time?

We believe that medical leadership is a crucial contributor to performance, and a valuable asset – if done well. Some British research shows good human resource management practices in hospitals are associated with decreased patient mortality.[1] There is evidence that medical leadership compared with non-medical leadership is associated with higher ratings of quality of care in US hospitals[2] [Figure]. The evidence is not gold standard, and we are unsure if it applies to Australia.

As for the climate of change, health reform is not just in the air, it's on the move. The Commonwealth has initiated the Personally Controlled Electronic Health Record [PCEHR], Medicare Locals have been established, the Independent Hospital Pricing Authority [IHPA] has released a national efficient price for hospitals and the National Health Performance Authority will soon benchmark performance of Medicare Locals and Local Hospital Networks/Local Hospital Districts. Meanwhile, the Australian Commission on Safety and Quality in Health Care has established ten new health care standards and it will soon develop national clinical standards. Within States and Territories and private health care, too, much change and many improvement strategies are underway to IT systems, quality and safety programs and in consumer engagement, to name just a few.

The case prosecuted therefore is this: high quality medical leadership is not something to be taken for granted; not something whose time has been but whose time has come. Yet in a climate of change, it is timely to think through how we can demonstrate that medical leadership contributes – and contributes effectively.



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2 Amanda H Goodall (2011) Physician-leaders and hospital performance: is there an association? Bonn, Germany: IZA and Cass Business School, Discussion Paper number 5830.

1345 – 1415

Prof Graham Dickson
Founding Director of the Centre for Health Leadership and Research at Royal Roads University, Professor Emeritus of Leadership in the Faculty of Social and Applied Sciences Royal Roads University, Victoria, BC,

LEADING IN HEALTH

Dr Dickson is Research Advisor to the Canadian Health Leadership Network, and a member of the Physician Assistants Certification Council of Canada. Prior to leaving Royal Roads University (RRU), Graham was the founding Director of the Centre for Health Leadership and Research. Graham helped develop the Master of Arts in Leadership (Health specialization) at RRU.

Dr Dickson is the principal investigator on two participatory action research studies being conducted in Canada. The first is entitled, Evidence-Informed Change Management in Canadian Healthcare Organizations, a commissioned project for the Canadian Health Services Research Foundation. The second is entitled Leadership in Health Systems Redesign, a CIHR sponsored project, done in partnership with the Canadian Health Leadership Network, key Canadian decision makers and five universities across Canada. Dr Dickson has had a number of articles on leadership published in peer reviewed journals and professional magazines.

Dr Dickson was the principal investigator in the cross-Canada research project on the LEADS in a Caring Environment capabilities framework. This framework has been endorsed by Health Leaders Association of BC; the Canadian College of Health Leaders, and the Canadian Health Leadership Network. Recently, Graham oversaw the writing and publishing of five booklets dedicated to each of the capabilities of the LEADS framework. He co-authored the booklet on Systems Transformation. He has given numerous talks re LEADS across Canada and abroad in the past five years, including Uganda, Hong Kong, Whistler, and London (UK).

Dr Dickson teaches strategic planning for the Canadian Medical Association's Physician Management Institute (based on the LEADS framework). In the past two years he has designed and delivered LEADS programs for the Canadian Agency for Drugs and Technology in Health (CADTH); Eastern Health Region of Newfoundland, Health Canada; the Registered Nurses' Association of Saskatchewan, the Board of the Saskatchewan Medical Association; the Catholic Health Association of Manitoba, and the Atlantic Pharmacists' Association. He recently designed a program on effective teamwork for Accreditation Canada, and on public service leadership for the Tanzanian government. He teaches leadership in the International Foundation of Employee Benefits' Advanced Trustee Management Seminars for Canadian pension and health benefit trustees. Recently Graham presented at the World Federation of Medical Managers' meeting in San Francisco on competency assessment–conducted in partnership with the American College of Physician Executives.

Graham Dickson is a former teacher, administrator, and public servant in the BC civil service, before going out to Royal Roads in 1996.

A medical leader is quoted as once saying, "Six months ago I was a world renown neurosurgeon. Today, I am simply a bumbling idiot in a boardroom". Can doctors' transition from clinical practice to system leadership? And what is required of you to do so? This workshop aims at answering these questions.

Your capacity to lead is a function of the innate traits you are born with, how you are conditioned to think and act as a leader, and how you prepare yourself to lead. Research shows that many aspects of 'becoming' a physician, and practicing as a physician, either mitigate against, or facilitate your capacity to lead, depending on what different audiences expect of you. Becoming aware of your innate qualities that help define you as a leader, but also the aspects of the medical culture that either allow those traits to develop and grow, or diminish their capacity to do so, is an important step in growing your leadership capability. Together, we will explore the requirements of effective leadership within a medical setting and in non-medical settings; identify some aspects of your own innate personal leadership capability; and surface cultural attributes of 'becoming and being' a physician that influences your ability to lead in both settings. Finally, you will employ the discipline of personal mastery to lay out an action plan to become the leader that you would like to be, depending on where your leadership aspirations and responsibilities lie.

Concurrent Session 9
PUBLIC & ENVIRONMENTAL HEALTH ISSUES

1445 – 1515

Tarun Weeramanthri
Executive Director, Public Health Division, Department of Health, Government of Western Australia

THE PUBLIC HEALTH IMPACT OF FLY-IN FLY-OUT (FIFO) WORK IN WESTERN AUSTRALIA (WA)

Dr Tarun Weeramanthri is Executive Director, Public Health and Clinical Services Division, WA Health. He has served as Chief Health Officer in two jurisdictions (Northern Territory 2004–2007, and Western Australia 2008–present). He is a specialist public health physician, and also previously practised as a specialist clinician. His interests are in the contribution public health can make to Aboriginal health improvement, health services research, use of new social networking technologies in public health and the implementation of health policy.

In considering the benefits and downsides of fly-in fly-out work, there is a paucity of data but an abundance of opinions. This talk will consist of three parts:

a. presentation of a broad public health framework to assess health risks and impacts at individual, family and community levels;
b. recent population level data on the demography, health behaviours and health outcomes of FIFO compared to shift and other workers, derived from the WA Health and Wellbeing Surveillance System; and
c. consideration of chronic disease, mental health and sexual health in particular, as well as specific issues pertaining to workers from other countries on temporary visas.

The limited data we have demonstrates that FIFO workers are not a homogenous group, and specific aspects of FIFO work should inform physical and mental health policies. There is an urgent need for more data and research in this area.

1515 – 1545

Jim Dodds
Director Environmental Health at Health Department Western Australia

THE EFFECT ON HEALTH WITH THE MINING BOOM

Concurrent Session 10
HEALTH SERVICES RESEARCH

1445 – 1505

Prof Jeffrey Braithwaite
RACMA Board member, Director, Australian Institute of Health Innovation, University of NSW

THE IMPORTANT ROLE FOR RACMA AND WHERE WE SHOULD HEAD

Professor Jeffrey Braithwaite is Foundation Director, Australian Institute of Health Innovation, Director, Centre for Clinical Governance Research and Professor, Faculty of Medicine, University of New South Wales, Australia. His research examines the changing nature of health systems, particularly patient safety, leadership and management, the structure and culture of organisations and their network characteristics, attracting funding of more than AUD$36 million, chiefly from researcher-initiated National Health and Medical Research Council and Australian Research Council grants.

Professor Braithwaite has published extensively (more than 300 refereed contributions, and 500 total publications). He has presented at or chaired international and national conferences, workshops, symposia and meetings on more than 500 occasions, including over 60 keynote addresses. He has contributed several times each to the British Medical Journal and The Lancet. His research appears in journals such as Social Science & Medicine, BMJ Quality and Safety, International Journal of Quality in Health Care, Journal of Managerial Psychology, Journal of the American Medical Informatics Association and many other prestigious journals. Professor Braithwaite has received numerous national and international awards including a Vice-Chancellor's award for teaching from UNSW, a Gold Medal of the Uniting Church of Australia for services to older people and six separate awards for research papers in 2007 and 2008.

Surprisingly, there is no agreed definition for health services research. We might simply turn the words round and say it's doing research on health services. Or, more directly, by doing this kind of research we will aim to provide evidence for what we have to do to improve care and delivery systems.

Recent developments suggest that the concerns of health services research are converging with those of implementation science. This is a relatively new discipline [or some would say old wine in new bottles] concerned to increase the uptake of evidence in routine practice. If we accept the tenor of this argument, we will be doing research not just on how we run services or structure organisations but how we improve care, engender best practices, exploit new ideas, tools and methods, enact enhanced cultures and create better systems.

Recent research articles and books provide insights into what we need to do as a College to contribute to health services research in this vein. These include a 2010 book [Culture and climate in health care organisations] which provides models and ideas for culture and climate change;[1] our 2012 research showing how much appropriate care is being delivered in Australia [the CareTrack study];[2] and our 2010 review of the literature on doctors in medical management.[3]

In this presentation we discuss some of these culture change models, the results from the CareTrack study and our literature review, and use these as a platform to provide some guidance on where RACMA should head in health services research. There are many possible pathways, but realistically, choices have to be made in deciding what to pursue.

1505 – 1525

Dr Simon Towler
Medical Advisor – Blood and Technology Policy; Office of Chief Medical Officer – WA Health; Staff Specialist in Intensive Care – Royal Perth Hospital

WHAT'S NEW AND WHAT'S COMING

Dr Simon Towler is a practicing intensive care specialist at Royal Perth Hospital. He was Western Australia's Chief Medical

1 Jeffrey Braithwaite, Paula Hyde and Cathy Pope (eds) (2010). Culture and climate in health care organizations. Basingstoke, England: Palgrave Macmillan.
2 William Runciman, Tamara Hunt, Natalie Hannaford, Peter Hibbert, Johanna Westbrook, Enrico Coiera, Ric Day, Diane Hindmarsh, Elizabeth McGlynn, Jeffrey Braithwaite (2012) CareTrack: assessing the appropriateness of health care delivery in Australia. Medical Journal of Australia 197(2): 100–5.
3 Robyn Clay-Williams, Jeffrey Braithwaite (2010) Doctors in management: a review of the literature. Sydney: Centre for Clinical Governance Research, University of New South Wales.

Officer from 2006 until April 2012 and is continuing to work with the Office of the Chief Medical Officer as medical advisor on blood and technology policy.

Dr Towler served on the Council of the NHMRC for two triennia where he had a special interest in the translation of research into clinical practice.

Consistent with his new advisory role Dr Towler has a long standing interest in new technology in health care in Australia. He is the AHMAC sponsored member on the Medical Services Advisory Committee (MSAC) and is a member of HealthPACT – Australia's technology horizon scanning committee.

Dr Towler has been involved in the development of policies and programs for the care and treatment of patients where the use of fresh blood products is being considered. He has led the introduction of the statewide Patient Blood Management Program in Western Australia and is the Chair of the Patient Blood Management Steering Committee of the National Blood Authority. He is committed to the comprehensive implementation of the six Patient Blood Management Guidelines being developed by the National Blood Authority of which three have already been presented and endorsed by the Council of the NHMRC.

New technology in health care continues to deliver new treatments enhancing the care that can be delivered by 21st Century health systems. However, from an era 25 years ago when the cost of bringing a product to market was small, major technology advances now cost millions of dollars in development, research and implementation before being routinely used in clinical practice. As costs increase the dependence of technology companies to achieve support from governments and insurers to ensure widespread uptake has become paramount.

In Australia a major review by the Commonwealth Government considered the issues faced by companies in bringing innovative devices and pharmaceuticals to market whilst ensuring patient safety and evidence of efficacy. In Australian this process is closely linked to decisions about eligibility for access to Commonwealth funding under the Medicare and Pharmaceutical Benefits Schedules.

This presentation will review the important changes occurring at the Medical Services Advisory Committee, the relationship to horizon-scanning and the work of HealthPACT and will consider how this information should be made available to management at the service, hospital and jurisdictional level. A particular focus will be consideration of the integration of technology with to evidence-based clinical guidelines.

1525 – 1545

Dr Alison Dwyer
Medical Director, Quality Safety and Risk Management, Austin Hospital

INTRODUCING NEW TECHNOLOGIES INTO HEALTH SERVICES: GOVERNANCE FRAMEWORKS, PRACTICALITIES, AND ENGAGING MEDICAL STAFF

Dr Alison Dwyer is the current Medical Director Quality Safety and Risk Management at Austin Health, overseeing Clinical Risk Management, and providing medical leadership to the organisation in Quality and Safety, since September 2010. She was formerly the Director Medical Services at the Royal Melbourne Hospital for 4 years (2006–2010), overseeing the Medical Workforce Unit. She also performs an advisory role as a member of the Clinical Engagement Advisory Group, Department of Health Victoria.

Dr Dwyer is a Fellow of the Royal Australasian College of Medical Administrators (RACMA), Fellow Australasian College of Health Service Managers, and Graduate of the Australian Institute of Company Directors.

Dr Dwyer has played a significant involvement with RACMA as a current member of the Victorian State Committee, Continuing Education Program Coordinator for Victoria, Leadership of the Department of Health funded RACMA Peer Review Webinar process, and active involvement in of the Department of Health funded RACMA Self Audit and Peer Review project. She is a current censor for Examinations and Preceptor for Candidates.

She is a current Clinical Ethics Tutor with the University of Melbourne Austin Health Clinical School for 2nd year MD students, and an honorary Clinical Senior Research Fellow with University of Melbourne Department of Medicine, Austin Health.

Her research interests are in key Medical Administrative roles, including the overarching role of the medical administrator, peer review for medical administrators, junior medical workforce (poorly performing medical staff) and engagement of medical staff in clinical governance (new technologies introduction).

This presentation will outline the experience from 2 years of implementation of a Governance framework for introducing new technologies into a major tertiary teaching hospital (Royal Melbourne Hospital). The clinical and corporate governance systems will be outlined, practical challenges/ recommendations explored, and discussion of strategies for engaging medical staff in the process.

Concurrent Session 11
INNOVATIONS IN THE MANAGEMENT OF JUNIOR MEDICAL STAFF

1545 – 1505

Associate Professor Erwin Loh
Executive Director, Medical Services & Quality for Southern Health

MANAGING MEDICAL WORKFORCE COSTS – A PROGRAM OF WORK AT A LARGE PUBLIC TERTIARY HEALTH SERVICE

Dr Erwin Loh is the Director, Medical Services for Southern Health, Victoria's largest public health service. Before this he was Deputy Chief Medical Officer at the Peter MacCallum Cancer Centre. He graduated medicine from the University of Melbourne, has an honours law degree from Monash University and is a practising lawyer. He also has an MBA, a Master of Health Services Management and a PhD, with his thesis looking at doctors in senior hospital management. He is a Fellow of the Royal Australasian College of Medical Administrators, Australasian College of Health Service Management, Australian Institute of Company Directors and Australasian College of Legal Medicine. He teaches health services management and health law at Monash University. He is Adjunct Clinical Associate Professor at Monash University and Associate Professor at the Australian Institute of Business.

The cost of staffing is a major component of the overall operating costs of health services, accounting for up to 80% of all expenses. The medical workforce, in turn, forms a large proportion of such costs. Doctors, in general, are paid higher remuneration because of their expertise and skills, their ability to bring in revenue, traditional market forces and the structure of the relevant hospital awards. The way doctors work in hospitals have tended to be based on historical models, including the professional hierarchical structure they work in, the way they are rostered, the manner in which their ward rounds are run, and the clinical roles that they still hold in health, despite significant changes to funding, models of care, and population and workforce demographics. Most health services have found it difficult to address medical staff productivity and efficiency issues because of workforce shortages, clinical service needs and inflexible industrial frameworks. This presentation discusses a program of work addressing medical staff management, including medical establishment control, roster redesign and other related matters, in a large public health network. The key factors for successful change implementation and sustainability are medical staff engagement, strong medical leadership, and effective evaluation and monitoring systems.

1505 – 1525

Dr Colin Feekery
Executive Director Medical Services and Research, Eastern Health

WORK PRACTICE CHANGE AND JUNIOR MEDICAL STAFFING

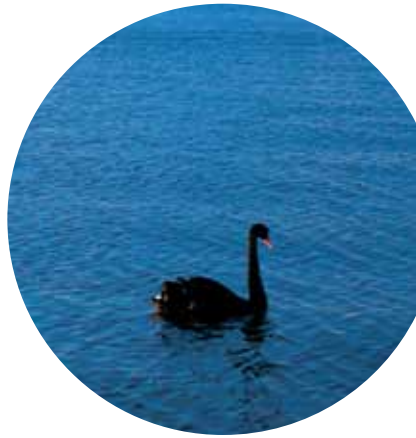
A/Prof Colin Feekery Graduated from the University of Qld Medical School in 1979. After training in Paediatrics in both Brisbane and Melbourne he became a Fellow of the Royal Australasian College of Physicians in 1990. He then spent the next 16 years working both at the Royal Children's Melbourne and in private practice specialising in Behavioural and Developmental Paediatrics. Having an abiding interest in mother infant interaction he was the director of the Masada Hospital Mother and Baby Unit for eight years. In 2002, A/Prof Colin Feekery was awarded a Masters in Health Management (Uni NSW). In 2005 he was appointed the Medical Director of Western Health, (Melbourne) and in 2008 he was appointed the Executive Director Medical Services and Research at Eastern Health (Melbourne). In 2011 he was awarded an A/Professorship by Monash University and in 2012 he sat and passed his fellowship exams for admittance to the Royal Australasian College of Medical Administrators.

1525 – 1545

Dr Benny Ng
Deputy Director of Medical Services, Peter MacCallum Cancer Centre

JMS FEEDBACK AND STRATEGY AT PETER MACCALLUM CANCER CLINIC

Dr Bennie Ng is the Deputy Director of Medical Services at Peter MacCallum Cancer Centre, the only public hospital solely dedicated to cancer treatment, research and education in Australia. After several years of clinical practice, he developed a professional interest in health management and medical administration. Dr Ng has held various policy and executive roles in Australia and abroad, including adviser to a former Federal Minister of Health and Ageing and Senior Manager for Service Planning and Development at the head office of the Hong Kong Hospital Authority.



Junior medical staff spend more time in direct patient care and interact more with other frontline health professionals compared to senior medical staff. Yet, hospitals often fail to effectively capture and relay their feedback on systemic and process issues. With the introduction of the national health reforms which impose higher standards of patient care and better hospital performance, pressure will be applied to make significant changes in how care is delivered. By creating robust formal and informal mechanisms to engage with junior medical staff, medical administrators will gain invaluable insights and the necessary currency to communicate practical opportunities and improvements in work practice to appropriately influence health service strategy.

POSTER PRESENTATIONS

The Poster session will be held on Wednesday 5th September 2012 in conjunction with the Welcome Reception. The following posters will be available for presentation

Poster 1: Dr Alison Dwyer
JUNIOR DOCTORS EMBRACING QUALITY: CLINICAL RISK REGISTRAR

Authors: Dr Alison Dwyer[1], Dr Fergus Kerr[2], Joanne Moorfoot[3]

1. Quality, Safety and Risk Management Unit, Austin Health, Heidelberg, Victoria
2. Emergency Department, Austin Health, Heidelberg, Victoria
3. Sub Acute Services, Austin Health, Heidelberg, Victoria

Current Medical Director for Quality, Safety and Clinical Risk Management at Austin Health in Melbourne. FRACMA, FACHSM, MBA, MHSM. Previous roles including Director Medical Services at Royal Melbourne Hospital. Current CEP Coordinator for Victorian RACMA State Committee, and leadership role with RACMA Peer Review DoH Funded project. Current research interests include the role of the medical manager, engaging medical staff in quality and safety (particularly in new technologies governance processes), and support for junior medical workforce.

BACKGROUND

Medical staff engagement is essential for successful quality improvement. In Australian public hospitals, junior doctors provide a large component of patient-care, and are therefore essential to engage in the quality process.

AIM

To establish a hospital Clinical Risk Registrar position to

1. increase medical input into quality and clinical risk processes,
2. increase exposure of junior doctors to quality improvement principles,
3. increase the quality profile within the medical profession.

METHOD

Through collaboration internally between the Quality and Safety Unit, Emergency Department and the Chief Medical Officer/ Medical Workforce Unit, a 20 hour per week Registrar for 6 months was established, as a formal rotation from the Emergency

Department Registrar pool. Internal evaluation following 18 months implementation of:

- quantitative assessment of contribution of Clinical Risk Registrar to clinical risk unit (specifics of tasks undertaken)
- Qualitative evaluation via survey of rotating Registrars (anonymous online survey)

External evaluation by ACEM in December 2010, at completion of 2 rotations, with aim for full Accreditation.

RESULTS

The key roles of the Clinical Risk Registrar include:

- Supporting the clinical risk management team to undertake critical incident reviews (with medical expertise)
- Active exposure to clinical risk structures (Clinical Review Panel, Clinical Outcomes Review Committee, unit audit)
- Develop skills in clinical risk management including Coronial processes and Root Cause Analysis methodology (including leading a RCA or critical incident investigation if one occurs during the rotation)
- Education of junior medical staff in clinical risk/ quality improvement (e.g. ISBAR communication tool education of interns).

An anonymous online survey was conducted of all registrars who undertook the role. 3 of 4 registrars responded (75%).

(1) Challenges/opportunities for improvement highlighted:

- Not enough time in role for educating medical staff
- Formal orientation and training less than required
- One registrar had a period of a gap in supervision whilst recruiting a new Medical Director.

(2) Positives of the role:

- All 3 felt the role had increased their knowledge of clinical risk management in the organisation
- All 3 felt that they would use the skills they had learnt in the role in their future
- All 3 would recommend the position to other registrars.

(3) Overall rating of experience:

- 2 of 3 (67%) rated strongly positive
- 1 of 3 (33%) rated positive,
- External evaluation resulted in the position being accredited by ACEM.

Recommendations for future directions include increased junior doctor education by the role, exploring other registrar groups as rotations (e.g. Intensive Care, Physicians) and consideration of a formal “referrals” registrar component for clinical risk issues by junior doctors.

CONCLUSION

The Clinical Risk Registrar role has become an integral part of the clinical risk team, both facilitating increased medical input to quality improvement initiatives, as well as providing a link for the junior and senior medical staff with quality improvement throughout the organisation, and broadly increasing clinician engagement in quality. The role is an exemplar for other organisations wanting to increase junior doctor involvement in quality.

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Poster 2: Carmel Sheridan

BLOOD TRANSFUSION PRACTICE IN ELECTIVE ORTHOPAEDIC SURGERY, A NOVEL EXERCISE IN BENCHMARKING USING LINKAGE DATA

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INTRODUCTION

Patient Blood Management (PBM) is an integral part of ensuring appropriate, safe and timely administration of blood and blood products (blood) while avoiding blood wastage and unnecessary transfusion and associated costs. In 2009, a PBM program was established at WA Health and piloted at a tertiary hospital in Perth. Traditionally, clinicians and administrators have relied on clinical records as a means of auditing and measuring blood usage at their institutions[1]. This method is inherently flawed by inconsistent and incomplete documentation, and hampered by time-constraints. Therefore, an alternative means of accurately analysing blood usage was developed, which cross-referenced data from the hospital admission data record and the laboratory transfusion/haematology data record (TOPAS and ULTRA, respectively)) and named "WA PBM Data System". The front-end allows for the automated generation of blood transfusion data reports, which may be analysed by any number of variables including hospital site, ICD-10-AM procedure and diagnosis codes, specialty groups and Diagnosis-Related Groups (DRG V6).

OBJECTIVE

The aim of this study was to establish the prevalence of red blood cell (RBC) transfusion for elective orthopaedic surgery, at 3 tertiary public hospitals in the Perth Metropolitan area. One of those tertiary hospitals had established a formal PBM program. In addition, a comparison was made between the length of hospital stay in the transfused and non-transfused patients.

METHODS

Elective orthopaedic surgery cases, excluding all fractures and trauma, performed over a 4 year period between January 2008 and December 2011 inclusive, were included in the study. Four principle procedures of primary hip replacement, revised hip replacement, primary knee replacement and revised knee replacement were identified by agreed ICD-10-AM procedure codes (Appendix A). The preliminary analysis was performed using the PBM Data System and validated using Microsoft Access data analysis software (version 2010).

RESULTS

Four thousand three hundred and three cases were reviewed in total. Table 1 outlines the variation in transfusion rates per procedural groups at each site.

Table 1

Elective Orthopaedic Procedure (group)	Hospital A % Transfusion rate (caseload)	Hospital B % Transfusion rate (caseload)	Hospital C % Transfusion rate (caseload)
Primary Hip Replacement	16.7 (546)	20.4 (672)	34.8 (336)
Revised Hip +/- bone graft	48.5 (101)	50 (90)	58.4 (89)
Revised Hip + allograft	25 (4)	66.7 (12)	66.7 (6)
Primary Knee +/- bone graft	7.6 (785)	7 (999)	26.9 (413)
Revised Knee + any graft	21.3 (109)	18.2 (77)	36 (64)

The total volume of RBC's transfused was 519 units (average 2.3 per transfused patient) at hospital A, 624 units (average 2.3 per transfused patient) at hospital B and 827 units (average 2.7 per transfused patient) at hospital C.

Table 2 outlines differences in the average length of hospital stay in days (ALOS) between transfused (T) and non-transfused (NT) at each site.

Table 2

Elective Orthopaedic Procedure (group)	Hospital A ALOS (T) versus ALOS (NT)	Hospital B ALOS (T) versus ALOS (NT)	Hospital C ALOS (T) versus ALOS (NT)
Primary Hip Replacement	8.9 (T) v. 7.7 (NT)	8.4 (T) v. 5.8 (NT)	7.8 (T) v. 5.9 (NT)
Revised Hip +/- bone graft	15.9 (T) v. 8.6 (NT)	10.7 (T) v. 8.1 (NT)	15.1(T) v. 7.9 (NT)
Revised Hip + allograft	6 (T) v. 8(NT)	7.6 (T) v. 5.8 (NT)	12 (T) v. 3.5 (NT)
Primary Knee +/- bone graft	8.9 (T) v. 8.3 (NT)	9.2 (T) v. 6.1 (NT)	8.5 (T) v. 7.3 (NT)
Revised Knee + any graft	21.3 (T) v. 9.8 (NT)	13.3 (T) v. 7.5 (NT)	10.1 (T) v. 7.2 (NT)

Hospital C has the shortest ALOS overall in both transfused and non-transfused patients, despite the highest overall transfusion rate. This would indicate that blood transfusion per se may not directly impact on hospital stay but rather there are many influencing co-variables (including bed management!). Wide variations in transfusion rates were identified, when comparing individual practitioners at each site. Practitioners at hospital C were more closely aligned in practice than at hospital A or B, but significant variations existed particularly for revision procedures.

CONCLUSION

Inter-hospital and individual practitioner variation in use of RBC's is not only explained by differences in clinical factors and therefore requires further attention. It is anticipated that the timely introduction of PBM programs at tertiary institutions, the recently published National Blood Authority guidelines regarding peri-operative blood loss[2] and the incoming requirements for nationally-accredited blood transfusion practice and policy standards[3], will merge to give impetus and credence to the drive towards more appropriate and responsible blood transfusion practice.

Appendix A

Elective Orthopaedic Procedure Description	ICD-10-AM codes
Primary Hip Replacement	49318-00
Revised Hip +/- bone graft	49324-00
	49327-00
	49330-00
	49333-00
Revised Hip + allograft	49339-00
	49342-00
Primary Knee +/- bone graft	49518-00
	49521-00
	49521-02
Revised Knee + any graft	49527-00
	49530-01
	49533-00
	49554-00

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Poster 3: Dr Sally Tideman

SOUTH AUSTRALIA'S EXPERIENCE OF NATIONAL ORGAN AND TISSUE DONATION REFORM: LOOKING BACK – LOOKING FORWARD

Authors: Dr Sally Tideman

Dr Sally Tideman FRACMA is the State Medical Director DonateLife SA.Prior to appointment to this role in 2009 Dr Tideman was the Director of Medical Services at The Queen Elizabeth Hospital in Adelaide. Her clinical background is in rural and remote General Practice in SA and NT.

INTRODUCTION

On 2 July 2008, the Australian Government announced a new National Reform Agenda, 'A World's Best Practice Approach to Organ and Tissue Donation for Transplantation'.[1]

The Government committed $151 million over four years to establish a nationally coordinated approach to organ and tissue donation processes. After the initial years of Reform 2011 data shows that 337 Australians became an organ donor saving and improving the lives of more than 1000 of their fellow Australians.[2] In 2011 Australia had a donor per million population rate (dpmp) of 14.9 dpmp. This represents a substantial 64% increase over the baseline (average 2000–2008) of 205 organ donors. However, international tables detailing dpdm rates demonstrate that Australia continues to rank well below comparable nations.

METHOD – THE SOUTH AUSTRALIAN IMPLEMENTATION OF REFORM

The South Australian approach to implementation of a National Reform Agenda has been tailored for the SA historical, clinical and political environment. SA agreed to national Reform in an environment where SA had been the national leader in donation rates for over 10 years and had reached internationally comparable high donation rates. The key features of the SA Reform method have been:

- Acknowledgement of and respect for, the success of the pre-Reform organ and tissue donation systems, combined with a view of organ and tissue donation as a complex adaptive system[3] and with a view to the future
- Sustained professional and clinical medical leadership
- A deliberate, paced 'Change Conversations' program to upskill and support all staff in working though change and transition and to embed leadership skills as core business for all members of the DonateLife SA network. The program is now entering the fourth year and is ongoing.[4]
- Utilising implementation of the National Health and Hospitals Reform, as an opportunity to deliberately position DonateLife SA within a new Local Health Network and a new visible State-wide service.

RESULTS – THE SOUTH AUSTRALIAN EXPERIENCE

South Australia has continued as the national leader in Organ and Tissue donation rates (21.9 dpmp) in 2011[5].Each of the four key features outlined above are now embedded in the DonateLife SA organisational culture. Deliberate attention to these elements supporting Reform is ongoing.

CONCLUSION

The SA context for National Organ and Tissue Donation Reform was unique amongst the states and territories from the outet. SA had experience of being the national and a world leader in the field. Four key features of the Reform program have been described and submitted as elements contributing to SAs ongoing leadership and high performance through the Reform period.

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Poster 4: Dr Ian Graham
COMPETENCE AND PERFORMANCE – ASSESSMENT AND DEVELOPMENT OF SURGEONS

Authors: Ian Graham[1], MBBS; M Health Planning; FRACMA1, Pam Montgomery[2], MAPS; PhD; BA (Hons), David Watters[3], ChM; FRCSEd; FRACS, David Hillis[4], MBBS (Hons) MHA FRACGP FRACMA FCHSE FAIM FAICD

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Dr Ian Graham is a specialist medical administrator (FRACMA) with 25 years' experience in medical management, postgraduate medical education and informatics. He works as a visiting Director of Medical Services for a network of four health services comprising 14 hospital campuses in the Grampians Region of western Victoria. He also runs a consulting practice in medical governance and management, clinician engagement, medical education and informatics. In this capacity he has worked for medical colleges (RACS, RACP, ANZCA); Ernst & Young Health and Risk Advisory practices; and numerous hospitals and health services in Australia and overseas.

The Royal Australasian College of Surgeons (RACS) has developed a framework and assessment tool to measure performance of consultant surgeons. The framework is based on a system of behavioural markers defined across nine surgical competencies. An initial pilot indicated that this approach is acceptable to surgeons and forms an important adjunct to the RACS Continuing Professional Development (CPD) Program.

The project considered methods to define and assess surgical performance and the resources and supports that are available for surgeons. The Non-Technical Skills for Surgeons (NOTSS) system was reviewed, adapted and expanded for this purpose. A group of practising surgical leaders oversaw the project. There was extensive consultation with this group.

The project has resulted in:

- A system describing three patterns of behaviour across each of the nine RACS competencies, each exemplified by four 'good' and four 'poor' behaviours (216 in total)
- An assessment tool supporting self-reflection and feedback from peers and/or co-workers that is suitable for use in the surgical workplace
- Demonstration that it is possible to assess the performance of consultant surgeons in a routine, acceptable and non-intrusive manner
- Potential models for integration of performance assessment into the CPD program

Surgical performance is increasingly under public scrutiny and its measurement is a complex and sensitive issue. CPD programs do not assess surgical performance, particularly non-technical skills. This work has made a significant contribution to addressing this gap by developing a performance assessment system that can be implemented on a routine basis with all surgeons. This will contribute to improvements in the quality and safety of surgical care. Other colleges, in particular the Royal Australasian College of Physicians, have adopted a similar approach e.g. the Supporting Physicians' Professionalism and Performance project.

It is anticipated that an on-line version of the current paper-based assessment tool will be developed and opportunities for enhancing Multi-Source (360 degree) Feedback using behavioural markers will be explored in the future.

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Poster 5: James MacWatt
MEDICAL ENGAGEMENT-MEASUREMENT, STRATEGY AND LEARNINGS

Author: Mr James MacWatt

James MacWatt is the Clinical Redesign Manager at Joondalup Health Campus (JHC) in WA .

The JHC Clinical Redesign Program includes projects on hospital wide patient flow with particular focus on ED access (inc. Four Hour Rule Program). James also has an interest in and coordinates a body of work around Medical Engagement which has included recent junior medical rotations in service improvement. Previous to working at JHC James undertook in a consultative role in WA Health innovations division and has a background in Physiotherapy.

James applies various change and program management methodologies including Lean Thinking, Six Sigma and ADKAR.

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PROBLEM/BACKGROUND

Medical engagement is defined as the 'active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organisation which itself recognises this commitment in supporting and encouraging high quality care' (Spurgeon, Barwell and Mazelan, 2008). Joondalup Health Campus has embarked on a Medical Engagement Program (MEP), which aims to improve communication channels with clinicians, increase their involvement in hospital reform, align doctors and the organisations goals, values and beliefs, develop a model of medical leadership and devise a strategy to improve medical engagement. JHC recently became the first site in Australia to quantifiably measure medical engagement in clinicians using the Medical Engagement Scale (MES).

METHOD

The MES consists of 10 valid and reliable scales, with an overall Medical Engagement score underpinned by 3 metascales (and associated subscales);

- Working in a Collaborative Environment (Climate for Positive Learning & Good Interpersonal Relationships),
- Having a Purpose & Direction (Appraisal and Rewards Effectively Aligned & Participation in Decision Making and Change);
- Feeling Valued and Empowered (Work Satisfaction & Development Orientation)

RESULTS

JHC performed favourably against the benchmark of 49 Acute and Mental Health Trusts in the UK (comprising approximately 5300 medical staff) being consistently high across all engagement scales. There was however significant differences between medical specialty groups and staff types (e.g. JMO).

OUTCOMES

The administration of the MES coincides with whole of hospital JHC Culture Development Plan. The MEP has established a clinician led advisory group focussed on improving engagement as well as implementing an RMO Improvement role.

Poster 6: Dr Sayanta Jana

TREATING EACH OTHER WELL

REVIEW OF PAYROLL AND RELATED SERVICES TO WESTERN AUSTRALIAN DEPARTMENT OF HEALTH MEDICAL OFFICERS – AN INDEPENDENT REVIEW OF HEALTH COPORATE NETWORK AND WESTERN AUSTRALIAN HEALTH MEDICAL ADMINISTRATION SERVICES

Authors: Dr Sayanta Jana, **Ms.Sheree Walker**

PURPOSE

To review the existing model of payroll and employment services provided to WA Health Medical Officers and recommend further improvements and efficiency through innovation and reform to ensure WA Health Medical Administration Group (MAG) and Health Corporate Network (HCN) operate in healthy partnership.

JUNIOR MEDICAL OFFICERS

Junior Medical Officer (JMO) is a term covering doctors from their last year of undergraduate training until completion of their vocational training.

MEDICAL ADMINISTRATION GROUP

Medical Administration Group (MAG) is a term covering administration staff dealing with and supporting HR related functions to WA Health Doctors on site.

HEALTH CORPORATE NETWORK

Health Corporate Network (HCN) provides Human Resources, Supply, Finance and Reporting and Business Systems services to WA Health.

WHY CHANGE IS NEEDED

Payroll services to JMO is characterised by dissatisfaction and fragmented approach across the Metropolitan Health Service Area. A series of recommendations were proposed through a "WA Health Payroll and Related Services Working Party" under the WA Medical Directors Forum including the development of benchmarked and uniform key performance indicators for areas such as Medical Administration.

The overall intent of all WA Health staff was to improve the efficiency of payroll services provided by overcoming inefficient work practices, system-wastes and work-rounds in favour of lean six-sigma supported practices.

QUALITY EDUCATION AND TRAINING

The Review received a consistent message from MAG respondents that they do not feel valued by their employers. Employment practices such as induction, performance management, support systems, education and training are uneven and leading to further frustration.

The introduction of the first of "collective" Medical Administration induction programs commence Tuesday, 31 July 2012. These sessions will provide MAG attendees from across the Area Health Services with a solid foundation to support and establish positive and productive relationships with JMO.

WORKPLACE CULTURE AND PRACTICE

Successful relationship building and engagement has been established in the first instance through various governance committees. Maintenance will be challenging and an ongoing commitment from all stakeholders and collective bargaining is designed to meet the changing needs of all stakeholders. This involvement provides a platform for good practice, innovation and improvement whilst achieving an empowering rather than restrictive agreement.

A collaborative approach has been established through involving the Area Health Service (AHS) EDMS, MAG, HCN, HIRS (Industrial Relations) and JMO.

OUT OF SCOPE AND OTHER WORK

Other work underway to address the complexity of issues affecting the medical workforce and demands on JMO work practices is the recent endorsement of 2 year "optional" contract for JMO and progress has been made towards more flexible working arrangements for those on maternity leave such as Job Share for JMO.

HOW DOES TREATING EACH OTHER WELL IMPROVE PATIENT CARE

The review and research centred on improving the payroll and related services experience of all medical practitioners, thereby improving medical workforce retention and satisfaction within WA Health by allowing clinicians to concentrate only on the delivery of safe and high quality clinical care instead of payroll issues.

There is a serious threat to long term medical administration workforce sustainability. In a time of workforce shortage we recommend that training and education be the context for ongoing learning programmes which incorporate comprehensive induction programmes, performance reviews and meaningful assessments.

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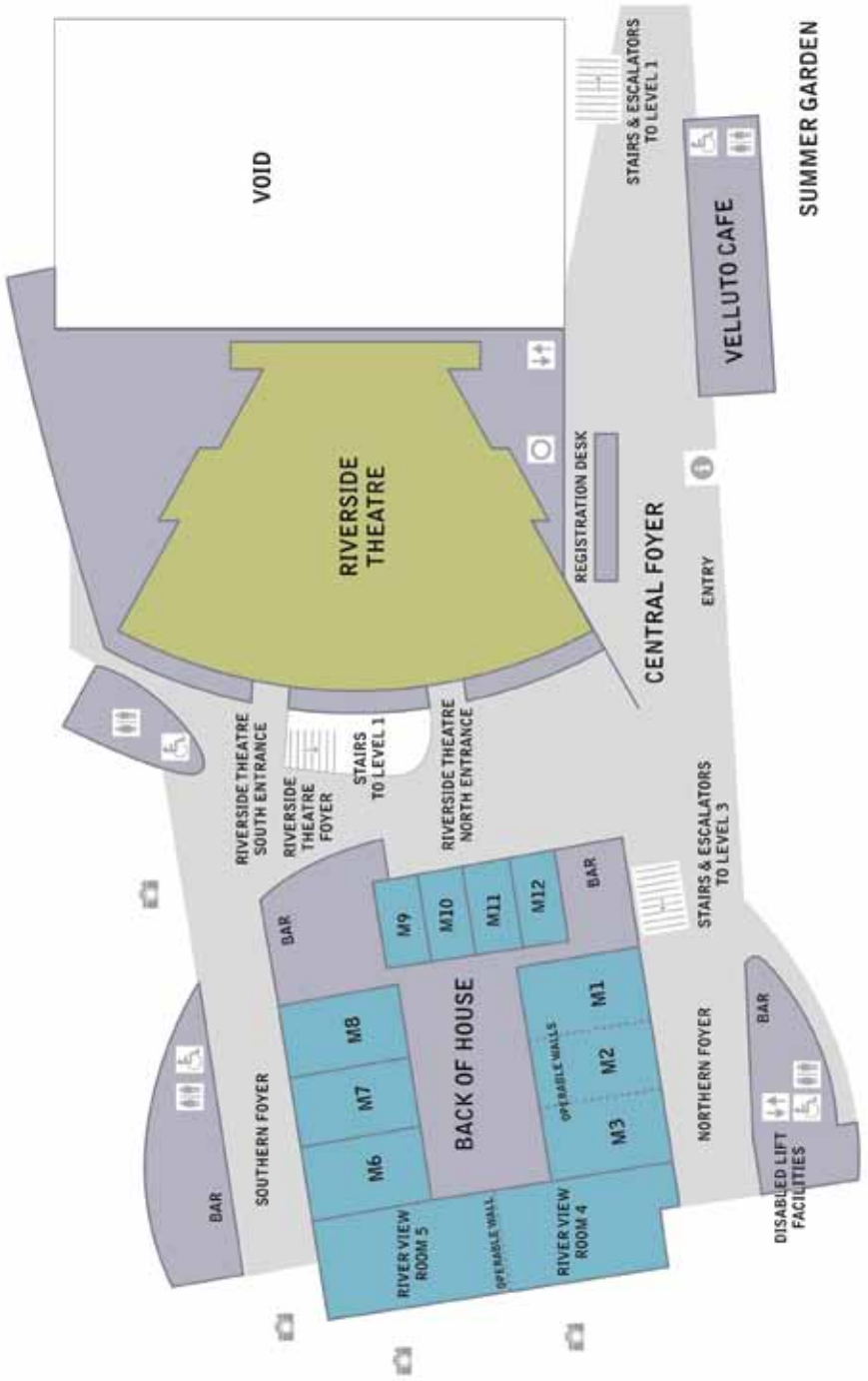

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