Six months of GROSS: turning member frustrations into system reform

August 2025

Introduction

Victorian healthcare is under sustained strain. Constrained budgets, workforce shortages and growing patient demand mean every dollar and every minute must be directed to patient care. Yet across the system, clinicians continue to lose time and energy to low-value, repetitive and unnecessary administrative tasks. These inefficiencies- what doctors themselves have called the "stupid stuff"- erode morale, contribute to burnout and undermine care.

The *Getting Rid of Stupid Stuff* (GROSS) initiative was launched by AMA Victoria in February 2025 to address this problem directly. Based on a program first developed at Hawaii Pacific Health and later adopted by organisations including the Cleveland Clinic, Queensland Health and Melbourne's Western Health, GROSS provides a structured, clinician-led framework to identify and remove inefficiencies. Its aim is straightforward: eliminate bureaucracy that adds no value, so resources can be redirected to the front line.

From the outset, GROSS has been grounded in the day-to-day experiences of the medical workforce. Publicly launched in partnership with ASMOF Victoria, the campaign began with a petition to the Premier and senior Ministers, letters to political and health system leaders, and a call for members to share examples from their workplaces. The response was immediate and candid. In the first months, over 1,000 petition signatures and dozens of detailed member submissions were received- from duplicate mandatory training modules and redundant Working With Children Checks to repeated onboarding paperwork and clinicians performing clerical tasks due to reduced support staff.

In its first six months, GROSS has developed from a targeted campaign into a recognised reform agenda. It has been raised in Parliament, covered across mainstream and professional media, and endorsed in principle by the Minister for Health, senior Department of Health officials and Safer Care Victoria. Early wins (such as work to develop a statewide approach to recognising prior learning in mandatory training, and active consideration of exemptions from duplicative WWCC requirements) show the campaign is gaining traction.

This paper sets out the first 6 months of the GROSS initiative: its origins, the engagement it has generated, the issues it has identified, and the progress achieved. It also outlines the next steps needed to embed red-tape reduction into the governance and culture of Victorian healthcare, ensuring that "getting rid of stupid stuff" becomes part of everyday practice rather than a one-off campaign.

Origins of the GROSS campaign

The concept of Getting Rid of Stupid Stuff did not begin in Victoria. It was first trialled at Hawaii Pacific Health in 2017 as a grassroots way to reduce meaningless paperwork and digital "clicks", particularly in clinical documentation. Staff were invited to identify low-value or unnecessary tasks in their workflow and propose practical solutions. The results were immediate: measurable time savings, improved morale, and visible action from managers in response to frontline feedback.

The idea spread quickly. The Cleveland Clinic in the United States, Queensland Health, and Melbourne's Western Health each adopted GROSS-style programs, reporting efficiency gains and improved staff satisfaction. Western Health's 2024 pilot showed the model could work in a Victorian setting, using staff input to streamline workflows and remove avoidable administrative waste.

By early 2025, then AMA Victoria President, Dr Jill Tomlinson, saw clear potential for GROSS to address a long-standing and growing problem in the state's health system. For years doctors had raised concerns about the steady build-up of compliance tasks, duplicated processes, and low-value reporting requirements. These burdens were well-known to government, but there was no formal mechanism to identify, prioritise, and resolve them. The prevailing culture was to "work around and put up with it" rather than fix it.

Dr Tomlinson also recognised that the state's fiscal constraints created a political and operational opening: a government under budget pressure would be more receptive to initiatives that improved efficiency and productivity without compromising care. By framing GROSS as both a workforce wellbeing measure and a cost-conscious reform, AMA Victoria could align member priorities with the government's own need to "do more with less."

The Victorian GROSS initiative was launched to shift the culture from "putting up with it" to systematically fixing it. It aimed to harness member-driven examples and turn them into a coordinated case for reform, showing decision-makers how removing low-value and no-value tasks could free up time, improve morale, and support better patient care. By aligning the push for red-tape reduction with the government's broader need to use resources wisely, AMA Victoria positioned GROSS as a shared priority for clinicians, health services, and policymakers alike.

Launching the campaign: petition and political outreach

AMA Victoria officially launched the GROSS campaign on 13 February 2025 in partnership with ASMOF Victoria. The launch was built around three coordinated actions: a public petition, direct political outreach, and a member call-out for examples of "stupid stuff."

The petition, hosted on the Megaphone platform, called on the Premier, Deputy Premier, Health Minister, Mental Health Minister, and Treasurer to adopt GROSS across all Victorian public health services. It set out three specific asks:

1. Publicly commit to GROSS as a priority initiative for improving productivity and reducing waste.
2. Appoint Department of Health Secretary Jenny Atta PSM as a high-level "GROSS champion" to lead the work across the system.
3. Embed GROSS into the annual Statements of Priorities for each health service to drive engagement and accountability.

In parallel, AMA Victoria wrote to government, opposition, and crossbench leaders, making the case that cutting low-value bureaucracy is not a partisan issue but a practical necessity for workforce retention and better patient care. Similar letters went to senior figures in the Department of Health, Safer Care Victoria, and other relevant agencies such as WorkSafe, linking GROSS to broader system reform efforts.

The political response was swift. Within a week, GROSS was raised in the Legislative Council by Victorian Greens MP Dr Sarah Mansfield, who said in the context of a debate on a motion on health service challenges:

> *There are other initiatives around cost saving. I know that the AMA has been out promoting the GROSS program, which stands for getting rid of stupid stuff. It has been embraced by hospitals worldwide. This focuses on really getting health services to identify areas where they could save costs themselves. It does things like reduce duplicative training models: if you work at three different hospitals and have to do some form of the same training across those three institutions, couldn't there be some way of centralising that so your training is all standard – for example, your fire safety training or something else that is applicable across the different sites? There is clunky information transfer between clinics and hospitals that could be improved, and many other initiatives. It has been done in hospitals around Australia and around the world.*

Soon after, Shadow Health Minister Georgie Crozier met with AMA Victoria to discuss the initiative, further signalling bipartisan interest.

The first formal meeting with the Minister for Health, Mary-Anne Thomas, took place in March 2025. The Minister expressed support for the principles underpinning GROSS. In the same month, AMA Victoria also met with Minister for Mental Health, Ingrid Stitt, to outline how GROSS could help address administrative burdens within the mental health portfolio. These meetings, followed by direct engagement with Safer Care Victoria and senior Departmental officials, established early policy footholds and helped identify a first set of priority issues.

This early political and departmental interest created momentum for the campaign, complemented by ongoing media coverage and a steady flow of real-world examples from members. Together, these kept the initiative visible and sustained pressure for action.

Media and public engagement

From its launch, GROSS attracted attention well beyond AMA Victoria's membership and the political and bureaucratic class. The plain language, concrete examples, and practical fixes made it easy for journalists to report and for the public to understand. This helped shift the conversation from a set of professional complaints to a recognised system-wide issue, one that resonates with anyone frustrated by unnecessary bureaucracy.

Media coverage has complemented political engagement from the outset. In launch week, ABC Radio Melbourne interviewed AMA Victoria President Dr Jill Tomlinson, who described how repetitive, near-identical training modules pull senior clinicians away from patients without improving safety. The Herald Sun ran "Cut silly red tape and save health system," giving the campaign mass-market reach.

Professional medical media coverage included:

- *The Medical Republic*'s feature, "Imagine a world without stupid stuff," which highlighted examples from member submissions, including duplicate Working With Children Checks, repeated onboarding paperwork, and clinicians doing clerical work.
- *Australian Doctor*'s coverage of the campaign to "weed out pointless administrative tasks," such as specialists ordering office supplies or sending faxes.
- *Pulse+IT*'s reporting, which connected GROSS to digital health priorities like single sign-on, interoperability, and improved system design.
- A recent episode of *PULSE, the podcast*, in which Dr Tomlinson discussed the origins and inspiration for GROSS, and emphasised the importance of reducing unnecessary work for doctors and driving systemic change to redirect resources towards patient care.

Coverage continued through May 2025, reinforcing the campaign's messages and amplifying examples already shaping discussions with government. Social media, particularly when clinicians shared simple, relatable examples, extended the reach beyond clinician and drew interest and responses from administrators and policymakers.

AMA Victoria's own channels- including the Check-Up online newsletter, and targeted member emails- also provided regular updates on advocacy milestones and reinforced the call for new examples. This kept member engagement consistent and ensured a steady stream of frontline insights to feed into policy work.

By late May, the petition had passed 1,000 signatures, a tangible measure of support noted in discussions with Ministers and departmental leaders. The combined effect of political advocacy, public engagement, and professional media coverage has been to establish the "stupid stuff" conversation as part of policy discussions. The term "stupid stuff" is now often used by policymakers and health service leaders as shorthand, when referring to inefficiencies, providing a clear and accessible way to describe the problem and the need for change.

Engaging the frontline: identifying the "Stupid Stuff"

From day one, AMA Victoria's GROSS campaign has been led by clinicians. Alongside the public petition, AMA Victoria invited members to submit concrete examples of low-value tasks and duplicative processes that waste time and reduce morale. Submissions have also arrived via the petition, social media, email, and direct calls, and they keep coming in. The call-out remains open and visible so new examples continue to shape our work program and discussions with government.

The themes are largely consistent across specialties and workplaces. Doctors working across multiple health services report being taken away from clinical work to repeat near-identical mandatory training modules at each site, even when the same content has already been completed or when the training relates to tasks that are outside of their scope of practice. The result is predictable: cancelled clinics, disrupted theatre lists, and hours spent ticking boxes with little or no educational value.

Senior specialists also report being required to complete low-value modules such as Basic Life Support (BLS) and Advanced Life Support (ALS), despite already maintaining advanced qualifications (FACEM, FANZCA, FCICM) and rigorous CPD obligations. For these clinicians, repeating entry-level or generic training adds no benefit, undermines trust in professional competence, and takes time away from patient care.

Another recurring issue is duplicative regulation. Geriatricians, other non-paediatric specialists, and indeed all medical practitioners are still required to hold Working With Children Checks to work in Victorian hospitals, despite Ahpra registration already providing robust national screening and ongoing oversight. Teachers and police are exempt from duplicative checks, and Queensland has already exempted Ahpra-registered practitioners from "blue cards"- a model Victoria could easily adopt.

Junior doctors face an endless loop of onboarding and credentialing: re-submitting the same HR, payroll, and credentialing packs every term and with every rotation, sometimes multiple times a year. Even short-term locum work can trigger another full round of forms, ID checks, and system logins. For doctors working across multiple services, it can feel like the same paperwork is being demanded on a continuous loop, consuming hours that could be spent on patients or training.

Where administrative support has been cut back, clinicians are increasingly taking on tasks well outside their scope. Faxing forms, ordering supplies, processing invoices, chasing signatures, booking patient transport, and even cleaning clinical spaces have all

been reported. Individually these jobs may seem minor, but in aggregate they erode clinical time, slow care delivery, and contribute to frustration and burnout.

Members are equally frustrated by waste, in time, money, and resources. Reusable items are too often labelled "single use only" without clinical justification, disposable products replace washable alternatives, consumables arrive in excessive packaging, and unopened items from procedure kits are routinely discarded. Patient information is printed automatically rather than shared digitally, and linen is changed more often than clinically necessary. These practices inflate costs and undermine health services' own sustainability goals.

Digital friction is a constant: siloed information, missing headers on results that make it unclear where tests were done, and the need to log in to multiple systems just to run a standard outpatient clinic. Members also flagged that some referral tools still require downgrading security settings (HTTP rather than HTTPS), the kind of avoidable workaround that belongs in the past. Paper requisitions for pathology or imaging still exist in some services despite digital alternatives, and immunisation/training records must often be re-entered at every health service instead of being accessed from a central source.

Outside hospitals, red tape piles up in predictable places: WorkCover certification and reporting, CPD reimbursement paperwork that other states process automatically in payroll, and basic government processes that force doctors to juggle multiple logins (permits, disease notifications, VicRoads forms). These are not edge cases; they are daily frictions that add up.

Specialty-specific examples round out the picture. Mental health clinicians point to administrative churn from legislative inconsistencies across borders, lack of a national forensic risk database, and meetings that absorb time without clear benefit.

These are not isolated irritations- they are daily frictions that have shaped GROSS's advocacy priorities and informed the issues now on Ministers' desks.

Theme	**Examples reported by members**	**Why it matters**
Duplicative mandatory training	Near-identical annual modules repeated at each health service; specialists required to complete basic courses despite daily high-level clinical work.	Disrupts clinics and theatre lists; minimal educational value; undermines trust in professional competence.
Low-value mandatory training	Specialists mandated to complete BLS/ALS and similar modules despite advanced qualifications and CPD requirements.	Provides little or no educational benefit; diverts senior clinicians from care; signals mistrust in clinical expertise.
Duplicative regulation	All Ahpra-registered doctors required to hold WWCCs to work in Victorian hospitals; duplication not required for teachers or police; Queensland exempts doctors entirely.	Adds cost and paperwork without improving safety; signals mistrust in existing professional regulation.
Onboarding and credentialing repetition	Same HR, payroll, and accreditation forms resubmitted every term or rotation; additional rounds for locum shifts.	Wastes clinical time; delays patient care.

Theme	Examples reported by members	Why it matters
Clerical work shifted to clinicians	Faxing forms, ordering supplies, processing invoices, booking transport, cleaning clinical spaces.	Pulls highly trained staff away from patients; increases frustration and burnout risk.
Environmental waste	Reusable items labelled "single use only" without justification; disposable products replacing washable alternatives; excessive packaging; unopened consumables discarded; automatic printing; unnecessary linen changes.	Increases costs; creates avoidable environmental impact; undermines sustainability commitments.
Digital system friction	Siloed patient data; missing headers on results; multiple logins; insecure referral tools; persistence of paper requisitions; duplicate entry of training/immunisation records.	Slows care; increases error risk; reduces efficiency of existing systems.
External bureaucracy	Excessive WorkCover certification; CME reimbursement claims processed manually; multiple logins for basic government processes.	Diverts time from patient-facing work; delays payments.
Specialty-specific burdens	Mental health/psychiatry: inconsistent laws across borders; absence of national forensic risk database; meetings without tangible outcomes.	Specialty inefficiencies compound general system pressures.

Advocacy wins and progress to date

Six months in, GROSS has progressed from gathering examples to securing concrete commitments from government, agencies, and health service leaders on a set of priority issues identified by members.

The clearest movement has been on duplicative mandatory training. In August 2025, the Department of Health confirmed it is working with health service executives on a statewide approach to recognising prior learning in mandatory training. The work will examine options to avoid requiring clinicians to repeat near identical modules when working across different services. This is a direct response to one of the most common frustrations raised by members, and the Department has linked the work explicitly to GROSS advocacy.

The requirement for WWCCs for Ahpra-registered doctors- despite national registration including robust, ongoing monitoring- remains under active consideration. Ahpra has confirmed it sees value in an exemption for doctors and has indicated a willingness to meet with Victorian government representatives to explain how the national framework may already offer sufficient assurance. As Ahpra put it: *"We recognise the potential for duplicative regulation and can understand why the AMA would be seeking an exemption from the Victorian government."* As noted earlier, Queensland already exempts Ahpra-registered practitioners from its "blue card" requirements. While the Victorian Government has not yet announced a position, the matter is now on its agenda and under consideration.

Beyond these flagship issues, GROSS has opened new areas of work. Safer Care Victoria has agreed to explore practical mechanisms for clinicians to report inefficiencies in real time, with options including a simple, direct reporting channel within each health service. Credentialing reform (e.g. reducing the repeated onboarding and paperwork faced by

junior doctors moving between services) has been acknowledged as a priority, though one that will require sustained, longer-term work to resolve.

The GROSS approach has also been applied to processes outside the hospital system. Discussions with WorkSafe Victoria have identified rules and requirements in the workers' compensation system that could be streamlined without loss of safeguards- for example, unnecessary medical appointments created by outdated certification rules.

These developments reflect a shift from GROSS being viewed as an advocacy idea to being treated as a live work program with agreed next steps. While system-wide reform will take time, specific inefficiencies are now on the desks of Ministers, departmental executives, and agency heads, with clear lines of accountability for progressing them. The task ahead is to convert these commitments into workable reforms with firm rollout timelines, and to maintain the loop between member experience, advocacy, and change until the "stupid stuff" is gone.

Conclusion: delivering on GROSS

In six months, GROSS has shifted from an idea to a recognised work program with visible traction inside government and the health system. It has reframed everyday frustrations as systemic problems worth fixing and put practical solutions in front of decision-makers.

The priority now is to turn commitments into consistent, lasting reforms. That means embedding red-tape reduction into formal accountability measures, securing champions at senior levels, and ensuring local fixes are scaled statewide.

AMA Victoria will continue pursuing these priorities with government, agencies, and health service leaders, while keeping member and wider clinician input at the centre. Extending the conversation into sectors beyond health services will broaden support and impact. The measure of success will be simple: fewer hours lost to "stupid stuff" and more time for patient care.

Appendix 1: Quick Reference- Priority Issues and Status (Aug 2025)

Priority Issue	Current Status	Next Step
Mandatory training duplication	DoH working with health-service executives on statewide recognition of prior learning.	Secure final model; confirm rollout timetable; ensure it ends duplication and is simple to navigate.
Working With Children Check duplication	Ahpra supports exemption for doctors; Queensland model cited; under consideration by Vic Government.	Press for exemption to be adopted; maintain safeguards while removing duplication.
Clinician reporting channels	SCV open to piloting direct "report stupid stuff" mechanisms in health services.	Possible pilot in select services; evaluate and scale.
Credentialing reform	Identified as priority but requires longer-term work.	Reduce repeated onboarding for doctors.
WorkSafe red tape	Issues identified with certification rules and claims processes.	Secure early reforms (e.g. reduce unnecessary re-issues); use as proof-of-concept for non-DoH GROSS wins.

Appendix 2: Member examples

The following (non-exhaustive) examples have been reported by AMA Victoria members since the launch of the GROSS campaign. They illustrate the breadth of low-value, duplicative, or outdated processes that waste clinician time and reduce efficiency across Victorian healthcare.

- Lack of standardised discharge summary templates across hospitals, leading to missing or inconsistent information for GPs.
- Electronic systems that automatically log staff out after very short periods of inactivity, forcing repeated logins and slowing care.
- Overly complex leave request processes requiring multiple separate approvals for the same absence.
- Medical imaging systems that do not interface with EMRs, requiring results to be printed and manually scanned.
- Multi-step, paper-based approval processes for basic clinical consumables.
- Poor information flow, such as pathology/radiology results arriving without headers, making it unclear where tests were conducted.
- The administrative burden of managing Workcover patients, particularly regarding certificates and reports.
- Doctors in training having to repeatedly fill out new employment paperwork each time they are re-employed (often yearly or even every six months), and again when rotating to different health services, sometimes completing multiple sets of employment forms in a single year.
- Doctors and other healthcare workers having to perform administrative tasks, like sending faxes or ordering office supplies, due to a lack of administrative support staff.
- Excessive paperwork required to claim CME allowances.
- Geriatricians being required to obtain Working With Children Checks.
- Needing to open five different computer programs just to conduct an outpatient clinic
- Ineffective, duplicate mandatory annual training modules that doctors must complete across different health services, even when the content is identical.

- Senior specialists mandated to undertake Basic Life Support (BLS) and Advanced Life Support (ALS) training, despite already exceeding these standards through fellowship training and CPD requirements.
- Mandatory training should be centralised at a state or national level. Locums, in particular, shouldn't have to repeat everything each time they work somewhere new.
- Doctors often have to clean their own clinic and office spaces due to a lack of support staff, time that could be better spent on clinical work.
- Doctors are required to undergo separate hospital credentialing processes for each facility they work in.
- Reusable items are stamped "single use only," unnecessarily increasing waste and costs.
- The lack of a state-based electronic medical record creates duplication, inefficiencies, and barriers to state-wide care coordination.
- Most medical records programs don't allow a simple "send to GP" function, delaying communication and adding administrative burden.
- Referrals to hospital outpatient paediatric clinics must be signed and submitted by a GP, even after a hospital admission. This wastes GP time and public funds.
- The PBS prescription approval system adds unnecessary red tape, takes time away from consultations, and involves costly call centres.
- Doctors must log into multiple systems daily to complete basic government processes, such as permit applications, disease notifications, and VicRoads forms. A single sign-on system would reduce time and errors.
- National inconsistency in mental health legislation creates serious gaps. Patients can exit compulsory treatment by crossing state borders. Clinicians face large administrative burdens- particularly in Tasmania- and lack access to a national forensic risk database.
- No national website or app exists listing mental health supports. Clients often miss out on care due to poor access to reliable information.
- Psychiatry training programs place too much emphasis on note-typing in joint reviews, reducing opportunities for registrars to develop co-interviewing and active listening skills.
- There is no consistent system to provide supervised urine drug screening at community mental health clinics when requested by psychiatrists.
- Community mental health clinics lack basic safety measures like weapons detectors, putting staff and patients at risk.
- Radiology and pathology referrals still require paper forms leading to tracking issues, inefficiencies, and unnecessary printing.
- Rotating doctors are repeatedly required to complete onboarding paperwork, even when re-employed within a short time. There's no option to simply tick a box stating "no changes since last employment."
- Patients are still required to physically sign Medicare vouchers a time-wasting and outdated requirement.
- Medicare does not automatically recognise completion of advanced training in sleep medicine without additional back-and-forth paperwork, despite endorsement by the relevant college.
- Hospital procurement processes are fragmented and often environmentally wasteful. There's no oversight to share sustainable practices across sites.
- Immunisation and mandatory training records need to be resubmitted at every health service. A centralised record would reduce duplication.
- Daily discharge planning and weekly long-stay meetings take up significant clinician time, often with little value.
- Paper timesheets are still in use, even where staff are working fixed hours and leave is digitally tracked.
- Doctors are sometimes required to submit full business cases to access EFTs for funded projects, even after funding agreements are signed.

- Admin and pharmacy staff are no longer permitted to submit authorised prescriber reports to the TGA, doctors must do it themselves via a clunky interface, wasting time on an administrative task.
- Private health insurers automatically reject claims from medical specialists if the associated hospital claim hasn't been submitted yet. This forces doctors to resubmit later, despite having no visibility into the hospital's claim status. These claims should be held in the system for a grace period (e.g. 30 days) instead of being rejected outright.
- Footscray Hospital construction site lit up overnight, wasting electricity and contributing to environmental concerns.
- Incorrect name recording for doctors- Health services and Ahpra systems mis-record or alter names (e.g. reversing order of given/family names for doctors from Sinhalese, Chinese, and South Asian backgrounds). This creates inconsistencies across payroll, email, and clinical systems, hinders referrals, and in some cases results in Ahpra insisting on incorrect versions based on Department of Home Affairs records.

Appendix 3: Stakeholder Engagement & Outcomes (Feb-Aug 2025)

- **13 Feb 2025- Campaign launch & letters issued**
  GROSS launched jointly by AMA Victoria and ASMOF Vic. Petition opened; formal letters sent to the Premier, relevant Ministers, Opposition, and Greens.
- **19 Feb 2025- Parliamentary mention**
  Victorian Greens raise GROSS in the Legislative Council (Hansard), increasing political visibility.
- **24 Feb 2025- Meeting: Shadow Health Minister Georgie Crozier**
  Opposition engagement secured; openness to GROSS reforms; agreed to ongoing dialogue.
- **13 Mar 2025- Meeting: Minister for Mental Health Ingrid Stitt**
  Duplicative mandatory training raised as a priority burden across mental health; Minister acknowledged the problem and the case for streamlining.
- **24 Mar 2025- Meeting: Minister for Health Mary-Anne Thomas**
  Minister endorsed the GROSS approach; identified duplicative mandatory training as a clear, achievable first reform.
- **26 Mar 2025- Meeting: Safer Care Victoria & Department of Health**
  Strong alignment with GROSS principles. Agreed early focus on eliminating unnecessary/duplicative mandatory training. Suggested creating a central mechanism (e.g., inbox) in each service for clinician-reported inefficiencies. Credentialing identified as a longer term priority.
- **Mar–Aug 2025- Ongoing departmental engagement**
  Senior DoH officials engage on training duplication, clinician reporting channels, and WWCC duplication.
- **29 May 2025- Petition milestone & regulator stance**
  Petition surpasses 1,000 signatures. Ahpra confirms willingness to support efforts to reform potentially duplicative WWCC requirements.
- **19 Jun 2025- WorkSafe submission**
  AMA Victoria flags red-tape risks in proposed Worker's Injury Claim Form, including DSM-5-TR certification burden for GPs.
- **10 Jul 2025- WorkSafe meeting**
  Issues canvassed: enabling hand therapists (OTs) to issue Certificates of Capacity, DSM-5-TR practicality, certificate re-issue churn, payment flows, and online invoicing.
- **6 Aug 2025- WorkSafe/TAC Committee**
  WorkSafe to brief on program of work addressing provider pain points; AMA Victoria to table priority reform items and clarify which require legislative vs policy change.

- **7 Aug 2025- Department update (mandatory training)**
  DoH confirms work with health-service executives on a consistent statewide approach to recognition of prior learning; further details expected in 6–8 weeks.
- **Sep–Dec 2025- Mental Health Workforce Safety & Wellbeing Committee (planned)**
  Committee (co-chaired by DoH & WorkSafe) invites AMA Victoria to brief on GROSS; timing to follow circulation of this report.
- **Sep 2025- Victorian Hand Surgery Society (planned)**
  Abstract submitted highlighting WorkSafe certificate-of-capacity reform for hand therapists as a GROSS case study.