NSW Special Commission of Inquiry into Healthcare Funding

Witness Statement: July 2024 Public Hearing

12 July 2024

This statement reflects the views of each of its authors and sets out the evidence that we are prepared to give to the New South Wales Special Commission of Inquiry into Healthcare Funding as witnesses.

This statement is true to the best of our knowledge and belief.

1 # Introduction

Reference	Request	Witness
1	A brief overview of the College, including: a) any recognised subspecialties. b) the relationship with any subspecialty representative organisation or body.	Inam Haq

2 The RACP connects, trains and represents over 30,000 medical specialists and trainee
3 specialists from 33 different specialties, across Australia and Aotearoa New Zealand.

4 Recognised specialities fall within the RACP's the RACP's two Divisions, three Chapters and
5 three Faculties:

6 *Divisions*

7 • Adult Medicine [https://www.racp.edu.au/about/racps-structure/adult-medicine-
8 division]

9 • Paediatrics & Child Health [https://www.racp.edu.au/about/racps-
10 structure/paediatrics-child-health-division]

11 *Chapters*

12 • Australasian Chapter of Addiction Medicine [https://www.racp.edu.au/about/college-
13 structure/adult-medicine-division/australasian-chapter-of-addiction-medicine]

14 • Australasian Chapter of Palliative Medicine [https://www.racp.edu.au/about/college-
15 structure/adult-medicine-division/australasian-chapter-of-palliative-medicine]

16 • Australasian Chapter of Sexual Health
17 Medicine [https://www.racp.edu.au/about/college-structure/adult-medicine-
18 division/australiasian-chapter-of-sexual-health-medicine]

19 *Faculties*

20 • Australasian Faculty of Occupational & Environmental Medicine (AFOEM)
21 [https://www.racp.edu.au/about/college-structure/australasian-faculty-of-
22 occupational-and-environmental-medicine]

23 • Australasian Faculty of Public Health Medicine (AFPHM)
24 [https://www.racp.edu.au/about/college-structure/australasian-faculty-of-public-
25 health-medicine]

26 • Australasian Faculty of Rehabilitation Medicine (AFRM)
27 [https://www.racp.edu.au/about/college-structure/australasian-faculty-of-
28 rehabilitation-medicine]

29

30 The RACP's recognised specialties and associated qualifications are provided on the
31 College's website (Training pathways [https://www.racp.edu.au/become-a-physician/training-
32 pathways]) and summarised below in Table 1.

33 ***Table 1. RACP Training programs and associated qualifications***

Advanced training	Qualifications
Division training programs	
• Adolescent and Young Adult Medicine • Cardiology[1] • Clinical Genetics • Clinical Haematology • Clinical Immunology & Allergy • Clinical Pharmacology • Community Child Health [P] • Dermatology (NZ only) • Endocrinology • Gastroenterology • General & Acute Care Medicine [A] • General Paediatrics [P] • Geriatric Medicine [A] • Infectious Diseases • Medical Oncology • Neonatal/Perinatal Medicine [P] • Nephrology • Neurology • Nuclear Medicine • Palliative Medicine [2] • Respiratory Medicine • Rheumatology • Sleep Medicine	FRACP
Joint training programs	
Paediatric Rehabilitation Medicine [P]	FRACP and FAFRM
Endocrinology & Chemical Pathology	FRACP and FRCPA
Haematology	
Immunology & Allergy	
Infectious Diseases & Microbiology	
Paediatric Emergency Medicine [3,P]	FRACP and/or FACEM
Chapter training programs	

Addiction Medicine [3]	FAChAM
Palliative Medicine [2,3]	FAChPM
Sexual Health Medicine [3]	FAChSHM
Faculty training programs	
Rehabilitation Medicine [3]	FAFRM
Occupational & Environmental Medicine [3]	FAFOEM
Public Health Medicine [3]	FAFPHM

34 *P Trainees must complete Basic Training in Paediatrics & Child Health to enter this program.*
35 *A Trainees must complete Basic Training in Adult Internal Medicine to enter this program.*
36 *1 Training program must be undertaken with another division training program or undertaken post-RACP.*
37 *2 Trainees who have entered Advanced Training in Palliative Medicine via a RACP Basic Training Program will be*
38 *awarded FRACP upon completion and may subsequently be awarded FAChPM. Trainees who have not entered*
39 *Advanced Training in Palliative Medicine via a RACP Basic Training Program will only be awarded FAChPM upon*
40 *completion.*
41 *3 Entry to these training programs can be via Basic Physician Training or through other pre-requisites*

42 ## The current state of the specialty/workforce

Reference	Request	Witness
2	Information as to the following within NSW a) Accredited trainees. b) Unaccredited trainees. c) Fellows able to supervise trainees. d) Training sites.	Inam Haq

43 ***2A-B - accredited and "unaccredited" trainees***
44 In order to undertake RACP training, a doctor must be in an approved training position.
45 For core training periods, this is generally within an accredited training setting. The
46 College does not distinguish between Accredited and Unaccredited positions and hence
47 does not maintain data on Unaccredited trainees.

48 Data on the number of registered trainees in NSW is annexed to this statement at
49 Annexure A [ACP.0001.0095.0001].

50 ***2C – supervisors***
51 Credentialling requirements for Fellows to be able to supervise trainees vary per program
52 but typically are that they are qualified to work in the specialty the trainee is undertaking
53 training within and that they have completed the supervisor professional development
54 stipulated by the RACP (which, at a maximum is three x 3-hour workshops/online
55 courses).

56 Data on the number of credentialled (and to-be credentialled) supervisors for each training

57 program in NSW is provided below in Table 2.

58 ***Table 2. Supervisors in NSW per training program***

Fellowship Specialty (Fellows are counted multiple times, ie once for each specialty^)	Number of supervisors	
	Credentialed	To be credentialed
Basic Training – AMD	410	10
Basic Training – PCHD	111	0
Addiction Medicine	36	3
Adolescent and Young Adult Medicine	11	1
Cardiology	108	38
Clinical Genetics	29	3
Clinical Haematology	0	0
Clinical Immunology and Allergy	0	0
Clinical Pharmacology	13	0
Community Child Health	56	0
Endocrinology	106	12
Gastroenterology	97	15
General & Acute Care Medicine	129	5
General Paediatrics	270	20
Geriatric Medicine	208	11
Haematology	106	13
Immunology and Allergy	39	1
Infectious Diseases	104	4
Intensive care medicine	2	1
Medical Oncology	168	12
Neonatal/Perinatal Medicine	57	7
Nephrology	118	7
Neurology	126	12
Nuclear Medicine	24	5
Occupational & Environmental Medicine	8	1
Paediatric Emergency Medicine	25	2
Palliative Medicine	124	8
Public Health Medicine	76	17
Rehabilitation Medicine	116	6
Respiratory & Sleep Medicine	143	13
Rheumatology	42	9
Sexual Health Medicine	24	2

59 *^ Data is correct and accurate as of 8 July 2024 and represents a snapshot in time. Each unique member can be counted*
60 *across multiple specialties in which they are supervising. For example, a supervisor might be supervising a Basic Trainee*
61 *and an Advanced Trainee at the same time and will therefore be counted in Basic Training and the relevant Advanced*
62 *Training specialty.*

63 ***2D- training sites***

64 Training sites in NSW are annexed to this statement at Annexure # and are publicly

65 available here Accredited settings | RACP [https://www.racp.edu.au/trainees/accredited-
66 settings].

Reference	Request	Witness
3	The extent to which the current number of practising specialists can meet the demand for services within New South Wales – generally and in the public health system.	Kudzai Kanhutu

67 We do not routinely provide commentary or advice on supply versus demand evaluations
68 of the medical workforce. This is beyond the scope of our organisation's remit as a
69 specialist education provider. We do, however, cultivate positive relationships with sector
70 partners who hold important complementary data on workforce trends and community
71 healthcare needs. e.g. Federal Department of Health, jurisdictional workforce data leads,
72 MDANZ, Ahpra, MCNZ, AIHW, ABS.

73

Reference	Request	Witness
4	If there is a maldistribution of specialists across New South Wales (either geographically or between the public and private health systems): a) The nature of the maldistribution. b) The factors that contribute to that maldistribution.	Kudzai Kanhutu

74 The RACP is not in a position to provide an evidence-informed comment on this request.

75 Factors which contribute to effective specialist distribution are:

76 • adequate supervision workforce for training in location of potential eventual
77 practice, with educational resources including administrative support for education;
78 allocated and protected time for supervision; and recognition of service,

79 • outcomes based approaches to training and accreditation of training settings,
80 combined with training networks that allow for rural and/or regional immersion and
81 continuity in training.

82 Specialist training programs

Reference	Request	Witness
5	A summary of the specialty training program(s) administered by the College in New South Wales, by reference to the relevant policy documents and including: a) Entry requirements. b) Length of program(s). c) Location of delivery (metropolitan/rural). d) Program structure.	Inam Haq

	e) Number of trainees admitted in the relevant period, including how that number is determined.	

83 ***5A – entry requirements***

84 Entry requirements for each of the RACP's training programs (listed in Table 2) are
85 stipulated in the training program handbooks.

86 To commence **Basic Physician Training**, a prospective trainee must have:

87 - current general medical registration with the Medical Board of Australia/Ahpra
88 - an appointment to an appropriate training position at an accredited setting
89 - discussed their application and received approval to apply for Basic Training from
90 the hospital or network Director of Physician/Paediatrics Education (DPE).

91 The DPE's approval is subject to local selection processes, training capacity and/or
92 performance of the prospective trainee. Australian trainees are required to have their
93 online application approved by their DPE.

94 To commence **Divisional Advanced Training**, a prospective trainee must have:

95 - completed Basic Physician Training in the relevant Division
96 - secured an accredited Advanced Training position.

97 Entry into **Chapter and Faculty programs** varies:

98 - Chapters- doctors can apply for entry if they have completed Basic Physician
99 Training or if they have Fellowship of one of the approved other specialist medical
100 colleges.
101 - Faculties – doctors can apply if they have general medical registration and have
102 completed the requisite number of postgraduate years after their primary medical
103 degree (along with some other requirements as outlined in training program
104 handbooks):
105 - Occupational and Environmental Medicine- must complete two postgraduate
106 years
107 - Public Health Medicine- must complete three postgraduate years
108 - Rehabilitation Medicine- must complete two postgraduate years.

109 ***5B- length of programs***

110 Training program handbooks outline the minimum duration of training programs, which are
111 summarised as follows:

112 - Basic Training - 3 years
113 - Advanced Training, inclusive of Chapter training - 3 years
114 - Occupational and Environmental Medicine- 3.5 years
115 - Public Health Medicine- 3 years
116 - Rehabilitation Medicine- 4 years.

117 Trainees may apply for recognition of prior learning, in accordance with the College's
118 Recognition of Prior Learning Policy [SCI.0011.0258.0001], which can reduce the duration
119 of training.

120 ***5C- location of training***

121 Training must be undertaking in settings as specified in the relevant training program
122 handbooks. Different training experience requirements align with different setting
123 accreditation requirements.

124 ***5D- program structure***

125 Training program structures are outlined in the Training Program Handbooks (provided in
126 response to Summons to Produce Item 1C.2). All programs are founded on supervised
127 work-based learning and assessment and include an array of core and non-core/elective
128 workplace experiences that provide breadth and depth of exposure in alignment with the
129 relevant curricula (provided in response to Summons to Produce Item 1C.2).

130 ***5E- Number of trainees admitted in the relevant period, including how that number***
131 ***is determined***

132 Data regarding the number of trainees commencing each RACP training program each
133 year for the past 5 years is annexed to this statement at Annexure B
134 [ACP.0001.0095.0001].

135 The RACP does not 'cap' training numbers, although it requires that all trainees acquire a
136 suitable job in order to be eligible to commence training. The RACP provides training
137 settings with Capacity to Train Guidance annexed to this statement at Annexure C
138 [SCI.0011.0259.0001 and SCI.0011.0260.0001]. Some programs (eg Basic Training)
139 accredit settings and support settings to determine how many trainees they recruit based
140 on the Guidance. Other programs (eg Advanced Training in Gastroenterology) accredit
141 training settings for a requisite number of positions based on the established accreditation
142 criteria. It is optional for doctors in accredited training positions to register for physician
143 training although, anecdotally, we understand the majority of incumbents elect to do so.

Reference	Request	Witness
6	An overview of the role/function of other agencies/bodies, etc., in administering specialty training programmes relevant to the college, including NSW Health.	Inam Haq

144 The RACP works closely with a range of other agencies/bodies in NSW for administering
145 training including:

146 - **HETI -** The RACP has a representative on the Physician and Paediatric Training
147 Councils, the General Medicine State Advisory Group and the Basic Physician
148 Training Networks group. These representatives relay important information from
149 the RACP to the Councils/Networks group, and act as a conduit to support queries
150 from Council/Networks group members to relevant RACP business units. HETI
151 works in conjunction with NSW Health to facilitate annual medical recruitment for
152 networked Basic Training and some Advanced Training specialty positions.
153 - **NSW Health -** The RACP is committed to working with NSW Health to share best
154 practices in relation to work based training, which will assist in providing trainees a
155 breadth of experience in the discipline. Refer to Item 8 below, to see how the RACP
156 collaborates with NSW Health in Accreditation.
157 - **Training Settings -** Training Settings are responsible for funding Directors of
158 Physician/ Paediatric Education, providing protected time for trainees and support
159 the supervisor workforce to maintain accreditation Standards.

160 • **Other Colleges -** The RACP works collaboratively with the other Colleges to
161 administer joint Advanced Training Programs:
162 ○ Australasian College for Emergency Medicine [https://acem.org.au/]
163 (Advanced Training in Paediatric Emergency Medicine),
164 ○ Royal Australian and New Zealand College of Radiologists
165 [https://www.ranzcr.com/] (Advanced Training in Nuclear Medicine), and
166 ○ Royal College of Pathologists of Australasia [https://www.rcpa.edu.au/]
167 (Advanced Training in Endocrinology and Chemical Pathology,
168 Haematology, Immunology and Allergy, Infectious Diseases and
169 Microbiology).
170 • The relevant Training Committees are comprised of representatives from both
171 Colleges as per their Terms of Reference.

172 ## Specialty societies and other colleges

Reference	Request	Witness
7	A summary of the process for the accreditation of training sites/places in New South Wales by reference to relevant policy documents, including: a) The role/function of the College in the accreditation of training sites/places. b) The criteria applied for accreditation of training sites/places. c) The process by which new sites are identified for possible accreditation. d) The process of determining how many training places will be accredited at a particular training site, and who is responsible for making those decisions. e) The processes for reviews of accreditation, including the withdrawal of accreditation. The body responsible for setting criteria applied for accreditation of training sites/places, and the process for the review of those criteria.	Inam Haq

173 ***7A- The role/function of the College in the accreditation of training sites/places.***

174 The RACP is accredited by the Australian Medical Council as an education provider. As
175 part of this accreditation, the RACP is responsible for developing and maintaining
176 standards for physician workplace training in Australia. The RACP accreditation program
177 provides a framework for the assessment and recognition of Training Providers.

178 The RACP primarily delivers its training through participation in supervised work-based
179 activities with specialist physicians. The RACP sets the standard of competence for each
180 training program it offers through its curriculum, with RACP accredited programs ensuring
181 the RACP that:

182 • workplace training is likely to develop competent physicians who deliver safe and

183 effective health care to patients, now and into the future
184 • trainees and trainee-delivered patient care is safeguarded
185 • high-quality learning that integrates medical practice, training and research in an
186 optimal environment is promoted
187 • quality teaching and supervision is supported
188 • the medical profession is enabled to reflect on training practices and continuously
189 improve
190 • transparent information is provided to trainees that informs training choices.

191 The RACP accreditation framework is at SCI.0011.0176.0001 operates under the
192 following principles:

193 • **Focused on training**- the RACP assesses workplace characteristics and training
194 functions which influence the trainee's ability to achieve learning outcomes.
195 Improvement, quality, and best practice training are acknowledged. Less
196 satisfactory practices are identified, and recommendations are made for
197 improvement.
198 • **Supportive of patient safety and quality care**- patient safety and quality of care
199 are paramount. The RACP will not support training in environments where safety
200 and care are not adequately protected.
201 • **Flexible**- the RACP takes into consideration training, Training Provider,
202 environment, and service diversity.
203 • **Proportionate**- when requiring improvements, consideration will be given to the
204 training environment, risk level and cost.
205 • **Independent and accountable**- accreditation decisions are independent of
206 external and internal influence and consistent with assessment findings. They are
207 based on evidence, clear, predictable, consistent, publicly available, equitable and
208 fairly represented. Real or perceived conflicts of interest on the part of assessors
209 and committee members are recognised and managed appropriately.
210 • **Transparent**- accreditation information is published. Written and verbal guidance
211 is provided. The accreditation program is guided by principles, a code of conduct
212 and conflict of interest policies.
213 • **Effective**- the accreditation program has sound governance, sustainable
214 resources, and effective processes.
215 • **Relevant**- accreditation is responsive to changes in training. The RACP reviews
216 its accreditation program regularly, and participates in accreditation projects,
217 research, and stakeholder consultation.
218 • **Collaborative**- the RACP undertakes accreditation respectfully and
219 collaboratively. Effective communication occurs between the RACP, Training
220 Providers, jurisdictions and trainees. Trainees are central to the accreditation
221 process, and their opinions are respected.
222 • **Coordinated**- the accreditation program is streamlined and coordinated to reduce
223 administrative burden.

224 ***7B- The criteria applied for accreditation of training sites/places.***

225 The criteria applied for accreditation of training sites/positions varies for each training
226 program. Accreditation requirements for Basic Training Settings and Networks are set
227 out in:

228 • Adult Internal Medicine - bt-accreditation-requirements-aim.pdf (racp.edu.au)

229 [SCI.0011.0167.0001]
230 • Paediatrics and Child Health - bt-accreditation-requirements-pch.pdf
231 (racp.edu.au) [SCI.0011.0168.0001]
232 • Training Network Principles - training-network-principles.pdf (racp.edu.au)
233 [SCI.0011.0175.0001]

234 Each requirement is linked to a criterion, which are assessed throughout the accreditation
235 process. The Accreditation Requirements are to be read in conjunction with the RACP
236 Training Provider Standards [SCI.0011.0177.0001].

237 Criteria for accreditation of Advanced Training programs were provided in response to
238 the Summons to Produce within Item 1B.77.

239 ***7C- The process by which new sites are identified for possible accreditation.***

240 The Initial Accreditation Process [SCI.0011.0169.0001] outlines the procedure for the
241 Initial Accreditation of a Training Provider and/or Basic Training Program. Health services
242 must apply to be accredited if they wish to provide RACP training programs. If a Setting
243 reaches out seeking accreditation and wanting to join a network, the RACP supports the
244 Setting by collaborating with HETI.

245 ***7D- The process of determining how many training places will be accredited at a***
246 ***particular training site, and who is responsible for making those decisions.***

247 As outlined in 5E, the RACP does not 'cap' training numbers. The RACP has developed
248 Capacity to Train Guidance and an e-module which supports settings offering Basic
249 Training in Adult Internal Medicine or Paediatrics & Child Health to determine their
250 capacity to train. The RACP defines 'capacity to train' as the number of trainees that can
251 be trained to meet their respective training program requirements and ultimately meet
252 the standard required to comply with the professional and educational requirements of
253 the RACP. The RACP uses accreditation as the tool to monitor training settings' capacity
254 to train. The new Training Provider Accreditation Standards and Basic Training
255 Accreditation Requirements require settings to determine the number of trainees they
256 have in relation to their capacity to resource training and ability to deliver training
257 experiences in alignment with the Basic Training curricula.

258 In Basic Training, the Accreditation Subcommittees for Adult Internal Medicine and
259 Paediatrics & Child Health are responsible for determining a Settings Capacity to Train.
260 In Advanced Training, the Advanced Training Committees for each specialty would be
261 responsible for determining a Settings requisite number of positions based on the
262 accreditation criteria. Please note, Advanced Training in General Paediatrics and
263 General Rehabilitation both have an Accreditation Subcommittee who make these
264 decisions.

265 ***7E- The processes for reviews of accreditation, including the withdrawal of***
266 ***accreditation.***

267 RACP accreditation programs operate across four- or five-year accreditation cycles and
268 is articulated in the Accreditation of Training Provider Process [SCI.0011.0165.0001].
269 The RACP accreditation cycle consists of five stages:

270 *Self-Assessment*

271 The Training Provider self- rates their compliance with the relevant accreditation
272 standards, requirements, or criteria by completing the RACP self- assessment forms.
273 Scheduled and on- demand training webinars alongside e-modules are available from the
274 Training Accreditation Services team to support stakeholders in the completion of the self-
275 assessment forms. The completed form and relevant documentation are submitted to the
276 RACP for review. The RACP sends a survey to trainees who have trained with the Training
277 Provider within the last 24 months.

278 *External Assessment*

279 A document review of the completed form and relevant documentation is undertaken by
280 a panel of at least two accreditors. The trainee survey results and relevant information
281 such as reports of potential breaches, change in circumstance, Medical Training Survey
282 results and media clippings relevant to training may also be included in the accreditors
283 pack. Where required, a physical or virtual site visit may be undertaken incorporating
284 interviews with stakeholders such as the Setting Executive, Directors of
285 Physician/Paediatric Education (DPEs), Head of Departments and trainees. The
286 Accreditors complete the Accreditation Findings Form and this is submitted to the Training
287 Provider for factual verification.

288 *External Validation*

289 The Accreditation Findings Form is presented to the relevant RACP accreditation body by
290 the accreditors. The accreditation body discusses the findings and reaches an
291 accreditation decision.

292 *Reporting*

293 The Accreditation decision is communicated to the Training Provider through a notification
294 letter. The process for reviews of an accreditation decision is subject to the RACP's
295 Reconsideration, Review and Appeals Process By-law [ACP.0001.0018.0001]. After the
296 28-day Reconsideration, Review and Appeal timeframe has lapsed the accreditation
297 status of the Training Provider is published on the RACP website
298 [https://www.racp.edu.au/trainees/accredited-settings]. As of 2024, the RACP will begin to
299 publish an executive summary detailing the accreditation decision and which accreditation
300 standards, requirements and criteria are met, partially met, or not met.

301 *Monitoring*

302 The RACP monitors its Training Providers to ensure that compliance with the standards
303 is maintained across the accreditation cycle. The Monitoring of a Training Provider
304 [SCI.0011.0170.0001] process articulates the mechanisms by which the RACP
305 undertakes mid-cycle monitoring and how potential breaches of the Training Provider
306 Standards are managed. The RACP published its Active Management process
307 [SCI.0011.0166.0001] in late 2023. This process articulates the RACP's response to the
308 very small number of accreditation reviews where serious non-compliance issues are
309 identified. The process also ensures that the RACP communicates any identified issues
310 to the relevant jurisdiction to allow for a collaborative response to resolution. The
311 withdrawal of accreditation process is highlighted on page 10-11 of this document.

312 **Site Visits**

313 The RACP currently undertakes physical site visits for Basic Training program providers
314 that are classified as level two or level three. Physical site visits are also undertaken where
315 serious non-compliance issues are identified within in any accreditation program. The
316 RACP sets its accreditation schedules six months prior to the calendar year and
317 collaborates with Training Providers to allocate dates that cause the least inconvenience.

318 The physical site visit provides the RACP accreditation panel with the opportunity to tour
319 the training setting and interview key accreditation stakeholders such as DPEs, Setting
320 Executive and trainees. The RACP also undertakes virtual and hybrid accreditation
321 reviews acknowledging the benefits of technology in site visits.

322 ***7F- The body responsible for setting criteria applied for accreditation of***
323 ***training sites/places, and the process for the review of those criteria***

324 **Basic Training**

325 The Adult Internal Medicine Basic Training Accreditation Subcommittee, Paediatrics and
326 Child Health Basic Training Subcommittee are responsible for implementing criteria. A
327 working group originally developed the criteria, which was approved through the RACP
328 governance process outlined below.

329 **Advanced Training**

330 The Advanced Training Committees for each of the remaining Advanced Training
331 specialties are responsible for developing and reviewing criteria with the exception of the
332 following two subcommittees who have this role: Australian Faculty of Rehabilitation
333 Medicine Accreditation Subcommittee and the General Paediatrics Accreditation
334 Subcommittee.

335 Any changes to both Basic Training and Advanced Training Accreditation Standards are
336 reviewed and approved by the College Education Committee who ensure there is
337 compliance with policies and frameworks.

338 A guide is in the final stages of development to assist Accreditation Committee's in
339 reviewing the criteria for Accreditation. The guide:

340 • lists the principles that accreditation committees should follow when
341 recommending changes to the Training Provider Standards, Basic Training
342 Accreditation Requirements and Program Classification;
343 • explains how to assess the potential effects of changes on Training Providers and
344 the RACP through an impact assessment;
345 • outlines the process for consultation, approval, and implementation of changes
346 to the Training Provider Standards, Basic Training Requirements and Program
347 Classification.

348 Program evaluation is conducted across all accreditation activities to ensure the RACP is
349 meeting the outcomes of the new accreditation program.

Reference	Request	Witness
8	An overview of the role/function of other agencies/bodies in the accreditation of training sites/placements.	Inam Haq

350 The RACP works closely with a range of other agencies/bodies in NSW for accreditation
351 of training sites/ placements including:

352 - **HETI-** The RACP has a representative on the Physician/ Paediatric Training
353 Council and Basic Physician Training Network group and the General Medicine
354 State Advisory Group.
355 - **NSW Health-** The RACP is committed to working with NSW Health to share best
356 practices in relation to work based training, which will assist in providing trainees a
357 breadth of experience in the discipline. The RACP meets with NSW Health
358 quarterly to provide updates on accreditation, discuss the health care system and
359 notify of any accreditation concerns with Training Providers. A communication
360 protocol has been developed between the AMC, medical colleges and jurisdictions
361 to articulate communication between accreditation stakeholders at the point of
362 which a trainee setting was identified as being at risk. There was agreement to
363 involve the jurisdictions early when serious concerns are identified.
364 - **Training Settings -** Training Settings are responsible for funding Directors of
365 Physician/ Paediatric Education, providing protected time for trainees and support
366 the supervision workforce to maintain accreditation Standards.
367 - **Local health districts -** Local Health Districts are responsible for funding Network
368 Directors of Physician/ Paediatric Education as well as administrative support for
369 the networks.
370 - **Specialty societies and other colleges -** There are other Colleges and
371 Associations who are responsible for the management of some of the RACP's
372 Advanced Training programs accreditation. Accreditation for the following
373 programs is not currently managed by the RACP:
374 - Neurology - The Australian and New Zealand Association of Neurologists
375 [https://www.anzan.org.au/Index.asp] (ANZAN) undertakes site accreditation
376 for neurology positions.
377 - Nuclear Medicine - The Australian Association of Nuclear Medicine Specialists
378 [https://www.aanms.org.au/] (AANMS) undertakes site accreditation for nuclear
379 medicine positions.
380 - Paediatric Emergency Medicine – The Australian College for Emergency
381 Medicine [https://acem.org.au/] (ACEM) undertakes site accreditation for
382 paediatric emergency medicine positions.
383 - Laboratory accreditation for RCPA/RACP joint program laboratory positions –
384 The Royal College of Pathologists of Australasia [https://www.rcpa.edu.au/]
385 (RCPA) undertakes accreditation for joint program laboratory positions.
386 - Acute Care (PICU) accreditation as part of Advanced Training in General
387 Paediatrics - The College of Intensive Care Medicine
388 [https://cicm.org.au/Home] (CICM) of Australia and New Zealand undertakes
389 site accreditation for Acute Care (PICU).

390 Internationally trained doctors

Reference	Request	Witness
9	An overview of the process by which internationally trained doctors may attain Fellowship of the College.	Inam Haq (Dr Louise Rigby, Executive General Manager

		Professional Practice would be the appropriate person to call as an expert witness at the hearing, if required)

391 The RACP's specialist assessment process is outlined in the RACP's Overseas Trained
392 Physician (OTP) Assessment Policy and Overseas Trained Physicians OTP Guidelines
393 (Australia) [SCI.0011.0171.0001] (provided as Items 1F.1-2 in response to the Summons
394 to Produce).

395 To summarise, after an overseas trained physician (OTP) submits their application to the
396 RACP, there are 3 assessment stages:

397 1) **Interim assessment stage.** The RACP determines the applicant's comparability
398 to an Australian trained specialist and the requirements the applicant must
399 complete for specialist assessment. This process considers the applicant's
400 training, experience, recent practice, CPD, technical clinical skills and non-
401 technical professional attributes per the RACP Professional Practice Framework
402 [https://www.racp.edu.au/fellows/professional-practice-framework]. In doing this,
403 the RACP reviews the application, interviews the applicant and requests referee
404 reports. The majority of OTPs receive their interim assessment decision within 4
405 months and 14 days from the date their complete application was received (this is
406 a timeframe set by the Medical Board of Australia).
407 2) **Ongoing assessment stage.** The RACP monitors the OTP's ongoing training,
408 assessments, supervised practice requirements and associated timeframes in
409 Australia. Additional assessments may be required, depending on the OTP's
410 progress. The RACP notifies AHPRA that the OTP is eligible for registration to
411 progress their specialist assessment requirements if necessary. Requirements for
412 supervised practice are determined on a case-by-case basis; the minimum
413 requirement is 6 months and maximum 24 months of top up training and/or peer
414 review.
415 3) **Final assessment stage.** The RACP assesses if the OTP has satisfactorily
416 completed their requirements for specialist assessment. It also establishes if the
417 OTP is comparable to an independent Australian trained specialist in the
418 subspecialty and eligible for admission to Fellowship and able to register as a
419 specialist.

420 The RACP is meeting its applicable compliance measures, benchmarks and expectations
421 set by the Australian Medical Council. Our internal compliance rate for the 2023 calendar
422 year was 98.3%.

423 The RACP OTP Team provides individual support to OTPs, both those who are doing well
424 under supervision and those who are struggling. Support from a dedicated Case Officer
425 is significant and assists an OTP during and after their supervision period, including the
426 transition to continuing professional development (CPD) requirements and Fellowship.

427 ## Workforce planning

Reference	Request	Witness

10	The extent to which the specialist training programmes administered by the College are currently producing sufficient specialists to meet current and future demand in NSW.	Kudzai Kanhutu

428 The RACP does not routinely provide commentary or advice on supply versus demand
429 evaluations of the medical workforce. This is beyond the scope of our organisation's remit
430 as a specialist education provider. We do, however, cultivate positive relationships with
431 sector partners who hold important complementary data on workforce trends and
432 community healthcare needs. e.g. Federal Department of Health, jurisdictional workforce
433 data leads, MDANZ, Ahpra, MCNZ, AIHW. The Federal Department of Health is in the
434 process of developing a workforce data sharing framework and multiple supply and
435 demand models.

Reference	Request	Witness
11	If the College considers that specialist training programmes are not producing sufficient specialists to meet current and future demand in NSW: a) How many more specialists are required to meet that demand, including by reference to particular locations within New South Wales (i.e., metropolitan/regional, etc)? b) An identification of any particular impediments/obstacles/challenges in training sufficient specialists to meet that demand.	Kudzai Kanhutu

436 The RACP is not in a position to provide an evidence-informed comment on whether or not
437 specialist training programmes are producing sufficient specialists to meet current and
438 future demand in NSW.

439 We do, however, produce reports on:

440 • Numbers of trainees in NSW
441 • Numbers of fellows in NSW by specialty area
442 • Number of new Fellows each year in NSW.

443 These reports have been included in Annexure D [ACP.0001.0089.0001,
444 ACP.0001.0090.0001, ACP.0001.0091.0001, ACP.0001.0092.0001,
445 ACP.0001.0093.0001, ACP.0001.0094.0001].

446 Generally, impediments/obstacles/challenges to training specialists which can occur in
447 NSW but are not limited to NSW include:

448 • The RACP's training programs are designed to produce a specialist doctor capable
449 of practising medicine within the relevant field of specialty across a range of
450 settings. As such, the programs need to ensure sufficient breadth and depth of
451 essential training experiences, as defined within the relevant training program
452 curricula and handbook. Access to some workplace experiences are sometimes
453 only possible within certain service types. For example, the Neonatal/Perinatal

454 Advanced Training Program requires that trainees spend six months working in a
455 neonatal centre that is accredited for and performs major neonatal surgery. These
456 essential experiences are natural limiters on training locations and how many
457 positions are available for trainees to access as they progress through training.

458 • Ensuring a sufficiently resourced and stable supervision workforce with capacity to
459 provide quality work-based training and associated formal education for specialist
460 trainees in alignment with relevant curricula.

461 • Medical training pathways were recently extended in NSW (which has also
462 occurred in some other jurisdictions) due to changes in jurisdictional recruitment
463 eligibility criteria, which now specify that applicants for accredited Basic Physician
464 Training positions must have completed two postgraduate years of training under
465 the new Australian Medical Council National Framework for Prevocational Medical
466 Training. The RACP's eligibility criteria for commencing Basic Physician Training
467 specifies that applicants must have completed one postgraduate year of training,
468 and the AMC specifies that only one year of training under its new Framework is
469 essential.

470 • A goal of the RACP's Accreditation Renewal Program is the establishment of
471 integrated training pathways. This is discussed in the RACP's Training Network
472 Principles [SCI.0011.0175.0001] which represents the first step in the RACP's
473 Integrated Training Program strategy. The strategy involves creating pathways for
474 trainees through their Training Program, whereby delivery of the curriculum and
475 training requirements is coordinated by a Network. In NSW, most Basic Physician
476 training occurs within HETI's network structures. There is an opportunity to expand
477 this throughout Advanced Training. There is also potential for establishing
478 rurally/regionally-centred training networks, especially for Basic Training, with the
479 vision to facilitate trainees completing the majority of their training in a rural/regional
480 location. This would support the perseveration of rural training pipelines and build
481 upon the successes of rural clinical schools. Establishing these AT and
482 rural/regional networks would, however, involve substantial logistics and contract
483 management across multiple Local Health Districts.

Reference	Request	Witness
12	The extent to which the College considers the demand for specialist services – generally and between different locations within New South Wales – in the administration of training programs.	Inam Haq

484 Drawing direct links between training and specialist services is not something the College
485 currently undertakes as the activity can be confounded by a range of factors:

486 • Demand side assessments are complicated to establish. There is no uniform
487 agreed minimum data set to inform an assessment of true community demand.
488 We rely on proxy measures such as published data on disease prevalence,
489 MBS/PBS billing patterns and hospital outpatient waiting lists. Our membership
490 also provides insights on community disease trends through their lived
491 experience of delivering care across contexts (public hospital, community care
492 and private sector). We also acknowledge there are sectors of our community

493 who are routinely underrepresented in the data which can limit the generalisability
494 of estimations of true community specialist care demand.

495 • Doctors have autonomy in determining where and how they wish to work. This
496 includes the right to part-time or more flexible arrangements which can have an
497 impact on the distribution and availability of specialist services.

498 Recognising the importance of health equity for people living outside metropolitan areas
499 and the need for a systematic and coordinated approach to addressing this, the RACP
500 developed a Regional, Rural and Remote Physician Strategy [ACP.0001.0129.0001].
501 This strategy articulates five groups of recommendations to (a) advocate for change and
502 (b) guide activities to support equitable health outcomes for Australians and New
503 Zealanders living in regional, rural, or remote locations. These are:

504 1) Prioritise regional, rural, and remote (RRR) healthcare at the RACP.
505 2) Build capacity and capability to provide physician training in RRR areas.
506 3) Improve the attraction and retention of RRR physicians.
507 4) Collaborate to improve RRR healthcare provision.
508 5) Respect, promote and acknowledge Indigenous peoples.

509 The RACP is in the process of developing an implementation plan for this strategy.

510 **Training Programs**

511 Service provision and delivery of work-based vocational training programs, such as
512 the RACP's physician training programs, are intertwined and hence health service
513 needs are considered throughout the design and administration of the RACP's training
514 programs.

515 To support achievement of the graduate outcomes (competencies) in the curriculum,
516 there must be sufficient congruence between workplace experiences in training
517 (service provision as a registrar) and post-Fellowship practice (service provision as a
518 specialist). In educational terms, this is referred to as constructive alignment.

519 Our in-train curricula renewal program considers the competencies required for
520 contemporary practice as a physician and, amongst other things, considers:

521 • Developments in medical practice
522 • Patient, consumer and employer expectations.

523 In the past two years, 23 of the RACP's 41 curricula have been updated through a
524 comprehensive review process that includes input from specialists, doctors in training,
525 peak bodies and health system stakeholders. The remaining 18 curricula are currently
526 being updated and are on track for completion by Q1 2025.

527 Training program requirements, linked with the renewed curricula outcomes, are
528 developed in consideration of available workplace experiences and wherever possible
529 designed to maximise flexibility in training. As outlined in Item 11, some essential
530 workplace experiences can only be accessed in specific training settings (eg large
531 health services) which can mean that rural training opportunities are less acceptable.

532 To support implementation and improvement to our programs we have a range of
533 initiatives in various stages of development such as:

534 • Commonwealth Specialist Training Program placements – RACP administers

535 332 positions equivalent to 328 FTE.

536 • RACP-related projects funded through the Commonwealth's Flexible Approach
537 to Training in Expanded Settings (FATES) grants scheme including an inter-
538 College project on Rural Networks and the Rural and Remote Institute of
539 Palliative Medicine project (refer to Item 13B below for details)

Reference	Request	Witness
13	In relation to "unaccredited trainees" working within the College's specialty area: a) A description of an "unaccredited trainee" from the perspective of the College. b) The role played by "unaccredited trainees" within the public health system in NSW.	Kudzai Kanhutu

540 The College does not distinguish between accredited and unaccredited trainees as all
541 doctors in suitable positions are eligible for registration for RACP training programs.

542 The RACP acknowledges that there are some health services that recruit to hospital registrar
543 positions in physician-related specialties, although does not have involvement in this
544 process. The RACP is committed to collaborating with the Commonwealth's Medical
545 Workforce Reform Advisory Committee on its work regarding a Career Medical Officer and
546 Hospital Registrar Framework. We note that this Framework would require an ecosystem
547 approach to resource management, especially regarding resourcing for supervision and
548 educational leadership where there are significant overlaps with the resourcing required to
549 sustain physician training. In many training settings, educational leadership roles for the
550 junior medical workforce are fulfilled by physicians, and often these roles are responsible for
551 the oversight of medical students, interns and other prevocational doctors in training, and
552 physician trainees. The demands on these roles are significant and expanding. We are
553 concerned by anecdotal reports from College Fellows occupying these positions that
554 resourcing is insufficient to meet these increasing demands. Introduction of new programs
555 for oversight of 'unaccredited' trainees (sometimes also known as hospital registrars or
556 career medical officers) should be considered with reference to impacts on the rest of the
557 medical training ecosystem, seeking to mitigate risk of unintended negative consequences.

558 Case studies

Reference	Request	Witness
13	Suitable case studies to demonstrate: a) Workforce challenges/issues/obstacles. b) Challenges in implementing the training programs by the College, including examples of how challenges have been overcome.	Kudzai Kanhutu

559 ***13A- Workforce challenges/issues/obstacles.***

560 Multisource feedback from our members has identified some common workforce challenges.
561 Sources of College feedback include member surveys, College governance bodies,
562 communications channels and direct feedback. We also observe trends in the lay press and

non-College data sources.

Case study 1. Workplace wellbeing

Members report they are working beyond their capacity or are experiencing burnout. This is evident for those who hold education stewardship roles like Directors of Physician Education who must manage clinical responsibilities alongside supervision. Accreditation review feedback points to inadequate time allocation for non-clinical workload.

Case study 2. Access to flexible work arrangements

Trainees are entering medical careers at more advanced stages of life relative to previous generations. Despite RACP policy permitting training at a minimum of 0.2FTE, practical access to part-time training roles is limited. Structural supports like out of home childcare do not align with the standard working hours for training settings, leading to a higher out of pocket costs and reliance on private care arrangements.

Case study 3. Increased fractionalisation of roles

Overall concerns about capacity to secure employment upon training completion has reduced but remains high at 63%. We observed an increase in the proportion of trainings entering part-time roles (58%). Of these, a third did so as it was the only option available.

Case study 4. Limited opportunities for end-to-end training outside of metropolitan areas

Published literature identifies rural immersion as a key driver of retention in rural regional remote career pathways. Previous iterations of curriculum necessitated urban exposure, with the potential to increase permanent departures from rural practice. The current curriculum renewal process is being engineered to allow greater capacity for trainees to meet their clinical competencies within rural settings.

Case study 5. Specialties at risk due to low trainee numbers or inadequate funding to sustain consultant services

Some of the smaller specialties have trainee growth rates that fall well below expected attrition rates through retirement. This has been compounded by member observations that they encounter significant barriers and hurdles to re-hiring into unfilled consultant positions, largely due to funding constraints or the perception that the work can be redistributed to non-medical workforce or trainees.

For example, when compared to the average Fellow age across the RACP (53.3 years) and average annual growth rate (5.1%) the following specialties would appear to be at risk:

- occupational and environmental medicine - has an average Fellow age of 64.8 with an annual specialty membership growth of < 1%.
- sexual health medicine – has an average Fellow age of 60.5 with an annual specialty membership growth of 2.1%.
- public health medicine – has an average Fellow age of 63.9 with an annual specialty membership growth of 2.2%
- rehabilitation medicine - has an average Fellow age of 55.0 with an annual specialty membership growth of 2.3%.

The above data reflects the membership across all locations (Australia, Aotearoa New Zealand and internationally).

605 ***13B- Challenges in implementing the training programs by the College, including***
606 ***examples of how challenges have been overcome.***

607 The key challenges for the RACP in implementing the training programs relate to the
608 devolved model of implementation which creates challenges in:

609 - ensuring capacity, resourcing and capabilities for supervision and educational
610 leadership
611 - effectively stewarding and coordinating training capacity across a variety of
612 settings and programs
613 - maintaining a flexible outcomes-based approach to training program
614 implementation which focusses on standards rather than prescriptive
615 implementation models.

616 National Health Practitioner Ombudsman specialist medical 617 training site accreditation processes review

Reference	Request	Witness
14	The extent to which the College agrees or disagrees with the conclusions and recommendations set out in the National Health Practitioner Ombudsman report titled *"A roadmap for greater transparency and accountability in specialist medical training site accreditation"*, dated October 2023.	Inam Haq

618 The College is collaborating with the NHPO project to respond to the recommendations
619 of the NHPO and recognises the benefits in a system-wide approach to improving
620 processes and outcomes for training setting accreditation.

621 The RACP is on track with meeting the NHPO recommendations. The Active Management
622 [SCI.0011.0166.0001] and Initial Accreditation [SCI.0011.0169.0001] processes have
623 been published on the RACP website. Processes have been developed to support the
624 reporting stage of the Accreditation Cycle. Accreditation decisions regarding Training
625 Providers (ie training sites) will now be published as an executive summary from Q3 2024.

626 All Advanced Training Accreditation Programs have been reviewed to align and streamline
627 policies and processes.

628 The RACP evaluation team have conducted research for the Training Provider Standards
629 review. Significant findings have been discovered through a duplication identification
630 exercise against other Colleges and legislation. An RACP workshop was conducted in
631 June 2024 to review the Training Provider Standards. The report is currently being
632 finalised and will be sent out to RACP committees for consultation. Preparations are
633 underway in organising a workshop in Q3 2024 focussed on a risk-based framework for
634 accreditation.

635 The RACP continues to attend the AMC project team, Miller Blue Group's, working group
636 meetings to assist and work in conjunction with all Medical Colleges on the implementation
637 of the joint College NHPO recommendations.

638 Other matters

Reference	Request	Witness
15	Any other relevant matters raised by the College in relation to the administration of specialist training programs and the sustainability of the workforce generally.	Inam Haq

639 The RACP strongly advocates for any initiatives related to medical training and workforce
640 development that emerge from this Special Commission to:

641 - In general,
642 - Adopt an ecosystems approach to strategic planning and change
643 with vertical and horizontal integration across the sector
644 - Address issues in the culture of medicine and healthcare, including
645 high rates of bullying, harassment and discrimination reported
646 through surveys such as the Medical Training Survey, to support a
647 safe and sustainable work environment for physicians and other
648 professions, support delivery of high-quality care and reduce risk of
649 attrition from the profession
650 - Empower all stakeholders to engage in evidence-based change
651 through the development and sharing of linked training and
652 workforce data
653 - Collaborate with specialist medical colleges and associated
654 specialist societies on defining issues and developing solutions
655 - Link with existing initiatives, such as the National Medical Workforce
656 Strategy, NHPO, AMC Prevocational Framework, Health Workforce
657 Taskforce project on streamlining JMO recruitment, Medical
658 Workforce Reform Advisory Committee CMO/ Hospital Registrar
659 Framework and similar to ensure a coordinated approach to
660 managing and monitoring change including unintended
661 consequences and stakeholder burden
662 - And specifically, include recommendations that:
663 - Support the sustainability of work-based medical education by
664 ensuring the provision and access to sufficient allocated and
665 protected time for training and education for trainees, supervisors
666 and educational leaders
667 - Expand training positions in areas of workforce need, inclusive of
668 supervision and trainee support resources
669 - Resource and support the creation of integrated training pathways
670 especially in areas of workforce need
671 - Resource continued investment in innovation to support training and
672 workforce outcomes to meet community need in similar models to
673 the FATES projects outlined above
674 - Address the support and supervision needs of international medical
675 graduates undertaking the short term training in a medical specialty
676 pathway
677 [https://www.medicalboard.gov.au/Registration/International-
678 Medical-Graduates/Short-term-training.aspx] in NSW.

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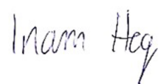
Signed: 

Name: Professor Inam Haq, Executive General Manager, Education, Learning and Assessment, Royal Australasian College of Physicians

Date: 12 July 2024

Signed:

Name: Associate Professor Kudzai Kanhutu, Dean, Royal Australasian College of Physicians

Date: 12 July 2024