ANZCA
FPM

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"This statement reflects the views of each of its authors and sets out the evidence that we are prepared to give to the Special Commission of Inquiry into Healthcare Funding as witnesses. This statement is true to the best of our knowledge and belief."

Witnesses for any oral evidence: To be confirmed.

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NSW Special Commission of Inquiry into healthcare funding – ANZCA witness statement

Introduction

1) A brief overview of the College, including:

   a) any recognised subspecialties.

   b) the relationship with any subspecialty representative organisation or body.

Specialities and subspecialties

1. The college is responsible for the training, assessment, examination, qualification and continuing professional development (CPD) of specialist anaesthetists and specialist pain medicine physicians, the standards of anaesthesia and pain medicine in Australia and New Zealand, and specialist international medicine graduate (SIMG) assessment.
2. The college training program in anaesthesia is intended to produce a generalist in that specialty. The training program in pain medicine is towards an "add-on", new and developing specialty, and intends to extend and broaden existing knowledge, skills and attitudes.
3. The college is governed by ANZCA Council, with matters relating to pain medicine overseen by the Faculty of Pain Medicine (FPM) Board, both covering Australia and New Zealand.
4. Anaesthetists apply their knowledge and skills to caring for patients in a variety of clinical contexts, providing anaesthesia and sedation for surgery and other procedures, providing pain management and periprocedural care, working in resuscitation, trauma and retrieval teams and working with specialists in intensive care medicine. There are sub-specialised areas of practice based around patient groups such as paediatric anaesthesia and obstetric anaesthesia, or surgical sub-specialties such as anaesthesia for cardiac surgery, medical perfusion and neurosurgery.

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Relationships with any subspecialty representative organisation or body

5. ANZCA is an active participant and contributor to the Council of Presidents of Medical Colleges (CPMC), the unifying organisation for Australian specialist medical colleges.
6. The Anaesthesia Continuing Education (ACE), a tripartite partnership between ANZCA, Australian Society of Anaesthetists (ASA) and New Zealand Society of Anaesthetists (NZSA), supports continuing medical education (CME) and events as well as shared knowledge, education and training.
7. Special Interest Group (SIG) and CME meetings, courses and workshops promote the diversity of the specialty across private, public, regional and remote areas of practice, as well as specialty disciplines, for example airway management and obstetric anaesthesia. There are 17 SIGs, with ANZCA administratively responsible for 14 and the ASA for three.
8. The Chapter of Perioperative Medicine (discussed in question 5) has a multidisciplinary approach with connections to anaesthetics, general medicine (especially geriatric medicine) and surgery.

The current state of the specialty/workforce

2) Information as to the following within NSW:

a) Accredited trainees.

b) Unaccredited trainees.

c) Fellows able to supervise trainees.

d) Training sites.

9. **Accredited trainees:** The number of NSW ANZCA active trainees as at 1 July 2024 is 502.
10. **Unaccredited trainees:** ANZCA does not use the term ‘unaccredited trainees’. We do use the term ‘independent trainees’ or ‘non-rotational trainees’, who are all accredited trainees. The only difference between independent v rotational trainees is their employment contract (refer to question 13 for independent trainees and question 5 for rotation trainees, who are those that are part of the ANZCA anaesthesia rotational training program). Both independent and rotational trainees' numbers are determined by the sites (ANZCA has no control over these numbers at any time, across Australia – refer to question 6). Data collected as of 5 June 2024 (a single point in time) indicates NSW has approximately 150 independent trainees across the full training program (introductory Training (IT), Basic Training (BT) and Advanced Training (AT) and Provisional Fellowship Training (PFT)).
11. **Fellows able to supervise trainees:** ANZCA is unable to ascertain how many fellows “are able to supervise trainees”, which is separate to the total Fellows quantity (which ANZCA does have visibility of) as it relates to the role in which they’re undertaking in the hospital site (i.e. hired as a staff specialist compared to a Visiting Medical Officer (VMO)). However, most employees of public hospitals regardless of VMO or staff specialist contractual arrangements must participate in teaching and training. All Fellows of the college working in government-funded hospitals are able (and expected) to supervise trainees. The college expects Fellows to supervise trainees, although the level of supervision is variable. No trainee would work unsupervised, even at the most senior level. This is a requirement of training, mandated by the college. Further information on the supervision principles, levels and acceptable supervisors of ANZCA trainees’ clinical experience is provided in clause 2.5 of the ANZCA Handbook for Training (previously provided to the Inquiry1).

[1] https://www.anzca.edu.au/getattachment/6fc9618b-2476-47aa-b86a-5cc27671d4ec/ANZCA-Handbook-for-Training

12. **Training sites:** The NSW training sites as per the ANZCA website (https://www.anzca.edu.au/education-training/training-site-accreditation/anaesthesia-training-sites-and-rotations) is provided in Appendix A and summarised below.

26 weeks	52 weeks	104 weeks	156 weeks	Total site number
2	11	9	12	34

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.

13. Individual health services have limited incentive to increase funding for junior medical staff training positions beyond what is necessary for service provision which is primarily to cover in-hospital attendance after hours where that is required. Day-time training in anaesthesia is sometimes viewed as slowing the turnover of lists which may be a further disincentive to increase training numbers by health services.
14. To address this problem, funding would need to be made available from governments for this specific purpose. We consider that strategies to continue to grow our domestic workforce over time is essential to the sustainability of the anaesthesia workforce.
15. Prior to 2020 the number of practising anaesthetists was generally able to meet the demand for services in metropolitan NSW. There was a workforce shortage in some rural and regional centres, and several metro hospitals were unable to fill the desired number of staff specialist positions and were backfilling with VMOs. Since 2021 there has been a severe statewide workforce shortage. Data is not available to determine causes, but a build-up of surgical activity, increased part time work and some early retirements are likely to be contributors. Working and award conditions have exacerbated the shortage by driving staff specialists (who would normally be the backbone of training programs) out of the public system, out of NSW and into contract and locum work. This is based on observed practice in hospitals. The college doesn't cover award and pay items, this is covered by the ASA. However, the college works together with ASA on relevant items.
16. Further to this, meaningful and consistently agreed national data to provide advice on matters such as current and projected medical workforce requirements for anaesthesia should be a priority. Failure to continually review health care demand and determine public health system operational capacity requirements has resulted in workforce reaching breaking point.

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.

17. It is difficult to know if the problem relates to lack of or insufficient numbers (question 11) or maldistribution – suspect it relates to both.
18. There is a greater unmet need in rural, remote and regional centres for anaesthetists. The number of locum positions being advertised by recruitment companies is testament to this.
19. A significant benefit of the anaesthesia rotational training schemes throughout Australia and New Zealand is that by including regional centres, trainees are routinely exposed to non-metropolitan settings. Trainees also require exposure to all subspecialty areas to complete training and some of these (notably cardiac, neuro and tertiary paediatrics) are predominantly provided in major metropolitan teaching hospitals.
20. Accreditation for anaesthesia training sites requires a minimum specialist staffing level and an appropriate range of experiences and volumes of practice to achieve training outcomes. This

limits the ability of some smaller regional and rural locations to achieve accreditation. However, where an accredited training site supports a smaller site with outreach clinical services, then additional campus accreditation supports trainees to gain exposure to these more remote sites. Recent examples of additional campus accreditation supporting smaller rural hospitals include Casino Hospital in NSW (parent hospital Lismore Base Hospital).

21. There has been a long-standing maldistribution of anaesthesia workforce in NSW whereby some (but not all) rural and regional public hospitals struggled to recruit to all their available consultant positions in anaesthesia. This was relevant prior to COVID-19. The workforce maldistribution has continued since the end of the COVID-19 pandemic whereby the workforce shortages everywhere were exacerbated post COVID-19. The rural and regional centres were impacted the most because many of them already had a prior shortfall, i.e. increased vulnerability pre COVID-19. Fellows no longer have to seek work further afield from major centres thus reducing availability in rural areas. There is also a change in expectations in maintaining a preferred work-lifestyle balance related to generational change, effects of COVID-19 amongst other reasons. We don't have data (yet) to support these observations but believe this is the reason why the use of locums in rural NSW is so much higher than in the metro hospitals.
22. ANZCA recognises the need to increase the employment and retention of anaesthetists in rural and regional NSW and is looking to increase the number of regionally based training programs. Wagga Wagga/Albury has commenced a comprehensive anaesthetic training scheme in 2023 and other centres are likely to follow within the next two years.
23. The nature of the recruitment process in NSW further hinders this workforce maldistribution. Currently each individual hospital advertises and shortlists from the same pool of applicants every year, creating a massive duplication of work everywhere (sites and applicants).
24. Smaller (mainly regional/rural) sites frequently lack the full range of subspecialty services required to complete training. This commonly results in these sites only being accredited for 1-2 years of training, meaning they can only appoint to Independent (1y) positions. Contrast this with major metro centres who offer most/all subspecialties, are accredited for the maximum time, and can offer Scheme (4y) positions. Refer to question 7 for information on training site accreditation and timeframes, where sites are accredited for 26, 52, 104 or 156 weeks of training.
25. From some applicant's perspective, scheme positions are more desirable than independent positions. Consequently, the stronger applicants tend to get the scheme jobs and the developing applicants, the independent positions. Refer to question 13 for information on independent trainee positions.
26. 12 months later, these independent trainees can find themselves overlooked for scheme positions by metro sites in favour of the known, able Senior Resident Medical Officers from the metro site, leaving regional/rural sites struggling to support advancement of trainees who are clearly performing well.
27. This enhances the 'out of sight, out of mind' perspective of applicants and further disincentivises working in regional/rural locations.
28. Yet all the evidence to date suggests the best way to promote increase of workforce in regional/rural centres is to promote training in those centres.
29. A centralised recruitment process within NSW would massively reduce workload on both hospitals and applicants and could be contrived to incentivise independent positions, by making these the stepping stone into scheme training.
30. Staff specialist award reform would also make a big difference in all areas but especially in rural, remote and regional (RRR) areas. In the RRR areas there are generalists doing specialist work – they should be paid and have the same conditions as specialists. SIMGs are often employed as staff specialists rather than VMOs because they lack a provider number – they are often employed in areas of need such as RRR areas.
31. Increasing total number of specialists does not address the maldistribution of specialists. Increasing the opportunities of rurally based trainees to access ANZCA training sub-speciality training via rural-based programs would assist in keeping specialists in the bush.

Specialist training programs

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.

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

32. ANZCA offers the following training programs, both based on competency-based medical education (CBME) principles:
    - In anaesthesia, leading to award of the following fellowship: Fellowship of the Australian and New Zealand College of Anaesthetists (FANZCA).
    - The Faculty of Pain Medicine of ANZCA offers one training program in pain medicine, leading to award of the following fellowship: Fellowship of the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (FFPMANZCA). As a post-fellowship specialty qualification, candidates for FPM fellowship must hold an approved primary specialist qualification.
33. The college also awards a qualifications in Diving and Hyperbaric Medicine (DHM) and Rural Generalist Anaesthesia (RGA), the latter with the Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP). The college has also recently developed a qualification in perioperative medicine (POM).
34. The Course in Perioperative Medicine commenced as a pilot in late 2023 with now altogether 30 anaesthetists, surgeons and physicians starting the course in this inaugural year. Those successfully completing the course qualify as graduates of our Chapter of Perioperative Medicine and receive the GChPOM postnominals. Nearly all of the 800-plus clinicians who have applied to receive the GChPOM via the recognition pathway have been processed.

Anaesthesia

35. The College provides an anaesthesia program undertaken in hospitals and clinical placements approved by ANZCA for training leading to the specialist qualification of diploma of fellowship.
36. Before doctors can apply for the ANZCA anaesthesia training program, they must have completed two years of general hospital experience after graduation from medical school. This can include up to 12 months in anaesthesia or intensive care, but the aim is to ensure a grounding in general medicine and in disciplines other than anaesthesia.
37. Anaesthesia trainees complete at least five years of training and are supervised by a network of qualified anaesthetists at accredited hospitals throughout Australia (and New Zealand). The program is accredited by the Australian Medical Council (AMC) and the Medical Council of New Zealand (MCNZ).
38. The training program (figure below) is a minimum of five years duration divided into four core units; introductory training (minimum 26 weeks); basic training (minimum 78 weeks); advanced training (minimum 104 weeks); and provisional fellowship training (minimum 52 weeks). Trainees must complete minimum requirements in each of the core units. These requirements include minimum training time, volumes of practice (VOP) for cases and procedures, courses and assessments. There are also maximum training time periods allowed for completion of all requirements for each unit.

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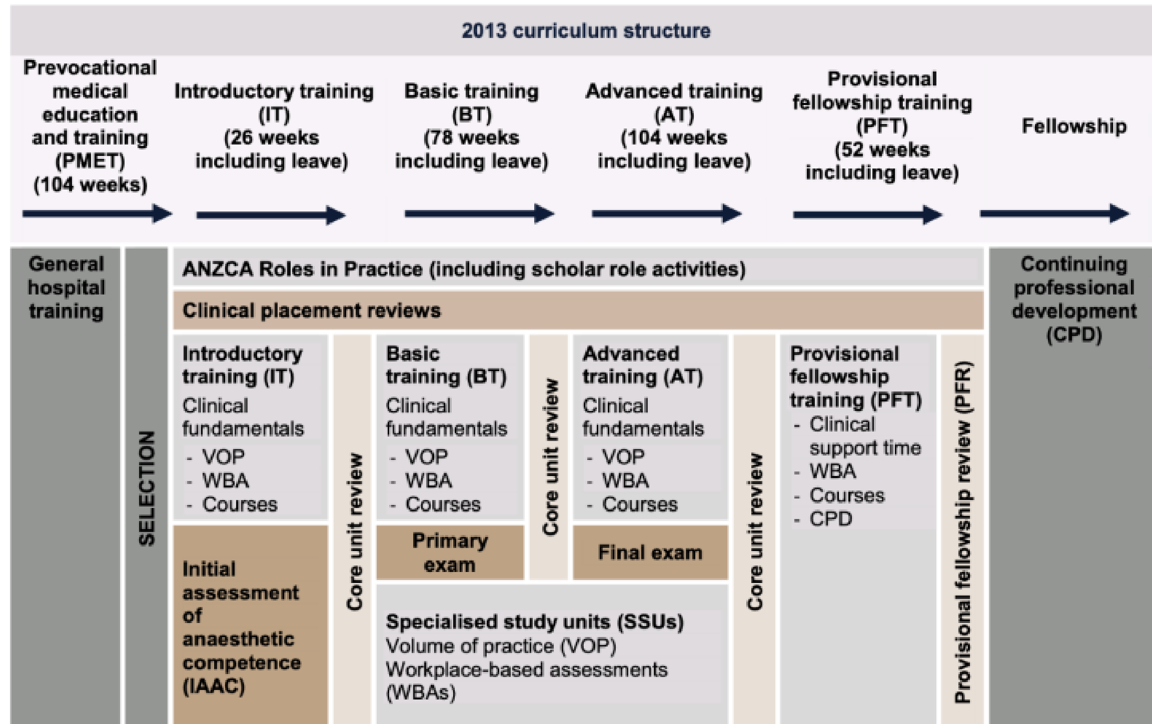

39. Specialist anaesthesia practice requires a unique range of clinical knowledge and skills in anaesthesia and sedation, regional anaesthesia, airway management, pain medicine, perioperative medicine, resuscitation, trauma and crisis management, and quality and safety in patient care.

40. Anaesthetists in Australia and New Zealand work in a range of clinical environments, from isolated rural environments to large metropolitan teaching hospitals in both public and private practice, and the armed services. ANZCA doesn't mandate an amount of regional / rural experience; just that all trainees must spent at least 1 year of the 4 core years outside their 'base' hospital. Some local hospital districts (LHDs) / hospitals have specific arrangements to send trainees to local private hospitals - known to be the case at Central Coast LHD (CCLHD), St Vincent's Hospital and perhaps Westmead Hospital and St George Hospital. CCLHD is covered by a MoU, which indicates an example of how the arrangements are created. The MoU is not an ANZCA document but refers to ANZCA standards.

41. For admission to ANZCA fellowship and college membership, an ANZCA Directors of Professional Affairs (DPA) assessor certifies the trainee's successful completion of all relevant education and training components (on application). The ANZCA Executive Committee, on delegation from council, approves admission to fellowship, on a weekly basis to ensure timely progression and workforce continuity.

42. The number of trainees entering the program in NSW each year is difficult to determine. There are approximately 100 positions each year offered to trainees by hospitals providing access to all specialised study units (SSUs) needed for core training. Most, but not all, of these trainees will be in their first or second year of training. The hospital offering the trainees jobs will sometimes determine that these new recruits will start from scratch at their hospital and the trainee may then take more than the requisite number of years to complete their core training. This extra time to complete training is often because the hospital has roadblocks to access subspecialised training in anaesthesia for cardiac, neurosurgical and paediatric surgery.

43. There are also approximately 100-130 positions per year in hospitals offering one year training contracts – trainees from these hospitals ultimately need to go to larger hospitals for all training needs. These numbers are based on the annual medical recruitment drive in July each year.

44. Across Australia over the last four years, the average number of trainees entering the training program has been 330, and the average number being admitted to Fellowship is approximately 300.

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

45. ANZCA is the professional organisation for specialist anaesthetists (Fellows) and anaesthetists in training (trainees) in Australia and New Zealand and is directly responsible for the training, examination and specialist accreditation of anaesthetists in these countries.
46. ANZCA is not directly involved in the selection/appointment of trainees in Australia, nor does the college have any direct influence over trainee numbers. This is the responsibility of states and territories and employers. As such, training numbers for specialist anaesthetists in Australia are limited by the state and territory health service allocation of registrar positions within anaesthesia training departments.
47. Whilst trainee appointment to accredited pain medicine and anaesthesia training sites is the role of employers, both training programs require each site to use the ANZCA selection principles. Selection processes must be consistent with relevant public sector employment legislation. The ANZCA guidelines complement employing authority policies and processes and are intended for use in conjunction with them. Principles include appropriate notice, equal employment opportunity, non-discrimination, formal procedures, lack of bias, rules of evidence and relevance, access to appeal and regular evaluation and review. The selection committee should include a college representative.
48. To join the ANZCA program you must secure a training position in an accredited rotation or training site. To apply for training positions in NSW, you must directly apply to the NSW Ministry of Health. The application form and recruitment dates for next year can be found on the NSW Ministry of Health website for all medical specialities.

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.

f) The body responsible for setting criteria applied for accreditation of training sites/places, and the process for the review of those criteria.

49. Accreditation of anaesthesia training locations is based on seven accreditation standards – quality patient care, clinical experience, supervision, supervisory roles and assessment, education and training, facilities and clinical governance. The process is governed by the ANZCA Training Accreditation Committee (TAC).
50. ANZCA accredits training sites which are anaesthesia departments and all facilities within the same complex. It also recognises training experience in sites accredited by other colleges, particularly the College of Intensive Care Medicine (CICM) and the Australasian College for Emergency Medicine (ACEM).

Anaesthesia

51. Clinical experience for the anaesthesia training program must be completed at an ANZCA-accredited training site. The college accredits training sites, not individual training posts, with each accredited site required to be part of a rotation. 'Rotations' are groups of hospitals that collectively provide a complete training experience.

52. The college interacts with training sites to support high quality teaching, supervision and professional development occur, predominantly through the training accreditation process. Accreditation identifies deficiencies in teaching, supervision, workplace assessment and continuing professional development and ways that these areas can be further improved.
53. ANZCA-accredited departments must meet training requirements as specified in the ANZCA handbook for training, ANZCA handbook for accreditation, regulation 37, college professional documents and ANZCA policies.
54. The criteria underpinning accreditation standards is provided below.

Standard	Criterion	Minimum requirements	Mode of evaluation
1	Systems in place to ensure the safe administration of injectable drugs	Compliance with professional document PG51(A)	Self-assessment Facilities inspection
2	Caseload and complexity suitable for training stages offered	See curriculum (standard 3)	Self-assessment Trainee portfolios Trainee opinions Trainee and supervisor of training (SOT) interviews
3	Sufficient FTE anaesthetists to provide supervision for all trainees	Adequate supervision levels Specialists involved in post-anaesthesia care and acute pain service	Trainee experience surveys Trainee feedback Trainee portfolio system Trainee, SOT and head of department (HOD) interviews
4	Undertake workplace-based assessments (WBAs) with feedback	Minimum mandatory WBA including feedback	Trainee feedback Training portfolio system
5	Formal teaching program	Meets trainee needs Adequate opportunities for scholar role activities	Copy of education program Trainee feedback
6	Ready access to computer facilities including for completion of TPS and WBAs	Mandatory	Trainee, SOT and HOD interviews
7	Organisation supports staff wellbeing	As per PS49(G) Organisational bullying discrimination and sexual harassment (BDSH) policy	Self-assessment HOD and hospital management interviews

55. The TAC accreditation process includes triangulation via both quantitative and qualitative measures. Key pieces of evidence include:
    - Self-assessment by the site using the accreditation management system (AMS).
    - Pre-visit trainee survey.
    - Training portfolio report.
    - Site visit meetings separately with HOD, trainees, supervisor(s) of training, and other specialists.
    - Site visit meetings with hospital executive representatives.

56. Sites are accredited for 26, 52, 104 or 156 weeks of training. The criteria that determine these durations are:
    - A department in which each trainee can meet the requirements of one complete SSU, or a greater number of partial SSUs (with partial units adding up to at least one in total), may be eligible for up to 26 weeks accreditation.
    - A department in which each trainee can meet the requirements of three complete SSUs, or a greater number of partial SSUs (with fractions adding up to at least three in total) may be eligible for up to 52 weeks accreditation.
    - A department in which each trainee can meet the training requirements of more than five complete SSUs, or a greater number of partial SSUs (with fractions adding up to more than three in total) may be eligible for up to 104 weeks accreditation.
    - A department in which each trainee can meet the training requirements of 10 complete SSUs, or a greater number of partial SSUs (with fractions adding up to at least 10 in total) may be eligible for up to 156 weeks accreditation.
57. Before a training site is accredited for Approved Vocational Training (AVT), it is inspected by the college to assess its ability to provide training and supervision to the required standard, and its degree of compliance with ANZCA professional documents and standards.
58. An accreditation inspection may be undertaken in the following circumstances:
    - A site inspection of new departments.
    - Routine inspections which normally occur as part of a five-yearly cycle.
    - Out-of-sequence on-site accreditation inspections which are requested by a department, hospital or any committee of ANZCA. This type of inspection may be considered after review by the chair or deputy chair of the TAC which may lead to an urgent inspection.
    - A scheduled re-inspection arising out of concerns raised at a previous inspection or as part of the monitoring process.
    - Change in accreditation status inspections may be undertaken if a hospital department or other training site requests a change in accreditation (for example, increase in duration of accreditation).
59. Following an accreditation inspection, the accreditation team prepares a report with recommendations based on published accreditation standards and ANZCA professional documents. This report is reviewed at the next TAC meeting. If an issue requires more urgent consideration, TAC teleconference or videoconference is arranged. TAC may make further amendments to the recommendations, following additional consultation with the accreditation team and the department, as necessary.
60. Following the TAC meeting, the report and recommendations are sent to the director/HOD with an invitation to correct any factual inaccuracies within a specified timeframe. A letter incorporating the final recommendations is then sent to the director of medical services/chief medical officer and senior hospital management and copied to the director/HOD and the supervisor(s) of training with the outcome, which is one of the following:
    1. **Unqualified accreditation:** All standards and criteria are met. The training site is accredited for five years from the inspection date and may employ anaesthesia trainees from the beginning of the next hospital employment year. A certificate of accreditation is provided to the hospital.
    2. **Conditional accreditation:** The training site is granted full accreditation subject to corrective actions to address the accreditation standards and criteria within a specified timeframe, sometimes subject to reinspection. Conditional accreditation is usually granted for one hospital employment year only. Unqualified accreditation depends on full compliance with mandatory corrective actions.
    3. **Accreditation not approved:** For new applications or applications for a change in status, where accreditation is not approved, feedback is given to the site about what

conditions must be met for future approval. Once these are addressed, a new application and reinspection is required.

4. **Withdrawal of accreditation:** If a site can't comply with accreditation standards and criteria, and where there is significant impact on training quality or professional standards, ANZCA may withdraw accreditation from that site. This requires approval by ANZCA Council.

61. The outcome of almost every visit is "conditional accreditation" which we consider to be a "monitoring" activity and not "proposed or actual imposition of conditions". Accreditation continues uninterrupted during this process. Most sites with conditional accreditation write back to TAC with an update and then TAC approves unconditional accreditation following a single written response to corrective actions that satisfies TAC (i.e. 5 years from initial visit date).
62. For a small number of sites TAC requests further updates before approving unqualified accreditation. Sometimes further written updates are required. In some cases, a follow up visit is arranged to assess progress. Once again, TAC considers these to be monitoring activities and accreditation continues uninterrupted during this process.
63. ANZCA will notify NSW Health with reasonable notice of any intention to limit of withdraw accreditation.
64. There is no written agreement with accredited sites. Once accredited, the HOD/director must agree to notify TAC of any changes that might affect training. Importance is placed on changes such as alterations in workload and case-mix, new facilities and increases or decreases in senior staffing and trainee numbers in the department. Concerns may also be raised via other avenues such as the relevant ANZCA national or regional committee, the national or regional trainee committee or individual fellows or trainees.

8) An overview of the role/function of other agencies/bodies in the accreditation of training sites/placements.

65. ANZCA TAC works with anaesthesia departments to ensure high quality teaching and supervision are achieved and appropriate CPD opportunities provided. The college assists training institutions in achieving training and education standards, within the limits of its own regulations and policies. Examples include:
    - Working with hospitals to ensure specialists have sufficient clinical support time for supervisory roles and their personal CPD.
    - Running national and regional SOT meetings, led by education officers, supporting dissemination of college resources and promoting feedback from supervisors on planned training developments.
    - Ensuring departments have quality assurance programs with opportunities for input from all trainees and fellows for continuous care improvement.

Internationally trained doctors

9) An overview of the process by which internationally trained doctors may attain Fellowship of the College.

66. ANZCA's SIMG assessment process evaluates the ability of a specialist to practise as an unsupervised specialist anaesthetist and/or pain medicine specialist at a standard comparable to that required of a fellow of ANZCA (FANZCA) or fellow of the Faculty of Pain Medicine (FFPMANZCA).

67. SIMGs apply directly to the college, with the process conforming to the MBA good practice guidelines and is regularly reviewed for consistency with regulatory changes.

Area of need (AON) process

68. The AON process addresses medical workforce shortages in designated areas and doesn't lead to fellowship or specialist registration by the MBA. The relevant state or territory jurisdiction, not the college, declares that a position is AON. College support is site-specific and cannot be transferred to another position.

69. The process assesses suitability for the specific position, rather than comparability to an Australia-trained specialist. However, to determine SIMG suitability for a specific position, the college requires combined assessment for specialist recognition and AON. Following interview, the college issues a "combined report" to the SIMG and uploads this to the AMC portal confirming that the SIMG "is" or "is not" suitable for the position and including details of the comparability assessment.

Comparability with Australian specialists

70. The SIMG assessment process compares training qualifications, specialist practice and CPD with that of locally trained specialists and whether the SIMG is substantially, partially or not comparable. SIMGs are assessed to be at the standard of a new consultant, therefore the college never requires more from SIMGs than it does from locally trained specialists. SIMG requirements are based on those of the relevant training program and the ANZCA and FPM CPD program.

71. The comparison considers:

    - Basic medical training and experience prior to specialist training, ensuring a good general medical foundation for specialist training.
    - The specialist training program duration, structure, content (including subspecialty experience and practice domains), supervision, assessment, governance, and progression.
    - Specialist qualifications including their governance.
    - Specialist experience, especially in the previous 36 months. This includes case mix, credentialing, compliance with international and national standards of practice and practice across the ANZCA or FPM specialist roles in practice.
    - CPD, especially participation in practice evaluation activities (e.g. audit), and emergency response activities.
    - The comparability of the health system in the country of origin and Australia or New Zealand, as relevant.
    - Understanding of the context of specialist practice including community, cultural and professional expectations.

72. SIMGs assessed as substantially comparable in Australia are asked to undertake 12 months or shorter CPA, and don't sit the SIMG exam. The requirements for those assessed as substantially and partially comparable are summarised below.

<table>
<tr><td>Substantially comparable requirements: anaesthesia and pain medicine</td><td>Complete a period of up to 12 calendar months FTE clinical practice in the relevant specialty (anaesthesia or pain medicine). This period may be reduced if the applicant:
Has suitable previous experience in the Australian or New Zealand healthcare system, of at least 12 months duration.
At the time of interview, has been working in an approved post for at least six months.
Successfully complete the SIMG performance assessment (PA).
Complete a multisource feedback.
Actively participate in the ANZCA and FPM CPD program.</td></tr>
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	• For anaesthesia, complete an Effective Management of Anaesthetic Crises (EMAC) course.
Partially comparable requirements: anaesthesia	• Complete a period of between 12- and 24-months FTE of clinical practice in anaesthesia, normally in an ANZCA-accredited hospital department. ANZCA accredited departments are categorised by duration of allowable training time each trainee may spend at that site and this information is available on the college website. Individual SIMG requirements are in the interview outcome report. This period may be reduced if the applicant: o Has suitable previous experience in the Australian or New Zealand healthcare systems of at least 12 months duration. o At the time of interview, has been working in an approved post for at least 12 months. • Successfully complete the SIMG examination or SIMG PA, as determined by the interview panel. • Complete a multisource feedback. • Actively participate in the ANZCA and FPM CPD program. • Complete an EMAC course.
Partially comparable requirements: pain medicine	• Complete a period of 12 months FTE clinical practice in pain medicine. This must be completed in a level 1 FPM accredited training unit. • Complete a multisource feedback. • Successfully complete the viva component of the FPM fellowship examination or the SIMG PA. • Actively participate in the ANZCA and FPM CPD program.
Not comparable	These applicants are not eligible to continue in the SIMG pathway and must contact the AMC and MBA or MCNZ, as relevant, to discuss assessment options via the general pathway and then, if relevant, the college training pathway. These applicants may be eligible for limited or provisional registration through another pathway that will enable general registration; subsequently, they can apply for entry into a college specialist training program. Applicants are advised to contact AHPRA or the MCNZ, as relevant, for further guidance on their options for practising in Australia or New Zealand.

Preliminary review

73. The preliminary review determines whether the application is complete and if the applicant satisfies criteria for an interview. College staff confirm the application is complete. The DPA SIMG completes the summary of preliminary review which is sent to the applicant with 21 calendar days for a response and provision of additional information.

Interview panel

74. The interview panel assesses SIMG training, qualifications, specialist experience and CPD, and include a minimum of three (preferably four) interviewers for each interview day. The panel must contain mixed gender, one community representative and a chair.

75. Once applicants are assigned interview dates, staff check for any potential conflict of interests (i.e. if an applicant is currently working in Australia those working in the same hospital are not invited as panel members).

76. Training for SIMG panel members includes observing their first interview day and participating in the panel on their second interview day. The panel chair completes a performance report at the end of the second day which the DPA SIMG reviews prior to approving their appointment. Any issues raised in the report are escalated to the SIMG Committee for review.

77. This apprentice-style training completed at the start of the role is supplemented by regular workshops. Prior to the pandemic, Australian-based members of the SIMG PA assessor and interview panels had annual training days covering similar topics.

EMAC for anaesthesia SIMGs only

78. As part of the SIMG assessment process, anaesthesia SIMGs are required to successfully complete an EMAC course which is also a compulsory component of ANZCA anaesthesia training. The EMAC course involves interactive learning for emergency responses, including underlying human factors. It provides excellent learning on the non-hierarchical nature of the medical workforce in Australia and New Zealand, which may be different from some SIMGs' experiences. It also teaches the common language, protocols and checklists used in emergencies.

External assessment

79. Depending on the interview outcome, SIMGs must complete either the SIMG performance assessment (SIMG PA) or the SIMG examination.

SIMG examination

80. The anaesthesia SIMG examination is conducted by the Final Examination Sub-committee and consists of the anaesthesia and medical viva (oral) components of the ANZCA final fellowship exam. The FPM SIMG examination is conducted by the FPM Examination Committee and consists of the viva component of the FPM fellowship exam. Relevant exam reports are available to all SIMGs.

The clinical practice assessment period (CPA)

81. The CPA period familiarises the applicant with anaesthesia or pain medicine practice in Australia or New Zealand, and facilitates practice PA. The SIMG process is not a training program, however, the CPA period may address specific deficiencies in training or experience. Each SIMG's performance is assessed every three months by their supervisor using the CPA report form. All anaesthesia and pain medicine reports are reviewed by the DPA SIMG, and any concerns dealt with as detailed below. The supervisor role is clearly outlined by both regulatory authorities and the application to anaesthesia and pain medicine is described in the SIMG supervisor agreement.

SIMG PA

82. The SIMG PA is a comprehensive peer review assessment undertaken by two trained fellows. It is held over one day in the hospital or unit in which the SIMG is employed. The SIMG PA assesses professional performance against the standard that is expected of a FANZCA or FFPMANZCA and covers all ANZCA or FPM roles in practice, respectively. Information on the PA is in the SIMG Handbook and specific information is given to the SIMGs in advance of their assessment.

Cultural safety

83. The SIMG interview assesses in detail comparability to an Australian or New Zealand trained specialist anaesthetist or specialist pain medicine physician. The interview expands on the information provided in the application and focuses on the following areas:

    - Training.
    - Qualification.
    - Specialist practice.
    - CPD.
    - Cultural safety and community awareness.

84. The community representative listens to the answers given by the SIMG applicant regarding their training, qualifications and experience. This helps to form questions for the community awareness component of the interview. The panel explores the applicant's understanding, attitudes and skills in non-technical areas of anaesthesia or pain medicine practice at a specialist level. Questions may include understanding of the meaning and application of patient-centred care with particular focus on cultural safety and its impact on the care provision and patient outcomes. The applicant is also asked about professional behaviours and ethical standards and may be asked to describe a personal experience detailing their role in handling a challenging situation.

85. The SIMG's initial job description is checked to ensure that cultural safety is part of their orientation program. As a result of their interview performance, a few SIMGs have been advised to undertake extra cultural safety training.

Criteria for success

86. Success comprises:
    - Successful progression through the SIMG assessment process.
    - Successful SIMG program completion: Most SIMGs complete the process successfully. Up to one per year (but not every year) fails the SIMG PA. Most of these successfully complete a repeat assessment, after a remediation program lasting at least six months.
87. SIMGs assessed as needing significant training to reach the standard of a locally trained specialist are referred back to the AMC.
88. SIMGs are recommended for specialist recognition following satisfactory completion of all requirements specified by the college. They are eligible to apply for admission to ANZCA or FPM fellowship.
89. The college reports outcomes of all phases of assessment to relevant stakeholders within required timeframes (usually within 10-14 business days of the assessment). An annual report is provided to the AMC. While there are common elements to pathways in Australia and New Zealand, the processes accommodate regulatory differences.

Workforce planning

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.

90. ANZCA is not directly involved in the selection/appointment of trainees in Australia, nor does the college have any direct influence over trainee numbers. This is the responsibility of states and territories and employers.
91. ANZCA has more than enough accredited trainees in NSW, however the reason why that doesn't convert into higher consultant numbers is because many of those trainees are in independent training positions which don't automatically roll over into scheme training jobs. Refer to question 13 for the bottleneck of "independent" accredited trainees waiting to get onto comprehensive schemes.
92. Comprehensive scheme positions are limited by the number of available training posts in subspecialty areas (particularly paediatric anaesthesia, but potentially also in cardiac and neuro anaesthesia). Despite recent increases in subspecialty positions in paediatric anaesthesia, further training positions (which are funded by NSW Health, predominantly in tertiary paediatric hospitals) would allow more trainees to complete their training and increase future workforce numbers.
93. If government or other stakeholders want to increase anaesthesia workforce by increasing trainee numbers it must be done by increasing scheme positions that provide comprehensive sub specialty training. Otherwise, it simply exacerbates the existing bottleneck between independent and scheme jobs. It is a common misconception (made most recently by the ACI surgical taskforce) that simply increasing accredited trainee numbers will result in more anaesthetists.
94. ANZCA has the capacity to train additional anaesthesia trainees if the number of training positions in hospitals are increased by state and territory governments. ANZCA would like to work together with states and territories to implement sustainable strategies to increase local domestic trainee numbers.

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.

Part a

95. Without current (post COVID-19) data the answer to this is unknown.

Part b

96. An increase in funded paediatric and other subspecialty training positions (see answer to question 10) needs to be matched to the predicted future workforce requirements. Incentives to attract and retain specialists in rural settings (such as rural training schemes with access to the subspecialty training mentioned above) are needed to reduce rural-metro maldistribution.
97. Increasing capacity to train specialists will be contingent on increasing capacity to complete the ‘bottleneck modules’ of cardiac-, neuro- and paediatric anaesthesia experience plus ensuring there are sufficient specialists willing to be supervisors of training (historically a role most commonly filled by Staff Specialists). This will require both funding of additional training positions and addressing the terms of the NSW State Award to incentivise specialists taking up SS positions in NSW public hospitals.
98. NSW has a disproportionate number of VMOs rather than staff specialists compared to other states and territories. VMOs typically are “a casual pool” of employees. The majority of clinical support tasks including teaching, training of junior medical officers (JMOs), representation on hospital committees and quality assessment and quality improvement (QA/QI) activities rely on staff who are based in the hospital for more than one day per week and typically employed as staff specialists. There has been an exodus of staff specialists from the senior anaesthetics workforce in public hospitals due to non-competitive award structures.
99. Workforce shortages are much greater in the public than the private sector due to huge potential differences in incomes. Declining rates of private health insurance cover may have significant effects on the private hospital sector as cost-of-living pressures increase – this will impact the distribution of anaesthetists in the future.

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.

100. It should be noted that the college accredits facilities, not trainees (refer question 7).

Independent trainees

101. ANZCA does not use the term ‘unaccredited trainees’. We do use the term ‘independent trainees’ or ‘non-rotational trainees’, who are all accredited trainees. The only difference between independent v rotational trainees is their employment contract.
102. ‘Independent’ trainees, sometimes called ‘non-rotational trainees’, are those who are not appointed to an ‘anaesthesia rotation’ and are appointed by hospitals, independent of anaesthesia rotation. In some regions there is a single rotation with a common selection process (e.g. WA, SA, Qld). In others (e.g. NSW and Vic), employment is primarily by hospitals. Regardless, the term ‘rotational trainees’ is recognised in all Australian regions as designating trainees who are part of an ‘anaesthesia rotation’, and who have confirmed employment and clinical placements for the first four years of their training, usually subject to expected progression in minimum timeframes. Rotational trainee placements are

controlled by rotational supervisors who ensure their clinical placement support them meeting all training requirements.

103. A key difference for independent trainees is they lack confirmed clinical placements for IT, BT and AT, including planned access to subspecialty rotations. If they remain independent trainees, they need to arrange their own employment (generally 12-month contracts) and clinical placements. Trainees in provisional fellowship training are excluded from this issue and, by design, organise their own clinical placements in line with the defined objectives of that training period.

104. Trainees may commence their training with either rotational or independent status. Some trainees join rotations part-way through training; thus, there are lower proportions of independent trainees in AT than in IT and BT. Other trainees start in rotations and then become independent trainees, most often due to repeated examination failure. Some trainees may prefer to take up an independent training post with the benefit to choose their own clinical placements, not those mandated by the rotation, especially where geographical re-location is involved. Others prefer the security of rotational training; however, this will require them to rotate around different sites (depending on the rotation scheme they belong to). Trainees who have partly completed overseas training and become ANZCA trainees may also elect to remain as independent trainees. There are many different advantages/disadvantages depending on the jurisdiction and location.

105. College policy is that all trainees receive the same supervision and guidance within their employing, accredited hospital, regardless of whether they are independent or part of a rotation. By the end of training, all trainees (whatever their employment status) must meet training requirements to achieve graduate outcomes. The college provides the same support for all trainees, regardless of status, providing the same access to central teaching and learning resources, assessments, and support processes such as the trainee support process (TSP), exam remediation courses, and Converge International. Converge International is part of ANZCA Doctors' Support Program, where ANZCA has engaged the professional services of Converge International, a specialist in psychology, mental health and wellbeing who will provide a confidential and independent counselling and coaching service.

106. Over time, the college has increased the flexibility and support for all trainees to complete training. For example, the 2013 curriculum better articulated the outcomes expected in the subspecialty area of paediatric anaesthesia. Volumes of practice are designed to allow trainees to meet outcomes without a clinical placement at a specialised paediatric hospital (although many rotations and trainees prefer such placements to the experience obtained caring for children in general hospital settings). There is also support for some retrospective recognition of non-anaesthesia placement experience undertaken prior to formal anaesthesia placements.

Unaccredited trainees

107. In addition to the ‘independent’ training positions described above, NSW does have a small number of “unaccredited” training positions. This exist in hospitals with anaesthesia service requirements that have not been accredited for training by ANZCA (not all hospitals are accredited with ANZCA).

108. There are sometimes “unaccredited” trainees who are not considered accredited trainees within accredited facilities because they do not participate predominantly in the same activities (including after-hours rostering) as the accredited trainees. For example, registrars who may do after-hours work in areas other than anaesthetics, or registrars who do a mix of critical care work that involves supervisors other than anaesthetists. These “unaccredited” registrars are often not registered with ANZCA.

109. Each hospital needs to meet minimum standards for training in anaesthesia before they can employ accredited (independent or scheme) trainees, however increasing independent training positions without increasing the number of subspecialty (e.g. paediatric) positions will have no effect on workforce numbers because there is already a bottleneck to get into comprehensive scheme training positions.

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Case studies

14) 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.

110. Continued concern among HOD/directors about increased difficulty to maintain sufficient levels of staff specialists. Some examples from the Central Coast LHD (CCLHD) is identified below.

- 6 staff specialists (SSs) to 64 VMOs.
- Recent SS appointment only because they're still under Section 19AB requirements.
- x2 SIMG SS appointments both of whom are now FANZCAs and only want VMO appointments.
- Last 5 SS appointments converted to VMO within 12 months.
- Now advertising SIMG SS because x3 SS adverts have gone with no applicants.
- Lack of SS means anaesthetic representation on hospital committees is poor, making services increasingly disjointed and inefficient.
- Teaching of junior staff is difficult and reliant on good will, which is wearing very thin.
- Our anaesthesia Safety & Quality meeting usually has only 1-2 attendees (including the chair!) because it's in-hours. But out-of-hours meetings are so numerous that people are too fatigued to attend (even when on-line).

111. Some impacts from CCLHD's inability to recruit include:

- Since COVID-19, regularly cancelled lists each week due to anaesthetist unavailability (on average 5 sessions/week at a particular LHD). For the 15 years prior to COVID-19, there was only one single session cancelled due to anaesthetist unavailability.
- Many sessions are covered by provisional fellows and advanced training trainees. Risk of not meeting accreditation standards, and trainees at risk of missing out on appropriate supervised training lists.
- Consultants weary over being expected to both run their own list and supervise a trainee in another theatre. This constant request for consultants to do 2 jobs at once is starting to make some consultants less inclined to work here.

112. Insufficient comparable remuneration:

- Insufficient funding of trainee and staff specialist positions commensurate to the workload, and lower levels of remuneration for staff specialists compared with other jurisdictions. Other states are paying specialists up to 50% more.
- More anaesthetists are also choosing to work in private practice and/or as VMOs, which can offer higher rates of pay, more flexible working hours and fewer clinical support duties.

National Health Practitioner Ombudsman specialist medical training site accreditation processes review

15) 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.

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113. The college has a “middle ground” perspective about agreeing or disagreeing with the conclusions and recommendations within this review and report. Overall, the college is supportive and working collaboratively with the Miller Blue Group (contracted to manage the NHPO AMC/Medical Colleges Working Group) in the implementation of the NHPO recommendations. We generally support the concept of uniform overarching accreditation standards.

114. Some general positives and challenges are provided below.

Positives	• We see the opportunity to align practices across the colleges, with the flexibility to build in specialty specific requirements • Provided clear objectives for how to lift our internal processes and support for staff training • Guided how to make our complaints pathway more visible • Engaging Miller Blue to take a programmatic and collaborative approach to develop cross-college standards appears to be working well
Challenges	• Disrupts the existing initiatives we had in train (initiating the recommendations from our own Accreditation and Learning Environment Project (ALEP) report had begun this year) to uplift the hospital site accreditation process • Initial timeframes proposed were challenging • Impact on an already busy unit

Other matters

16) Any other relevant matters raised by the College in relation to the administration of specialist training programs and the sustainability of the workforce generally.

115. A key threat to the sustainability of training in anaesthesia in NSW is the severe reduction in applicants and appointments for staff specialist positions in teaching hospitals. There is an exodus of anaesthesia staff specialists away from NSW Health into VMO positions, locum positions, private practice and to other states. The NSW Staff Specialist Award urgently needs to be reformed in order to preserve the key workforce involved in providing and administering teaching programs across NSW. The college does not have data on staff movements from staff specialists to VMOs, locum positions, interstate moves etc. This would be available via hospital level data (presumably rolling up to NSW Health aggregated data).