Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Level 2, 121 Macquarie Street,
Sydney, New South Wales

Thursday, 25 July 2024 at 10.00am

(Day 039)

Mr Ed Muston SC	**(Senior Counsel Assisting)**
Mr Ross Glover	**(Counsel Assisting)**
Dr Tamsin Waterhouse	**(Counsel Assisting)**
Mr Ian Fraser	**(Counsel Assisting)**
Mr Daniel Fuller	**(Counsel Assisting)**

Also present:

Mr Richard Cheney SC with Mr Hilbert Chiu for NSW Health

THE COMMISSIONER: Good morning.

MR FULLER: Good morning, Commissioner. First this morning we have two witnesses being called concurrently from the Royal Australasian College of Physicians, Professor Inam Haq and Associate Professor Kudzai Kanhutu, who are both online. I call those two witnesses.

<INAM HAQ, affirmed: [10.00am]

<KUDZAI KANHUTU, affirmed: [10.01am]

<EXAMINATION BY MR FULLER:

MR FULLER: Professor Haq and Associate Professor Kanhutu, my name is Dan Fuller, I'm one of the counsel assisting the Commission and I'm going to be asking you some questions this morning.

Firstly, each of you have signed off on a witness statement dated 12 July 2024. Do you have each a copy of that statement with you?

A/PROFESSOR KANHUTU: Yes.

PROFESSOR HAQ: Yes.

MR FULLER: That's exhibit H6.1 in the tender bundle.

Professor Haq, starting with you, have you had the opportunity to review that statement recently?

PROFESSOR HAQ: Yes.

MR FULLER: Is everything in it true and correct, to the best of your knowledge and belief?

PROFESSOR HAQ: To the best of my knowledge and belief, yes.

MR FULLER: Thank you.

Associate Professor Kanhutu, have you had the opportunity to review the statement recently?

A/PROFESSOR KANHUTU: Yes, I have.

MR FULLER: Is everything in it true and correct, to the best of your knowledge and belief?

A/PROFESSOR KANHUTU: Yes, it is.

MR FULLER: Thank you. Each of you have helpfully identified in the statement which of you will speak to particular topics, so I will try to address my questions to the appropriate person, but please, if either of you have anything to add on any of the questions that I've directed to the other witness, please feel free to let me know.

PROFESSOR HAQ: Sure.

MR FULLER: Just starting with some background, Professor Haq, can you describe your current role in the college, please?

PROFESSOR HAQ: Sure. So I'm the executive general manager of education, learning and assessment and my portfolio is trainees and their training up and to fellowship, from entry to basic training to exit as fellows.

MR FULLER: For how long have you held that role?

PROFESSOR HAQ: Since January 2023.

MR FULLER: Have you previously held any leadership roles within the college?

PROFESSOR HAQ: No.

MR FULLER: Associate Professor Kanhutu, can you please describe your role?

A/PROFESSOR KANHUTU: Yes. I'm the dean of the College of Physicians. My work portfolio encompasses workforce planning, data research, and I also have leadership of the research foundation that provides philanthropic grants to our members.

MR FULLER: For how long have you held the role of dean?

A/PROFESSOR KANHUTU: I commenced in September 2022.

MR FULLER: And did you hold any leadership role within

the college before that time?

A/PROFESSOR KANHUTU: Nothing that was paid. I did hold some advisory roles and leadership roles as a representative of the college on other bodies, but non-college bodies.

MR FULLER: Do you also have a clinical role outside of the college?

A/PROFESSOR KANHUTU: I do. I still retain 0.3 clinical work outside of the college of physicians but that's based in Melbourne.

MR FULLER: Can you just tell us what that clinical role is?

A/PROFESSOR KANHUTU: Yes, so I'm an infectious diseases physician so I work in the hospital setting as well as community-based care and refugee and migrant health.

MR FULLER: Thank you.

Professor Haq, do you have a clinical role as well?

PROFESSOR HAQ: Yes. I continue clinics at the Redfern Aboriginal Medical Service in rheumatology, which is my clinic.

MR FULLER: Thank you.

Associate Professor Kanhutu, starting with you, in lines 68 and 69 of the statement, if you can just have a look at those, you have described the college's remit as being a "specialist education provider". Do you see that?

A/PROFESSOR KANHUTU: Yes. I do, yes, I see that.

MR FULLER: Do you see being a specialist education provider as being the limit of the college's role?

A/PROFESSOR KANHUTU: No, it's not, and I think what I refer to, or what I refer to in terms of my understanding of what the college remit is, is what is within our constitution, which really clearly sets out our role as an education provider as well as a steward of ethics for physicianly practice within both Australian and

New Zealand. So my source of - my frame of reference really is what's bound within the constitution, and which is extensive, but really focused closely on education, maintenance of professional standards for the specialties that we have care of.

MR FULLER: Do you see part of the college's role as being to advocate for the interests of its fellows?

A/PROFESSOR KANHUTU: The advocacy that is stepped out in the constitution mainly relates to advocacy for work that relates to promoting good health and good health outcomes for community and to the extent that revolves around advocacy for certain groups of physicianly, I guess, craft groups, yes, there is some overlap there for direct advocacy for craft groups, for example, where we identify that there are community care needs that aren't being met due to either inadequacies in the way that our workforce is being deployed to address those needs.

MR FULLER: Do you see it as being any part of the college's role to advocate for individual fellows or groups of fellows in relation to workplace disputes?

A/PROFESSOR KANHUTU: No. We have traditionally not engaged in any industrial matters. Our focus for advocacy tends to be around topic areas or areas of community need, where we can potentially provide support or can help contribute to better outcomes for community. So the advocacy lens is usually focused on community care needs and gaps or perceived gaps there.

MR FULLER: Professor Haq, do you agree with that description of the remit of the college?

PROFESSOR HAQ: Yes, yes.

MR FULLER: Professor Haq, I understand - tell me if I'm wrong - that you previously worked in the UK; is that right?

PROFESSOR HAQ: That's right.

MR FULLER: Did you complete your training in the UK as well?

PROFESSOR HAQ: I did.

MR FULLER: Are you familiar with the current way in which accreditation, specialist accreditation works in the UK?

PROFESSOR HAQ: Yes.

MR FULLER: Are we right in understanding that, at the moment, at least, accreditation is not performed by colleges but instead is performed by a central body?

PROFESSOR HAQ: I think it's by the GMC and their work, yes, as I understand it.

MR FULLER: So not by individual colleges as it is in Australia?

PROFESSOR HAQ: No, no, not in - not certainly the college of physicians, anyway.

MR FULLER: Do you have a view as to the advantages or disadvantages of that sort of model, where accreditation is not performed by the colleges, compared with the model in Australia?

PROFESSOR HAQ: Yes, I think they're two very different health systems and populations and I think the current set-up is that the colleges have worked through accreditation. I think there's always room for continuous improvement there and working together. However, I feel that, at the moment, the direction of travel that we're going on with accreditation through the work of the AMC and the National Health Practitioner Ombudsman has been really helpful in bringing us all together to a common understanding, working much more closely with the health jurisdictions.

I think that the benefits of it being managed by the colleges are that you have the subject matter experts as fellows within the college, who understand the local context, and are able to make informed decisions based on that local context and understanding of the specialty field as required.

I think it also is excellent as a peer review, as much as anything else, and that, I think, engenders trust between those being reviewed and those asking the questions to allow, I think, a safe space for issues to be raised,

knowing that they will be dealt with in a manner that's professional and appropriate.

So to answer your question, I think there is always room for improvement but I think there are benefits of it being managed at a college level. I think there - and there are improvements in communication. If it was to be a third party, let's say, who manages this, I think that the process and procedures would have to be duplicated. It may lead to a complexity in the system and communication and decision-making, which, you know, health systems are already very complex. Do we want to add complexity? And it may take away some of that sort of positive constructive approach of peer review and make it much more of a sort of a top-down assessment.

MR FULLER: Associate Professor Kanhutu, did you have anything that you wanted to say on that topic?

A/PROFESSOR KANHUTU: Look, I definitely concur with what Professor Haq has articulated there. My experience of accreditation has been there is so much to be gained from the nuance and the understanding of context that we have. So for Australia, being a very large country geographically, a lot of the challenge that we find in terms of accreditation really relates to local and contextual factors and it's that benefit of having local people and people who understand both the craft group and the skill group from within the college who are there doing the accreditation that I think makes it a really valuable experience for both the accreditors themselves and also the sites, and that understanding that it is truly a peer review that's backed by a shared knowledge and a shared appreciation of a framework that has been developed over time.

So I think there is really benefit for having people who are doing the accreditation having a close working understanding of what it's like to work in various areas, whether it's, you know, urban settings versus small or outer metropolitan or even very small rural/regional remote settings as well.

MR FULLER: When you refer to "craft group" and "skill group" in that answer, can you just explain what you mean by those groups, please?

A/PROFESSOR KANHUTU: Yes, so what I mean, both of them, basically it's a synonym for the different specialties that we have under our banner. We have, you know, 33 specialties and then we also have some legacy specialties as well, and each of them can have very different needs and very different ways of meeting their professional needs.

So for some of the specialties they're very clinically oriented and are very much hospital based, and then we also have specialties there, for example, public health, where there is a really vast array of places and contexts where those training needs can be met. I think that's the true value of the way that we have accreditation running within our colleges, that we're able to bring in subject matter experts who are able to make that assessment on the ground and understand is this setting fit for purpose and does it actually meet the outcomes that have been set up for a particular curriculum stream?

MR FULLER: In relation to those 33 specialties, they're the ones we see in table 1 of the statement, which I think starts at line 33; is that right?

A/PROFESSOR KANHUTU: I will go back to that. Line 33?

PROFESSOR HAQ: Yes, that's right, they're the training programs, yes.

A/PROFESSOR KANHUTU: Yes. Yes, correct.

MR FULLER: Thank you. Professor Haq, I think this is in your section, so I'll ask you these questions. Are we correct in understanding that a trainee with your college will first undertake basic training in either adult medicine or paediatrics and child health; is that right?

PROFESSOR HAQ: Yes, the majority will enter that way and then enter into advanced training, but the chapters and faculties may allow a trainee from other areas as well, they're slightly more diverse in nature. But yes, the adult and paediatric internal medicine route is usually three years of basic training. You complete your examinations and then you enter your chosen advanced training stream.

MR FULLER: The chapters and faculties that you mention, I think we see from line 11 of your, statement, they deal

with a subset of the 33 specialties; is that right?

PROFESSOR HAQ: No, they are separate. They are separate. Yes, absolutely.

MR FULLER: In terms of the 33 specialties, after the trainee, generally at least, has completed basic training, then they undertake advanced training in one of those specialties; is that right?

PROFESSOR HAQ: Yes, that's right.

MR FULLER: The only way to become a specialist in one of the what I will call "physician specialties" is to complete a training program through your college; that's right?

PROFESSOR HAQ: Yes, yes.

MR FULLER: As a consequence, you would agree that there is no competition between your college and any other training provider for specialist training in those fields; that's fair?

PROFESSOR HAQ: I would say that we are the trusted provider, as in the UK. You know, you alluded to the UK. The college of physicians would be the provider of physician training programs in the UK. We're similar, yes..

MR FULLER: You would agree that because you are the trusted provider, the only trusted provider of those programs, it's important for your college to have fair, effective and transparent processes for governance and administering training programs?

PROFESSOR HAQ: Absolutely right.

MR FULLER: Professor, can you just explain to us what is it that your college accredits? Is it sites or positions or a combination? Can you just explain that, please?

PROFESSOR HAQ: Yes. So it is sites, and within that there will be the number of positions that are within the capacity to train of that site, dependent on the facilities and the number of medical personnel there to supervise. So it will be a mixture of the two. And that could be an individual site or it could be a network of sites as well.

MR FULLER: Let me ask you first, why is it that the college takes that approach to accreditation rather than, for example, accrediting individual positions?

PROFESSOR HAQ: We don't cap, at the moment. I know some colleges do, and we allow training sites to define what they feel they need for training - in training based on their infrastructure and resources. Then we would - you know, then there would be a decision about whether that number is correct based on the resources that have been available and the guidance that the college gives. But we do not cap positions at this stage.

MR FULLER: You mentioned the capacity to train guidance. I might just show you that document so we're on the same page. It's exhibit H1.36, [SCI.0011.0259.0001]. You'll see it come up on the screen, Professor, in a moment.

PROFESSOR HAQ: Oh, yes.

MR FULLER: You don't need to worry about that.

PROFESSOR HAQ: Yes.

MR FULLER: Do you see the document there on the screen?

PROFESSOR HAQ: I do.

MR FULLER: Is that the capacity to train guidance that you were referring to?

PROFESSOR HAQ: It is, yes.

MR FULLER: Can we just scroll to page 2, please.

We see under the heading "How does the RACP assess Capacity to Train".

PROFESSOR HAQ: Yes.

MR FULLER: In the first sentence, I think we see what you have just told us that the RACP doesn't cap the number of trainees; is that right?

PROFESSOR HAQ: Yes, yes.

MR FULLER: And then it goes on to say that the college monitors numbers of trainees and where required modifies the number when training provider accreditation standards are not met. Can you just elaborate on what that means, please?

PROFESSOR HAQ: I think that would be as part of the ordinary accreditation cycle. If a place is accredited for X trainees then the normal reaccreditation would be four years or so and then that - the numbers would be reviewed. If there was an issue with accreditation or conditions applied to a site, then those numbers would be reviewed, perhaps more on an interim basis, depending on the nature of the conditions and the nature of any concerns that have been raised.

MR FULLER: Just looking about halfway down this page, we see a reference to the basic training accreditation requirements and standard 5.2.1 --

PROFESSOR HAQ: Yes.

MR FULLER: -- which starts with a rotation supervisor.

PROFESSOR HAQ: Yes.

MR FULLER: Are we right in understanding that that is effectively a ratio of the maximum number of trainees per supervisor at a given site? Is that the right way of understanding?

PROFESSOR HAQ: Yes, that is guidance - that is guidance on a ratio, yes.

MR FULLER: I see. So it's guidance. It's not the case that if a site doesn't strictly meet that ratio, then it will be denied accreditation?

PROFESSOR HAQ: No. No, I think at that point there would be a decision based on in practice how does it work, and we would triangulate data from the supervisors and the trainees, and if there was an issue and actually it was felt that more supervision was required that could then be included in accreditation conditions or similar.

MR FULLER: Is there a similar requirement for advanced training?

PROFESSOR HAQ: Those would vary according to - as you can imagine, the very different number of specialties, and the number of trainees is much smaller there per site, so that's viewed - yes, there would be a view on that as well, done through advanced training at a particular site.

MR FULLER: Who determines that view or position?

PROFESSOR HAQ: So it would be the advanced training committee. There would be an accreditation visit. There would be accreditation criteria for each specialty that would be looked at and then the report would go to the advanced training committee and there would be a decision made there.

MR FULLER: Are there individual committees for each of the 33 specialties?

PROFESSOR HAQ: So there would be - the advanced training committee covers lots of or all aspects of training, but also includes accreditation as well, as a decision-making and review, yes.

MR FULLER: Associate Professor Kanhutu, was there anything that you wanted to add on the matters I've just been discussing with Professor Haq?

A/PROFESSOR KANHUTU: No, nothing. Nothing extra.

MR FULLER: Thank you. We can take that document down, thank you.

Professor Haq, you also mentioned the training networks and, as we understand it, basic training, at least basic physician training, is delivered within training networks at least in New South Wales; is that right.

PROFESSOR HAQ: Mmm-hmm.

MR FULLER: Can you just explain how that works, please?

PROFESSOR HAQ: Yes. So that is - there would be like a hub and spoke model, so there would be a sort of main hospital that would be running the network and there would be a mixture of metropolitan, regional and rural sites assigned to that network and then trainees would move

around those sites during their training.

MR FULLER: Does the college have any role in developing that network structure?

PROFESSOR HAQ: So that's where we work with HETI on that, very closely, and I'm a member of their adult and - both the adult council and the paediatric council, and we have representation on the network group as well. So that's where there's collaboration between the college and external bodies.

MR FULLER: What do you see as being the advantages of that structure for basic training in New South Wales?

PROFESSOR HAQ: Experience in different settings, yet still under sort of a home network, so to speak, so they understand where they sit. There is opportunity for more than - you know, for communities of practice with the trainees so they're not siloed on their own in particular areas and I think it allows training to occur, as I probably said, in different sort of areas, with different areas of specialism, different population, so the trainees can meet the curriculum requirements.

MR FULLER: I think we just missed the start of your answer but I think you were referring to experience in different settings.

PROFESSOR HAQ: Yes, in different settings --

MR FULLER: Does that have to do with --

PROFESSOR HAQ: In different settings in sort of you know, very specialist hospitals, with tertiary referrals maybe, versus more regional and rural hospitals as well. So a whole mix, yes.

MR FULLER: Is it the case that trainees are required to rotate into, for example, rural and regional settings as well as metropolitan settings? Is that right?

PROFESSOR HAQ: I think - with basic training I think that's often a discussion for the network director of physician education, to have with the trainee, as to where they would be going on an annual basis to do their training and if there are, you know, reasons why a trainee cannot go

to a particular place - and they may be family or personal reasons - those would be taken into account. There's no mandatory requirement for us at the moment to have experience in one particular place but we see it as desirable and part of our regional/rural (internet interruption) - the longer a trainee - or a medical student or trainee has experience in a non-specialist city centre, the more likely they are to sort of stay there, and that's part of managing workforce distribution, it is really important.

MR FULLER: Is the college doing anything in particular to help facilitate that?

PROFESSOR HAQ: Yes. So across - so we are, through our regional and remote strategy we will be working on - I mean, New South Wales is probably, you know, sort of a bit ahead of the game here. Through federal funding, FATES funding, we are working on network models in other areas of the country, particularly Western Australia in adults and paediatrics, and Associate Professor Kanhutu is working on those as well.

We actually very much want to facilitate working with other health jurisdictions to ensure that trainees have well-supervised experience rurally, because we now have medical schools that are end-to-end rural training, we have integrated training hubs for prevocational training, so there's lots of opportunities now to ensure that we retain that rural workforce in the appropriate places. And for vocational training, networks, rural networks either purely rural networks or networks that involve metropolitan and urban settings as well is I think the way forward, and New South Wales obviously is developed in that, well developed in that regard. There are other areas that we're working on to ensure that we can manage that as well. Professor Kanhutu may want to speak to the FATES projects, if you require.

MR FULLER: That would be helpful, Associate Professor Kanhutu. Do you want to comment on that?

A/PROFESSOR KANHUTU: Sure. So we have two projects that revolve around networked models. The first one is a college-driven one, which is a project running in Western Australia where they're looking to establish essentially end-to-end training for adult medicine in rural, regional

and remote areas with a very brief period spent at a larger site at the time that someone's performing their examination. So the whole ambition there is to do as Professor Haq alluded to, to allow people to spend as much time as possible in a rural setting whereas traditionally they would have had to rotate out or spend extensive periods in metropolitan sites in order to meet their training requirements.

So what we are enabling there is the ability to see that we can actually allow people to develop all of their core skills and competencies largely within a rural setting, and then encourage them to stay there as well, and that has been very well received for that Western Australian cohort.

The other project we're working with is a consortium project that involves a host of other colleges, including college of surgeons and the medical administrators, which is looking to establish what are the key components of a successful network model, and then one of the outcomes for the surgeons is to actually establish a rural network in the Northern Territory.

If I can perhaps reflect on some of the comments Professor Haq has made, one of the real benefits that we've seen with the networked models is it's not only about exposure to different context, it's the efficiencies that it also allows and delivers for the sites individually.

One of the things that we've had as reflections from the rural sites is the real challenge of recruiting, if you are a stand-alone rural site. Often there is a sense of prestige or allure for the larger metropolitan sites because they often have access to research partnerships and research linkages that can be a real drawcard, especially for those specialties where there is an expectation that there will be potentially an academic pathway or further academic study as part of, you know, career progression.

There's also huge benefits at that basic training and the advanced training level of having networks because then people are able to share the same educational resources, tutorials, and it really builds a sense of not feeling as though, you know, they're a second-tier or third-tier site, because people have an expectation that working within this network, I will have access to exactly the - you know, as

many opportunities as I like, particularly if there are some who are wanting to subspecialise. For example, some of the cardiology specialties have subspecialties within them, and it can be a bit of a challenge if people are working in certain settings if they feel that they won't actually have access or exposure to certain areas of subspecialisation if they are locked into a single site.

So there are huge, I think, benefits to be gained from those networked models, particularly as we're now working to build them proactively and to design them, because many of the existing networks, my observation has been, are often legacy networks or networks that are built on historical relationships and now what we're looking at, for example, with the Western Australian example is to actually say, "Look, if we're to start from scratch, how would we build a network that is mutually reinforcing, that doesn't have unnecessary duplication and also is networked in a geographic way that potentially doesn't draw people that still have to travel six hours or work in a network that's actually unworkable for the individual and forcing them to have to move house or move their families?"

That's really important that in this moment in time, because we have so many of our trainees who are coming through who are already postgraduate, have significant commitments and often have had previous careers as well that have bound them to particular geographies and giving them that confidence that they can work in a network, still have great exposure but aren't having to then recommit to having to move extensively or disrupt that - I think that sense of work/life balance that people increasingly value and should really have access to, if we're serious about wellbeing.

PROFESSOR HAQ: Yes, and I --

MR FULLER: Can I ask you - I'm sorry, Professor Haq.

PROFESSOR HAQ: Sorry, no, you finish your train of thought with Professor Kanhutu.

MR FULLER: Thank you. Professor Kanhutu, can I just ask you a few follow-up questions. Firstly, we've been talking about FATES. That's a Commonwealth funding initiative that's "flexible approach to training in expanded settings"; is that right?

A/PROFESSOR KANHUTU: Yes, correct.

MR FULLER: Do you see any impediments to implementing a similar model in New South Wales compared with Western Australia?

A/PROFESSOR KANHUTU: You mean a FATES funding model or --

MR FULLER: A similar networked structure to the one that you've described in Western Australia that has been implemented using the FATES funding?

A/PROFESSOR KANHUTU: Look, I think there's - I want to say not "impediments", but barriers and enablers. I can speak to the enablers and what we've seen is often the real driver is having a committed group of clinicians who are focused in understanding what is it that they're trying to build and also have the support and buy-in of local trainees who are saying, "Yes, that is exactly what we need."

Where I think things can fall apart is when there aren't those, I guess, relationship built bridges that allow people to then wrap around that network and actually formalise it and provide the governance structures. I feel that that's the role that our college can play, is really helping people to shape those connections and then make sure that the accreditation model that is drawn up for that network supports that to remain rigorous and balanced, because a lot of this work, for better or worse, often happen in its early phases through goodwill, and I think what we'd like to see is that we support people to develop networks where, firstly, there's a real recognition of the amount of work that goes into building a robust and fit for purpose network, because often the downfall is that, you know, organically formed networks can suffer from having individual or individual dependency as to, you know, there is somebody who drove the beginning of the network, they disappear or leave and then it falters.

I think what we would like to see is to give people some of those guide ropes of how do you set up a network for success, and that's one of the real outcomes that we hope to achieve from that FATES project, the consortium one, is: what does it take to do it right from start to finish', what sort of resourcing is required; what sort of

background work do you need to do; and who do you need to have over the lifetime of the development to make it successful?

So I don't think there are any - you know, there will be as part of this project, and one of them will be a catalogue list or a summation of what are the barriers and enablers for establishing a network. So absolutely doable and there will always be those context dependent considerations. For example, if you're trying to build one in far western New South Wales, it might be very different from trying to build one, for example, in northern New South Wales, or hinterland.

So I think the fundamentals will become clearer as we develop, but there's nothing that I would say would absolutely preclude setting up or working to establish something like that in New South Wales.

PROFESSOR HAQ: I think the work that Professor Kanhutu is doing will allow us to enhance what's going on in New South Wales, I think, already.

I won't mention the site name but we've had at least one site, rural/regional site, that has applied to us for accreditation, that has been given, and then we have worked with HETI, who will then help find a network place for that, so there is a procedure in place at the moment.

Now, I think there's work to do through the work that Professor Kanhutu has done, I think, to make that an easier proposition.

I do think that the other thing I would like to say, there is also one more project in palliative medicine, looking at fully rural networking across the country. So I think the college is leading this in a significant way through Commonwealth funding, which is a great enabler for us, and we're very engaged with the upcoming review of this portfolio with the Commonwealth Government.

Another couple of things to say, I think that supervision is really, really important here, either remote or in person. And the nature of that supervision across the network, that's something I think that we'll be having to work through as well. What does that mean, particularly for potentially smaller sites? And also a facilitation and

accreditation of smaller sites. We are currently going through a review of our standards and, I think up until now it would be fair to say that our standards have been a little metro-centric and it's been more complex and difficult for smaller - well not necessarily smaller, but regional and rural sites to gain accreditation. That is absolutely not our intention, and the current review of our training standards will actually - much more of a risk-based framework and allow regional/rural sites to get accredited where, at the moment, it's been more complex for them. So I think that will also be a great advantage to networking.

MR FULLER: Does the college currently take into account, for example, the fact that a rural or regional site will be part of a network when it's deciding whether the site meets the accreditation standards?

PROFESSOR HAQ: They would be on the basis that - you know, accreditation would be given on the basis that a network is found, yes.

MR FULLER: I see. So it's provisional, effectively?

PROFESSOR HAQ. And that's where we work with HETI on finding the network, yes.

MR FULLER: Professor Haq, you mentioned considering the idea of remote supervision. Is that something that you think is workable for your college's specialties?

PROFESSOR HAQ: I don't think - I think it's not a one-size-fits all here. I think it depends on the nature of the specialty, the nature of the acuity of the specialty and the sort of geographic location of that particular site. So I think that's something we need to investigate and it will be very different for each of the specialties, I think, as to what they will feel is there to the benefit of patient safety and community safety as well as the trainees' safety.

MR FULLER: Associate Professor Kanhutu, do you see any barriers in New South Wales to implementing a networked model arising from the sheer size of the system and the number of players, for example, or districts, versus the ministry? Do you see any barriers in that area?

A/PROFESSOR KANHUTU: Again it goes - it boils down to the governance and how you design it for success. We already have some excellent examples of networks that are working. So how we tend to work in that spirit of peer review is to look at what's working and then try and structure models that will, I guess, replicate the same foci of success.

Where you're trying to build a completely new network and bridging completely new relationships, I think it's always going to be a lot harder to do that and often that groundwork is actually seeing where there are potentially some already existing relationships that would facilitate a smoother transition to a formalised network.

MR FULLER: Are we right in understanding that currently in New South Wales there is no network structure for advanced training?

PROFESSOR HAQ: I think it probably depends on the specialty. I wouldn't know for each specialty.

A/PROFESSOR KANHUTU: Yes.

MR FULLER: So there may be some specialties that work within a networked structure; is that --

PROFESSOR HAQ: Yes. I mean, certainly rheumatology, I think - and whether they are networks or sort of de facto, I think, is probably to be discussed, but I think there are probably informal ways in which that is done in some areas, yes. But I couldn't speak for each of the specialties.

MR FULLER: Associate Professor Kanhutu, I think this is in your section of the statement, if you go down, please, to line 470 on page 17.

A/PROFESSOR KANHUTU: Yes.

MR FULLER: There's a dot point there that starts "A goal of the RACP's Accreditation Renewal Program". Do you see that?

A/PROFESSOR KANHUTU: Yes.

MR FULLER: Halfway down line 475, you say:

In NSW, most Basic Physician training occurs within HETI's network structures.

Which we have discussed. Then you say:

There is an opportunity to expand this throughout Advanced Training.

Can you just explain what you had in mind by that opportunity?

A/PROFESSOR KANHUTU: I'm having a look at that. I'm not sure that that was --

PROFESSOR HAQ: Maybe it's me.

A/PROFESSOR KANHUTU: -- my area of response.

MR FULLER: I'm sorry.

PROFESSOR HAQ: No, it's fine. I'm happy to look at that. Look, I think again it's - the issue is, I think, the sheer number and complexity of the number of sites and specialties. I think there are opportunities there. And again some of these may exist already, you know, around trainees moving from metro to regional places. I think we probably need to get a better idea of that across all the specialties and see how we can create, you know, sort of structures that support that.

I mean, there are also, of course, you know, as Professor Kanhutu has alluded to, in WA and the NT, fully rural networks as well that we need to think about potentially as well as options or ways to gain the requisite experience.

MR FULLER: Does your college have a role in selecting trainees?

PROFESSOR HAQ: At the moment we have - that's done in the workplace. We have a selection into training guidance that we provide and the workplaces then manage that at a local level and there are different ways in which that works. There's no one way in which it works. Either the - there are - different models could be that the site will work with, or a network will work with, a specialist society, as occurs in something like rheumatology, to select and then

match, or there's often in other areas, for example, endocrinology, where the specialty will work with NSW Health across the whole state on matching. So there are different models but all are needing to align with the college selection into training guidance.

MR FULLER: So the college doesn't have a direct role in, for example, recruitment processes?

PROFESSOR HAQ: No.

MR FULLER: Is that right?

PROFESSOR HAQ: No. No, ,that's right. So we provide the guidance and then it's down to the workplace to enact those.

MR FULLER: That's the case for both what I'll call basic trainees and advanced trainees?

PROFESSOR HAQ: Yes, yes, yes.

MR FULLER: Do you see that as an appropriate level or scope of the college's role?

PROFESSOR HAQ: So I think we're actually looking at that at the moment. We're going to be auditing our - with sites, as to how they meet those selection to training guidance, to ensure that they are, you know, equitable across an equitable process.

The question then arises as to whether we, you know, wish to maintain the local recruitment or would there be some sort of centralisation and what would that mean? I think that is - we haven't got there yet. That's a question to be answered but we are in the first stages of getting the data to understand how workplaces are currently enacting the selection to training guidance.

MR FULLER: Why do you think it's important for the college to at least be providing guidance on the selection of trainees?

PROFESSOR HAQ: I think there is - and appropriately so, I think we need to be transparent and open with trainees, our members and the public, that we are recruiting in a fair and equitable way, independent of personal

characteristics or location.

MR FULLER: Associate Professor Kanhutu, do you have any comments you want to make on the issue of selecting trainees?

A/PROFESSOR KANHUTU: Look, I think it's - if I reflect on my pathway or entry into training, there is always a spectre if you've worked somewhere, you're more likely to be known, you're more likely to be welcomed into or accepted on to a training program, and that was certainly my experience coming into advanced training.

So I think I concur with what Professor Haq has said, that we do have a role to play in trying to provide some of that guidance around how do you actually manage and maintain a governance process and a selection process that gives people a fair opportunity based on the skills that they've had rather than, you know, having people, you know, feel as though they must train in a particular location in order to get on to a training pathway.

MR FULLER: Associate Professor Kanhutu, do you agree with the general proposition that colleges' accreditation standards should be outcomes based and evidence informed?

A/PROFESSOR KANHUTU: Yes, that is a fair and a reasonable way to manage things that I think is in line with both trainee and community expectations.

MR FULLER: Professor Haq, do you agree with that?

PROFESSOR HAQ: Absolutely, and we're working very well with the Australian Medical Council and their group and the NHPO exactly on this.

MR FULLER: Referring to the Australian Medical Council and the NHPO, I take it you're familiar with the recommendations of the NHPO report?

PROFESSOR HAQ: Yes.

MR FULLER: Does your college, at a general level, support those recommendations?

PROFESSOR HAQ: Yes, absolutely.

MR FULLER: And Associate Professor Kanhutu, I take it you agree with that?

A/PROFESSOR KANHUTU: Yes.

MR FULLER: Associate Professor Kanhutu, I think, hopefully, this is in your section of the report, and I think within the scope of your role that you described to us earlier: from line 67 of the statement on page 6, you talk about supply versus demand evaluations and say that the college does not routinely provide commentary or advice on that issue, it's beyond the scope of your organisation's remit. Is that a policy decision that the college has made about the scope of its remit or it's a matter that comes back to the constitution that you described to us earlier?

A/PROFESSOR KANHUTU: It comes back to the constitution, which is very much embedded in that educating and providing stewardship of professional practice and standards. However, I think in my time in this role, it's become apparent that there's a real desire from other stakeholders for us to share and contribute to the conversation around supply and demand.

I think where we've often found it difficult to contribute more is that - it's a recurring question, it's a million dollar question: how many doctors do we need in order to provide care in location X or in jurisdiction X? What has been hard is that there are many people who hold data that would help to inform a reasoned to answer that question and there are still - but in saying that there are still lots of aspects of determining what is adequate supply and demand that are also un-agreed or areas of contest.

For example, there is a concept of what is called a medical care desert. There is still some disagreement about exactly what constitutes a care desert or an area where community needs are either partially met or completely unmet, and that can be due to a lack of access, long wait times or even sociodemographic factors that mean that you can have a specialist in a region but people can't actually access them because of financial barriers to care and access.

So when I say the college - I think we've tried to work where we can, so we now publish an annual member

insights report that steps out how many people do we have in various training pathways, how many fellows, and in which states, and that, I think, is our contribution at this point in time to helping people to draw some of those.

Any modelling will always have some measure of error because you've had to make a lot of assumptions and some of the assumptions we just can't reasonably make, and we also are not in a position, for example, to conscript people to work in particular areas or to bulk bill or to work in particular ways.

So when I say it's beyond our remit, I think it truly is functionally, but it's not something that we are shying away from in terms of finding ways that we can contribute to the conversation and share our data with other stakeholders. For example, the federal government has now committed to building supply and demand models for all of the medical specialties across the next 12 months, and we are part of that conversation, to test some of those models and the assumptions that underlie them, and also to feed in, I think - the other part of the supply/demand is feeding in the qualitative aspects, because the numbers can only tell you so much. It's also what we're hearing from trainees about how they would like to work or how they would like to carry out their professional scopes once they've actually become fellows.

So, yes, the big picture pieces of are we going to build all the supply/demand, I think that is a huge task and one that we're not frankly resourced for at the moment, but can we contribute to the conversation and provide both quantitative and qualitative data to inform that dialogue? Absolutely, and that's what we're working to try and do.

MR FULLER: Would it be the college's preference to have more access to data about workforce numbers and distribution?

A/PROFESSOR KANHUTU: Yes.

PROFESSOR HAQ: Yes.

MR FULLER: What would the college - what do you think - why do you think that would be useful for the college?

A/PROFESSOR KANHUTU: Look, one of the - so if you look

at the trainee or the fellow outcome survey, the new fellows outcome survey, one of the things that comes out is people do still have that sense of anxiety about "Where am I going to work?" "What does working look like?" "What are the options for me?" And if I think about our role in also supporting people to be - you know, to have thriving careers, having information around what is the lived experience of being a new fellow going to be like, I think would be really instructive to guide people and to help them, because there is still a real sense of being on your own when you first fellow, as opposed to when you're in a training pathway and are surrounded by people who are at the same stage of career.

Once you have become a fellow I think that information about where the opportunities might be for you would help us to also have more, I think, personalised conversations with individual fellows around how we can guide or direct them in a way that will allow them to fulfil their own career aspirations, acknowledging that, at that point, they've invested literally decades of education and work and effort to get to that point, and that sort of data around workforce dynamics would be really useful and useful evidence base for having a productive conversation with people.

MR FULLER: Professor Haq, is there any you want to add on the question of data?

PROFESSOR HAQ: Yes, I absolutely agree with everything Professor Kanhutu said and I think it's really that longitudinal date that's going to be so interesting because we have the data on our medical schools, from the medical schools outcomes database, that Medical Deans ANZ collate, together with the data that Ahpra collect. That's gold to enable any health system and the colleges and all sectors to make better informed decisions.

MR FULLER: That's, I take it, data that currently the college does not have access to?

PROFESSOR HAQ: We do have access to the - Kudzai may be able to answer.

A/PROFESSOR KANHUTU: Yes, so we have access to medical training survey and we contribute to that. We also have access to the Medical Deans of Australia and New Zealand

dashboards, which are really at that prevocational stage of where are people training in the medical schools and where would they like to train. Some of their statistics are really phenomenal in terms of guiding us as to career aspirations at that really early phase and showing us that that physician pathway is still very appealing.

The problem is, as you said, Professor Haq, that longitudinal piece of seeing where someone begins, how long it takes them to transit through training, where there are stops, starting points, people who may be stopped to locum, and then where they end up within the workforce and how permanent their existence in that work space is or if they are then going on to do academic work and what is happening. And it's joining the dots of those multiple sort of currently very siloed data points to build a really clear picture of what we can expect to see as people who are actually available to work and not necessarily full-time, either.

I think historically the models were based on you're going to be coming out working full time and that's just not the reality for, I think, the majority of people that we're interacting with as new fellows. They're not entering into full-time work.

MR FULLER: Do you know whether the data that would be needed to do that sort of longitudinal analysis - is that being collected across the system?

A/PROFESSOR KANHUTU: I think that it's a great question you've asked because what we've - the conversation that we've had within a lot of those data forums, so the federal ones and the jurisdiction ones and also the ones with Aotearoa New Zealand, is that there isn't a clearly defined minimum dataset for workforce. We have unified data points that would allow us to link people - for example, your Ahpra ID you do get very early on in your career, and that would allow you to identify individuals.

But as far as making sure that each section of that longitudinal pipeline is collecting exactly the same data, we've not been doing that. So what you might find is you'll be able to build some aspects of a longitudinal pipeline, but then there will be some points where, unfortunately, an organisation hasn't collected a particular piece of information and you won't actually be

able to build a consistent picture. But there's certainly enough there, and if I look - as a binational organisation, if I look at the work that the Aotearoa New Zealand colleagues have done, they are, I think, very advanced with respect to some of their specialty mapping, and they are able to not only see the individual, they're able to see time points when somebody has stopped working, they're able to see geographically exactly where someone is working, their fractional appointment as well, and then able to match that with community demand trends as well. So it's possible, but I think we suffer from having often a fragmented governance approach to how the data is stewarded to allow us to build a consistent picture across somebody's career and then across an entire specialty cohort.

MR FULLER: So am I right in thinking - is this a fair summary - that there are two issues: one is that there may be some gaps in the data that's needed to perform the longitudinal analysis; but then the second is the issue of pulling the data that does exist out of the silos and bringing it together to perform that analysis? Is that a fair summary?

A/PROFESSOR KANHUTU: Yes, absolutely. So no agreed minimum dataset, and then no governance framework to allow us to share data safely, and also, I think with the consent of our members as well. I know when we think about the data governance framework for our Indigenous fellows and members, there is a real sense that we have to get that right. We can't be in a position where we're sharing data where there hasn't been that deep conversation around consent and also identifiability of certain specialties.

I know at our recent graduation ceremony we had the first ever female Aboriginal fellow paediatrician. If you published data on that, she will know exactly who she is. So there are some real, I think, pauses for thought around how we actually build some of those data-sharing governance frameworks to make sure that they're safe and fair whilst still achieving that goal of giving people an evidence base to understand where are the areas of need and where can someone hope to have a thriving career where they're able to exercise their full scope and skill set.

MR FULLER: Did I understand you correctly to be saying that there is currently some work being done in this area?

I think you mentioned participating in data forums or something like that; is that right?

A/PROFESSOR KANHUTU: So there are a few data forums. So Medical Deans Australia and New Zealand have been very proactive in trying to reach out, for example, to Ahpra and link their data and have been very successful in that. They hold periodic data forums, so there's one coming up next week which I'll be participating in.

There's also the medical workforce advisory council, which is a federal body which looks at data as well and brings in stakeholders including Ahpra. Then there are a few things that are happening in academic space as well. So if you look at the ACT, they have enlisted ANU to build out some supply/demand - or stock and flow models for their workforce.

So it is happening in a lot of different places and what I have struggled to find is a single place I can go and feed into a consistent conversation around what does modelling look like for specialty workforce?

MR FULLER: In terms of if we were to imagine a world where there was that single place, do you have a view as to whose responsibility that needs to be, or group of people whose responsibility that is?

A/PROFESSOR KANHUTU: No. I think it comes down to building the foundations for if we were to even recruit somebody to do it periodically as a report, whether it's a census or other existing way of measuring it, is everybody clear on what they need to be collecting now and are they resourced to be able to collect it? So the minimum dataset piece is, I think, important and something that you could start to communicate to organisations now. If you're not already collecting information around, you know, absences of leave due to family leave, please start doing that because at some point it will help to inform models that will be created.

As to who fundamentally owns it, I think it is a - it would be a great if it sat at the level of almost a jurisdiction and federal collaboration that allows us to feed data in so that people can also see a consistently measured approach for all of the jurisdictions, as opposed to what I see emerging now, which is each state has

a different level of evolution or development as to what they're telling people the numbers look like, just some consistency and for that to sit really at the level of state and federal, to pull together that information, because it sits in so many different pots. But I think if we had the confidence that it was being held at that level, people would also feel a lot more comfortable to contribute or share their information in that space.

MR FULLER: Professor Haq, did you have any comments on this issue?

PROFESSOR HAQ: No, absolutely agree with all that has been said. It's working together, you know, we're all here for the same reason, we all want to serve our communities, and have the right number of people in the right specialties in the right place, and I think by working together and being comfortable with sharing our data in the right circumstances with the appropriate governance, that can only benefit all parties.

MR FULLER: Thank you. Associate Professor Kanhutu, can you please have a look at line 448 of the witness statement on page 16. I think this is in your section.

A/PROFESSOR KANHUTU: Yes.

MR FULLER: You have identified here some what you describe as general "impediments/obstacles/challenges to training specialists" which can occur in New South Wales but are not limited to New South Wales. Do you see that?.

A/PROFESSOR KANHUTU: Yes.

MR FULLER: I just wanted to ask you to elaborate on a couple of points. Firstly, in the first dot point, as I understand it - and tell me if I'm wrong - the point you're making here is, or the issue is, that some training programs require specialist training that can only be delivered in certain locations because of facilities and the like; is that right?

A/PROFESSOR KANHUTU: Yes.

MR FULLER: Are there particular specialties where that is an issue?

A/PROFESSOR KANHUTU: I think - my impression is, and I'm sure Professor Haq will also be able to reference, it can tend to be the procedural specialties. Whenever you have procedures or a skill set that requires expensive equipment or very technical equipment, you will almost always find that that ends up being in a tertiary metropolitan setting. For example neonatal intensive care is a good example; in cardiology, ECMO, or extra corporeal membrane, you know, circuit care. Really advanced - highly advanced or technical skills always tend to centre on large metropolitan settings and there's almost no way to get around that because there's not that critical mass or the resource intensivity to support that to happen in regions or in smaller settings.

So I think for most of those, yes, technical or procedural based specialties you will find that there is a heavy concentration or almost sequestration of that skill set only being able to be achieved in a single setting.

MR FULLER: Would we be right in thinking that some of the things we've discussed earlier today around networks and the like are what the college sees as potential ways of ensuring that that need for specialist facilities doesn't impede specialists from moving out into, for example, rural and regional areas; is that fair?

A/PROFESSOR KANHUTU: Yes, I think it's fair, but I think the other part of the conversation as well, which is still in evolution, is what do people want to be doing when they finish? I think one of the areas of dialogue we've had for some of the specialties is, "Well, if I'm going to - if my intention is to work outside of a large metropolitan setting, should I actually have to go and do a certain period of training in this location", or are there other ways that we can finesse someone's career progress or their training journey so that they can stay where they are and, I guess, emerge with the skill set that they feel they need for the career that they intend to pursue.

I think that's an area that's still unresolved, but one that, I think, is definitely in play as far as - when we look at some of the specialty areas who have traditionally had, as, I think, Professor Haq has alluded, a very metro-centric or a metro-leaning approach to that accreditation or that sign-off of competency and skills.

MR FULLER: Is that flexibility you have just described something that the college is looking at at the moment in terms of its curricula and so on?

PROFESSOR HAQ: Yes, absolutely. I think what we're creating with our new curriculum is outcomes, called entrustable professional activities, EPAs for short. Those are discrete sets of skills often collated into one - well, one domain that trainees can demonstrate anywhere. It doesn't have to be in a particular setting. So that, I think, will absolutely enable them to be developed, delivered, in different areas.

The other thing is, of course, you know, the continuum of medical education and health education, we're always all learning and the moment you gain fellowship is not the end of your learning journey. You may decide that actually what you're going to do for the first part of your career is work in a more generalist area, fantastic, and that can be in a regional or remote area, and then you credential up, if you wish to get sub-specialty skills or super-specialty skills, then you would credential those at a later date and then perhaps employ those skills in another setting with the appropriate environment.

So I think we need to be more flexible about trainees. We don't expect them to have all the skills all the time, because we're all learning new skills throughout our 30- to 40-year working life. So I think we need to be cognisant of that. People are now working longer and they're having more - as Professor Kanhutu alluded to, quite a lot of portfolio careers. So multiple jobs that are less than full time, often mixed with research or academia or working in government or, you know, health management, for example. So we need to actually be aware of those and allow that flexibility as part of our curricula as well. So absolutely that's something we need to work towards. It's complex and, of course, it's dependent again on some of that workforce data that we need to enable them to make the right decisions there.

MR FULLER: Associate Professor Kanhutu, coming down to the third dot point, so starting at line 461 on the next page, you've described there - tell me if I've understood this correctly - a change in the eligibility requirement for basic physician trainees so that they now have to have done two years rather than one year before they can enter

basic physician training; is that a fair summary?

A/PROFESSOR KANHUTU: Yes, it is.

MR FULLER: What, if any, do you see as being the impediments, obstacles or challenges arising from that?

A/PROFESSOR KANHUTU: This is something Professor Haq and I have discussed previously. I think one of the challenges in all the feedback we've had from members is that it really extends people's training time. You know, some of these people in postgraduate have been working as clinicians, whether it's a nursing background or physiotherapy or other allied health area, where they actually have a really solid foundation and grounding in terms of understanding how the health care settings work, and the idea that you just mandatorily have to have someone spend two years before they can start a training pathway doesn't actually allow that flexibility and the nuance that someone would expect as a postgraduate or, you know, a late-career individual.

So one of the - the bigger challenge, I think, is just the extended time and that has implications for people in terms of other aspirations they have for work/life balance or other stages of life, and I think that that's probably the main theme that has come out there, is that it's a rubber stamp and it's actually at odds with how the current curriculum renewal has been structured - I know Professor Haq can certainly speak to this - where we're looking at competency rather than time-based requirements for demonstrating that you're actually progressing on a career path.

Actually it's moving away from where we're trying to go, which is that if you have the competency and the skills, you should be able to start the training program and progress on it, rather than just saying, "You must do X amount of time before you move on to the next stage."

MR FULLER: So to your knowledge, there is no flexibility, for example, recognition of prior learning or experience in that current policy; is that right?

A/PROFESSOR KANHUTU: My understanding has been that it's to be deployed as a fixed two years, without any negotiation. That's my understanding. I'm happy to stand

corrected.

PROFESSOR HAQ: That's my understanding, that there isn't room for nuance in it. And I think that I understand some of the reasoning for that, in the networks and health districts wanting to have two- and three-year contracts to give surety for trainees, so I do understand that aspect of it, but I think, as a consequence of the AMC-led prevocational framework, this has led to perhaps an increasing training time and then delay in people getting out to where the communities need them and perhaps, you know, could be up for further discussion between us and the relevant parties.

MR FULLER: Associate Professor Kanhutu, coming down to page 20, line 564, you give a number of case studies here about what you describe as "workforce challenges/issues/obstacles". I just want to ask you about two of these. Firstly, case study 1, where you describe members reporting working beyond their capacity or experiencing burnout. Can you just elaborate on what you're hearing from members on those issues?

A/PROFESSOR KANHUTU: What we're hearing is that relative to people's expectations of what their working lives would be - ie, "I'll be at patient bedsides working with patients all day long", which is where the joy and the passion comes - people are increasingly finding, and this was really apparent during COVID, that a lot of their work is being drawn towards administrative tasks and leadership-type work that really places - extends their day and extends their bandwidth far beyond what they had expected.

Then, on top of that, you lay the responsibilities of doing good quality supervision where you may be dealing with people, you know, a cohort who are extremely strained and are needing additional supports and a real sense that people just don't feel as though they're able to do justice to anything very well.

If you're then thinking about somebody who then has - no longer has, I guess, the simplicity of having, you know, "I'm 0.9 clinical and I've got a tiny fraction of something else", you have people who are constantly context shifting. One minute I'm a supervisor; the next minute I'm in a director of medical service meeting with a governance team trying to decide on things like, in the hospital setting,

bed flow or patient flow, and it's just a real sense that people feel like they don't have enough time to do what they need to do well across all of the multiple areas that they have to try and cover and be competent and effective in.

MR FULLER: Do you have a sense from your members of the causes of that situation?

A/PROFESSOR KANHUTU: The causes are - if I look at - I guess my experiences as well is that your people are straddling multiple roles. They are no longer just a single role based requirement and there is an increasing requirement that if you hold, for example, a leadership role within an organisation, that will not only be clinical leadership, it will also be hospital level governance leadership requirements and attendance at meetings.

So there are lots of drivers and it depends on the site and the setting as to the relative burden or the weight of that, and it's generally a sense that there aren't enough people to do the work, although the work needs to be done. And I think I'll say a lot of people often feel a certain measure of compulsion to just help, even though it's not actually resourced within their work contract or the agreements that have been made. So there are a lot of informal stressors that come on top of what looks like a very sort of straightforward week, they're then finding themselves really drawn and stretched across multiple responsibilities, where there just isn't enough time to do it justice.

That certainly came out in one accreditation visit I did where a fellow was saying - a relatively new director of physician education saying - "I just don't feel like", with the training or the cohort that they had, "that there was enough time to really sit with those people as individuals and work with them to support them with the level of supervision and the care that they required."

That, I think, sort of extends us into that - we can make recommendations in the accreditation around the sorts of ratios that we think do allow someone to do that, but then the real lived experience can be very different from site to site and location to location, and also dependent on the, I guess, stage at which someone enters into that role as well and what other things they're having to

juggle.

PROFESSOR HAQ: I might add that I think there is allocated time, notionally, for non-clinical activities. Those have to cover all the things that Professor Kanhutu has said. I don't think there's enough time, and what we would really want to advocate for is protected time for supervision, to do it well, because we know that by doing it well, you benefit the supervisor, you benefit the trainee and you benefit the patient and their carers and families.

So I think at the moment it's being squeezed in as an additional part of things to do in the evenings, at the weekends, particularly if you have larger numbers of trainees, and I think we must do better to support our supervisors at all levels, at the college level, but also the jurisdiction and health district level, to ensure they can do their job properly and effectively, supported, with the appropriate time.

MR FULLER: Is there anything else that you or the college has a position should be done to address the issues that we've just been talking about?

PROFESSOR HAQ: I mean, advocacy is within our role here and Professor Kanhutu may or may not want to talk about some of that. We're seeing that we have more of a place now in some of this advocacy on behalf of our members, as you were alluding to earlier, counsel, so that's something I think will be a focus for us next year.

Again, it's a collaboration between us and our health partners as to how we do this to the best of ability. It's not an "us versus them" approach, because that way nobody will win. We've got to work together for the benefit of our community. So I hope that we can continue those conversations.

But there is increasing - the clinical work is increasing, clinical management work is increasing, and supervision requirements are increasing, and all of that cannot be done in the current sort of contractual and workload arrangements, I think.

MR FULLER: Associate Professor Kanhutu, do you have a view about anything else that could be done to try to

address the issues that you were describing for us earlier.

A/PROFESSOR KANHUTU: I think it is really repositioning ourselves from a position of wellbeing and acknowledging that these people are often people who have been trained in cultures where there's a deep culture of volunteerism and expectation that you'll just do things, and we need to start moving beyond that and that's why we're looking to try and formalise some of these expectations of what should a working environment be like as a supervisor; what is a reasonable ratio; and that those can become shared understandings and ones that are adopted by people.

That's, I think, the advocacy piece that we would like to see be embraced as a common or a shared value, that we do care to look after people and that we also have the metrics and the tools to evaluate when things are not going well, which is the data piece, that you should be able to compare yourself to another site and say, "Oh, hang on a minute. That's actually why I'm not - that's why I'm struggling". Because numbers-wise, it's a new metric that, I think, looks at ways to really embed that sense of wellbeing and safe working environments for people so that they can do the work that they need to do, which is around, you know, stewarding the profession and looking after themselves and also looking after the trainees under their charge.

MR FULLER: Does the college have a position on the adequacy of pay for its specialists in New South Wales?

PROFESSOR HAQ: I don't think that's within our remit, to - it's probably more of an industrial arrangement that we would not sort of get involved and I think - related to our constitution, I think, again.

A/PROFESSOR KANHUTU: Yes.

MR FULLER: Associate Professor Kanhutu, the other case study I wanted to ask you about was case study 5, where you mention some particular specialties that seem to be at risk because of low trainee numbers and then attrition of more senior specialists.

A/PROFESSOR KANHUTU: Yes.

MR FULLER: Other than what we have already discussed, is

there anything else that you think can be done to address that issue?

A/PROFESSOR KANHUTU: One of the challenges that some of those specialties have is really advocating for the value of their contributions, and I'll take occupational environmental medicine as one.

When you do have a specialty that is smaller in numbers, often it can be difficult for them to communicate how they work to contribute to better outcomes within the community, and the same goes for public health. Public health had a great, you know, renaissance in COVID, but then, once that flash point has moved on, it can be a real challenge for them as a small group to then say, "Look, we still need to be here and we have work that needs to be done and this is how we fit in."

So I think one of the other aspects that I'd like to see is that rather than seeing us as, you know, siloed specialties, is to start to really, I think, get the health service and the community outcomes perspective, start to see how we actually work together to deliver the outcomes because I, as an infectious diseases physician, can't do all of the things. It's actually about how it's connected and starting to get a sense of that multidisciplinary network of care and how even these smaller number specialties are part of that network, so that we can start to see the mutuality and the complementarity of the different specialties and the craft groups as opposed to just sort of tracking what looks like a dire trend for some of them, and it's because we, I think, haven't been able to articulate what is the value that they bring and how do they work across specialties and, you know, within their own specialty, to help our communities to be healthier.

MR FULLER: Do you think the college has an important role to play in relation to that issue?

A/PROFESSOR KANHUTU: Well, absolutely we do, and it's a common request from those specialties, is, you know, how do we help to communicate that? I think I would say from a cultural perspective, we're not - I don't think we're a skill group that like to get out there and say, "We're amazing and we're doing all of these things". So it's about also finding ways to do it that are - that feel authentic for those groups as opposed to sort of launching

some big branding campaign. It really needs to be embedded in. We know why these people have trained in these areas and these skills areas, and we can see how they fit in to supporting better community outcomes and communicating that in a way that feels true - true to them and true to the outcome that we desire. So yes, there is a role.

MR FULLER: Professor Haq, did you want to add anything to that?

PROFESSOR HAQ: I think also it's around being innovative with training pathways as well, that I think we're also going to be looking at, so that it's less siloed and could be done as part of other training, maybe. You know, nothing has been confirmed in any way, but could you sort of do other things together?

Also I think, you know, these groups are mainly non-hospital based, if I can, with a completely different set of requirements, cultures, contexts that we need to be aware of and appreciate, because they do contribute so much to overall health, community health and wellbeing. I think, you know, you can focus a lot on the public hospital, let's say, as an example, as the only way of delivering health care. There are many other ways, and that's something I think we could work very closely with other colleges but also state and federal governments on ensuring these key enablers of health and wellbeing are supported.

MR FULLER: Finally, Professor Haq, on page 22, from line 639, you have identified some other initiatives and recommendations that you think should be considered. I just wanted to ask you about some of those. Firstly, in the first dot point under "In general", you'll see "Adopt an ecosytems approach". Can you explain what you mean by that?

PROFESSOR HAQ: I think it's related back to the data issue, and that longitudinal data issue to allow us to make evidence-informed decisions around current requirements, future requirements, what's coming through the training pipeline to enable us to get the right people in the right place and in the right areas, and inform our trainees about where they may wish to work and in what context.

I think culture is really, really important. We know

from the medical training surveys that there is a - there are high rates of either having the sharp end or witnessing bullying, discrimination, harassment, and that is something I think we as a college really have a key place in, dealing with all aspects of the health system, to ensure that those issues are raised and dealt with and not hidden. Because none of us - you know, all of us want equity of health care but we also want good workplaces with good wellbeing of our staff to enable them to do their best work.

Collaboration, absolutely, yes, I think that's going to be really important. We're doing that really well as part of the accreditation work with the NHPO, and I think, you know, the confederation of colleges, the CPMC, are also, I think, seeing that there's strength in working together on key strategic issues.

I think again, if we do move into networking models and rural and regional remote areas, then adequate - and even in metropolitan - appropriate time for supervision must be given and supported and seen as valuable, and it's not an add-on, it's the key part of your, you know, medical sort of persona and contribution to the health system and should be managed accordingly.

MR FULLER: Can I, Professor, just pause you there and go back to something you mentioned about culture and what you said was the college's, I think, important role in relation to bullying and discrimination and harassment and so on.

PROFESSOR HAQ: Yes.

MR FULLER: Can you just explain what you view as the appropriate scope of the college's role in relation to those issues?

PROFESSOR HAQ: Yes. So I think we're not the employer. So, you know, I think there are sort of employer/employee related mechanisms that are clearly in place, but we want to be able to support our members and trainees in these times. I think through accreditation, I think there are ways we can sort of help lever to ensure that sites, you know, work towards the right culture and there may be outcome measures and metrics that we can use to help - to help that. Again, that's not a stick, but I think it's sort of a continuous improvement approach.

I think we can work through training, again, of all our members and fellows, you know, in unconscious bias issues, current issues in recognising and responding to bullying, discrimination and harassment, intimidation and by standard training and so on and so forth. So I think there's a massive training opportunity we have with our supervisors potentially as a first port of call. I think then, through accreditation, we can work to sort of lever to sort of get continuous improvement in culture and then policy and position statements as well, on, you know, zero tolerance approach, but --

MR FULLER: Sorry to interrupt you. Just in terms of the idea of levering through accreditation, is your college one that either has or would take effectively adverse accreditation action against a site because of what are identified as cultural or workplace issues?

PROFESSOR HAQ: I think we would - so we have an active management pathway and if we got notice through an expression of potential breach of standards of cultural, you know, bullying, harassment, we would investigate those and triangulate that evidence and there would be a decision made by the relevant committee on that. But it could be to impose conditions or requirements, and that site would then enter an active management process of ongoing monitoring.

MR FULLER: In terms of investigating, does the college have a particular policy or procedure as to how it would go about conducting such an investigation?

PROFESSOR HAQ: As part of our active management process, that highlights, you know, what we would do. That's not just for bullying and discrimination, it could be for any concern raised, there is an active management process. We would work closely with the jurisdictions and with the site on that.

MR FULLER: You understand that one of the recommendations from the NHPO report was around making sure there are transparent policies and processes for how colleges, in particular, deal with those sorts of issues of bullying, harassment and discrimination?

PROFESSOR HAQ: Yes.

MR FULLER: I take it from your earlier answer that you

agree with that approach?

PROFESSOR HAQ: Absolutely. We're here to work with those recommendations, not against them.

MR FULLER: Associate Professor Kanhutu, is there anything you wanted to add on that particular issue about bullying, discrimination and harassment?

A/PROFESSOR KANHUTU: Nothing further to add.

MR FULLER: Just finally, Professor Haq, at line 663, you have suggested a recommendation that starts with "Support the sustainability of work-based medical education." Can I just ask you to explain what specifically you have in mind by that?

PROFESSOR HAQ: Really this is, as we've alluded to earlier, giving supervisors the protected time to do their role. That's really what that alludes to. Because it is getting increasingly complex, with the increasing numbers of trainees but also the requirements for workplace assessment, which we see as being of high value and the best sort of - one of the best markers of trainee performance. That does require time and engagement to do properly, to make the right decisions, so that's why we would really much want to advocate for that.

MR FULLER: Thank you very much to you both.

Commissioner, those are my questions for these witnesses.

THE COMMISSIONER: Thank you.

Can I just ask both of you for your assistance just on one further matter. Early on in your evidence, Mr Fuller asked you about a model where accreditation was not performed by colleges.

PROFESSOR HAQ: Mmm.

THE COMMISSIONER: You both gave answers about the advantages of the colleges having that responsibility. I don't want to go back to the transcript, but I want you to assume for the purposes of my question that I accept the advantages that you both indicated to me concerning the

college's role in accreditation. Please don't think I'm wedded to this, I'm only asking you this for your opinion purely out of curiosity, but imagine a model where there was a statutory body which included some people appointed by the ministry that had great expertise and knowledge of the health system, demographics, those sorts of things, but where the colleges could also nominate relevant people - and these are obviously part-time appointments and they would be transitory depending upon the site that was being looked at. So nominations from the ministry, nominations from the colleges, and with that body having the power to accredit or withdraw accreditation. Would that be a model that might work?

And please, in answering that, feel free to tell me, "Look, it might work but we still prefer the colleges to have control of this." If you go first, Professor Haq, in relation to that.

PROFESSOR HAQ: Sure. Look, I suppose technically, Professor Kanhutu and I have discussed this, I suppose, you know, any sort of external model could work. I think that it would be more complex. It's adding a layer of complexity to the system. I think there's a lot - I think the cost of it could blow out significantly, because there's a lot of work that is not costed --

THE COMMISSIONER: It would be a public body, they wouldn't be paid that much, the people on it. Leaving that aside.

PROFESSOR HAQ: I think the resourcing side of it is not to be underestimated. I just think at the moment it is - it's seen as a peer review, it's seen as colleague to colleague, and I think if it's a hierarchical approach, I think that reduces the value of it and I think you may not get the quality of information that you require.

I think perhaps with the NHPO, that's maybe the best of both worlds, that there is an opportunity for an external review, and we hope - you know, most places don't get to that position but I think, you know, the bulk of the work - and the bulk of the places that are absolutely fine, you know, if we could put that - the problems with accreditation are not the majority in any way. We mustn't get the wrong idea. The vast majority of places are doing really fine. It's a small number that have concerns and

even smaller number that get to sort of the pointy end, single figures, really. So is that worth setting up a statutory body to do that? To me, I'm not sure the benefits outweigh the risks.

THE COMMISSIONER: Okay. Professor Kanhutu, do you have anything you wanted to add to that?

A/PROFESSOR KANHUTU: I would say again I think the biggest - one of the potential outcomes would be you'd end up with a statutory body that would still need to come back to the college to ask for questions and for clarification, and then you find yourself - you're still doing the work but then have actually lost the ability to have the close dialogue and the close working understanding of how people are navigating what can be very disparate work environments.

For example, an investigation of bullying - you know, bullying and harassment in one context - what would it take to build that sort of relationship, and sometimes having a third party or a higher-level body can actually move you so far away from the coalface that you actually lose that ability to detect what the problems are, but yes, to actually detect what is going really well and what are the key factors that are allowing a site to work very functionally. So there potentially is a space there for that.

You know, a collaborative space where everybody comes together, like the CPMC, could be a place where we come together and compare notes so that there is that level of calibration, and I think that is something that could help, a sense of calibration across the system. But to have the weight of all of that effort placed in a single location, I struggle to see how you'd get good representation and also be able to respond meaningfully and with deep understanding of the different contexts and the different specialty streams in the one location. It is not something that I would want to be on, for example, as a practitioner. I would find it really difficult to navigate a space like that with that sort of demand on it.

THE COMMISSIONER: Thank you. Was there anything, first of all, to you, Mr Fuller, that came out of that?

MR FULLER: Just one thing. Associate Professor Kanhutu,

can you just tell us what CPMC is?

A/PROFESSOR KANHUTU: The Council of Presidents of Medical Colleges.

THE COMMISSIONER: Thank you.

Mr Cheney, do you have any questions?

MR CHENEY: No questions, Commissioner.

THE COMMISSIONER: To both of you, thank you very much first of all for the written statement but secondly for your time today. We're very grateful. You are excused. Thank you.

PROFESSOR HAQ: Thank you very much.

A/PROFESSOR KANHUTU: Thank you. Bye.

<THE WITNESSES WITHDREW

THE COMMISSIONER: We might as well take morning tea. Okay, we will come back at 10 to 12, 11.50.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes, Mr Glover.

MR GLOVER: Thank you, Commissioner. The next witness is Jacqueline Dominish, who is in the witness box.

<JACQUELINE ANNE DOMINISH, affirmed: [11.58am]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Ms Dominish, can you state your full name for us, please?
A. Jacqueline Anne Dominish.

Q. And you are the director of health professional workforce within the ministry?
A. Yes.

Q. Does that sit in the workforce planning and talent development branch?
A. Yes, it does.

Q. Is that branch headed by Mr Griffiths?
A. Yes.

Q. And to assist the Commission in its work, you made a statement on 5 July; correct?
A. Correct.

Q. I'll just have it brought up on the screen. It is [MOH.0010.0243.0001].

It will come up on the screen to your right but if you have a hard copy, feel free to use what's most convenient to you. Have you had a chance to read it before giving evidence today?
A. Yes, I have.

Q. Is it true and correct, to the best of your knowledge and belief.
A. Yes.

Q. Would you go to paragraph 2, please. In paragraph 2 you tell us about some of the responsibilities of your role?
A. Yes.

Q. I just want to go through a few aspects of it and ask you to expand on some things.
A. Mmm-hmm.

Q. In 2(a) you tell us that in your role you are responsible for leading and advising on the scope of the health professional workforces, workforce modelling and monitoring. First of all, by way of clarification, what do you put within the term "health professional workforces"?
A. So the health professional workforces that my unit is responsible for are the clinicians and the primary groups of medical, nursing and midwifery, allied health. We're increasingly doing work with paramedicine with Ambulance New South Wales; Aboriginal workforce, in particular clinicians in that workforce; and I'm also responsible for the workforce modelling team as well.

Q. In relation to the workforce modelling team, what is their remit?
A. So their remit is to undertake workforce modelling for the health professional workforces, so the clinical

workforces, and their focus has been allied health, medicine, nursing and midwifery.

Q. When you say "focus", by that do you mean a recent focus of their work?
A. That's the scope of their work. That has been historically the scope of their work.

Q. What sort of modelling do they do?
A. So they do long-term modelling to look at the projected behaviour of workforces into the future and how that might relate to our ability as New South Wales health system to deliver the care that we need to.

Q. When you say "projected behaviour of workforces into the future", what do you mean by that?
A. I'm going to answer this just by saying, firstly, I'm not a data scientist or a mathematician, so in general terms I'll be talking to the best of my ability in that regard.

Q. Yes.
A. So the behaviour of workforces - workforce modelling looks at a - so we look at, they look at, the current workforce, which they call the stock, and then apply flows to that stock. And it's based on supply and demand. So the supply side is what's actually flowing into our current assets or workforce, and that will include thing like graduate numbers, people re-entering the workforce, people immigrating from overseas, flowing in, and then flows out will be people retiring, dying, leaving the sector, moving overseas, those kinds of things.

They will also apply other datasets such as national health workforce datasets or data from the Commonwealth Department of Education to inform the information going in. And then the demand side is far more complex in that that requires much more engagement with stakeholders and the system to understand the nuances of what happens in our business in NSW Health, and therefore, what is likely to put pressure on that workforce and its ability to meet the demands in the system.

Q. What is done with this modelling, once it's undertaken?
A. So the modelling is finally published online, so it is available publicly. It is used to provide guidance to

local health districts and specialty networks so that they have a more evidence-based tool to signal what's going on with certain workforces that they're responsible for, and then they can use that as one of the sources of evidence to inform their local workforce planning and service planning.

Q. Is this an ongoing process?
A. Yes.

Q. Is the modelling constantly being updated?
A. Yes.

Q. When you say it is "published online", is the current up-to-date modelling for each of these practice areas online now, for example?
A. So the current - the up-to-date modelling that is online is for the allied health professions. That was recently done. The medical professions now need to be redone. I believe the last time they were done was 2018/2019, and we've just commenced nursing and midwifery.

Q. Part also of that role is monitoring the workforce?
A. Mmm-hmm.

Q. Correct?
A. Yes.

Q. To the extent that it differs from the answers you've just given, in what way?
A. So the role of my unit is to have a very real-time connection with stakeholders in local health districts and external to NSW Health that have interest in our health professional workforces. So we get a lot of intelligence on a day-to-day, week-to-week basis from people like tier 2 executive directors that are responsible for medicine, nursing, allied health, Aboriginal workforce.

We also have close relationships with universities and the deans of the universities. We have a relationship with the Australian Health Practitioner Regulation Agency. We also have relationships with professional associations and from time to time, depending on what's happening, industrial associations as well. So we have a steady stream of intel that comes in to us through our normal business, that then assists us to identify whether things are changing or if there are issues we need to be cognisant of.

Q. And is that intel, as you put it, utilised in the modelling process that you described earlier?
A. Yes.

Q. In what way?
A. So when the modelling projects are initiated, when we're actually reviewing the modelling, what will happen is the team, at a high level, will look at the quantitative data sources that they have, and as I described before, what's going into the supply side in particular, and then there will be a process by which stakeholders will be spoken to and engaged with to gather qualitative information from a variety of places, such as - like, definitely within NSW Health and what's going on on the ground in our business; but also what we know that might be happening in the university sector - for example, whether a course is about to close or has closed, that's obviously going to affect the supply calculations or projections.

Then the team will treat the data in a way that is informed by the qualitative information that is provided by the stakeholders with the expertise, that have real-world understanding of what's going on with that particular clinical workforce.

Q. So that's on the supply side?
A. No, that's on the demand side.

Q. The demand side?

THE COMMISSIONER: Q. Can you just define for me what is the supply side and what is the demand side?
A. So at a very high level, the supply is where are we getting the work - where is the workforce coming from and what is influencing where they're coming from? That's at a very basic level, yes.

Q. And the demand?
A. And demand is what is creating the demand for that workforce? So what's changing in the community or the way we provide services or change in the population? So as a very general example --

Q. It's the demand for healthcare services that you're talking about?
A. Demand for healthcare services, yes, which will be

influenced by a variety of things.

Q. Like ageing, for example?
A. Like ageing, chronic disease, population growth, immigration, socioeconomic determinants, and that will differ from district to district. So whilst there will be trends that will be looked at at a state level, things will differ from district to district because populations are different, demands are different. For example, from a metropolitan to a rural.

Q. And how far in advance does the modelling look? Are the models producing predictions for, "This is likely to be the workforce required in two years' time"; "This is what it's likely to be in 10 years' time"? How does it work?
A. So currently the modelling is being done to 2040, so about 15 years ahead.

MR GLOVER: Q. What sort of data goes into the modelling for projections out to 2040?
A. That's a question I can't confidently answer for you. So either - we could gather that information, or Richard Griffiths is appearing later in the hearing and he may be better placed to give that.

THE COMMISSIONER: Q. The uncertainty in the inputs in the model not so much the supply side, because you currently know who is doing what courses and what the numbers are; the greater analysis perhaps and the more difficult inputs is what is going to be the demand?
A. Yes, that is the most complex part of it. So the supply side, for an example, if we were looking at nursing and midwifery, things like fertility and birth rates would be important in considering that workforce, where that might not be so important with other workforces, and so it's a bit more - it's a bit easier to identify what's coming in to that side of the model.

The demand side is definitely the most complex, and as an example, we might model for 15 years to 2040, but there might be events that occur that we can't predict, such as a global pandemic, such as the introduction of the NDIS, and really understanding the full impact of that policy over time, and so when --

Q. Also, I suppose, if there are different new models of care?

A. Correct.

Q. They might compress periods of morbidity?
A. Yes.

Q. And if, worst case scenario, we might have longer periods of morbidity --
A. Yes.

Q. -- and that creates an uncertainty, I suppose, in terms of your modelling out to 2040 or beyond?
A. Correct.

MR GLOVER: Q. Can I take you to paragraph 2(b), please? There you tell us part of your role is responding to education, training and accreditation impacts on workforce availability. You gave one example in an earlier answer if a university ceases a particular course, it might have an impact on workforce availability. What are the others?
A. So at a high level - and I know this has been covered in other submissions - one of the portfolios I'm responsible for is medical, and I have the chief medical workforce adviser who reports to me, and with the accreditation of hospitals or sites, or districts as they relate to, for example, medical training, if there's a situation where accreditation is lost or at risk of being lost from a particular facility or district, then that's important for us to know about.

And also, Justine Harris, Dr Justine Harris, who is the adviser, will often be involved in liaising with organisations like HETI, the district, and potentially the college, depending on what's going on, to either try and address or resolve that, but also consider what the impact of that loss of accreditation might be on the workforce.

Q. So this is doctors undertaking specialist medical training that you're speaking of?
A. Correct.

Q. And I take it from that answer that a member of your team might liaise with the interested parties to try and resolve the issue that is leading to the accreditation concern - have I understood you correctly?
A. That can be possible, yes.

Q. As well as looking at what a loss of accreditation

might mean for the training pathway for those particular clinicians?
A. Correct.

Q. Are there any other education or training or accreditation impacts on the workforce that your team might be responsible for responding to?
A. Yes, I can give an example that happened some time ago but it's a relevant one currently. So with clinical psychology, the board changed the requirements for who was able to supervise registrars and interns, and so what occurred was the psychology board determined that anyone supervising a registrar or an intern had to undertake an accredited supervisor training program, which is something very unique and different to psychology and doesn't apply to any other profession.

That then had a significant impact on local health districts at the time in the viability of them to continue to train registrars and also to take interns on board, because it meant that supervisors had to undergo that training, which was expensive and time intensive, and there was no sort of funding source centrally to support that.

So the unit, for example, would look at that, liaise perhaps with HETI and local health districts to negotiate ways of ensuring that we could support the supervisors to remain or become accredited, so they can continue to train the future workforce for psychology and clinical psychology.

Q. Can I take you to paragraph 2(c), the last of the three categories that you identify is the identification of opportunities to influence innovation in education and training and models of care. In what way does your team do that?
A. So that's probably the reason for the establishment of the unit and noting that I've been in this role for about 11 months now, is - I'm just thinking of a succinct way to answer this. So on commencement in the role, the health system in response to the future health strategy and the health professionals workforce plan identified, via chief executives, top priorities that needed to be looked at where there were innovative models of care that had been developed and evaluated or the opportunity for pilots to be developed and scaled. There were seven areas that were identified as a priority, and my unit leads some of those

or is involved in most of those areas and those projects.

Q. In what way?
A. So my team has the central expertise around the health professional workforces at the state level. We engage with other stakeholders, including the Agency for Clinical Innovation, Health Education and Training Institute, Clinical Excellence Commission and other internal branches within the ministry like the nursing and midwifery office, and we have a very close, ongoing relationship with local health districts which I described before in our stakeholder engagement.

So the unit and my role is like a bit like a broker but also knits or stitches together and creates traction between those various groups that have particular focus, but really, the workforce model and what the workforce is doing is a critical element of operationalising any changes to models of care or service delivery, and particularly when you're looking at it from a state scaling perspective.

So we don't just look at numbers and what's where; it's who are the people and what are they doing and what do we need them to do and therefore, are there different ways we can do that or are there areas of red tape or barriers we have to unlock that will then allow districts to just get on with it and implement the changes they need to?

Q. And under that umbrella, is one of the pieces of work that your team has been involved in looking at what is described as "scopes of practice"?
A. Yes.

Q. If we go ahead to paragraph 43 of your statement, please. By way of introduction to this topic, you tell us that there is no universal definition for scope of practice, with professions applying it differently. Appreciating that there might be many variations, what are the general differences between the way it is utilised?
A. So just going back to the term "scope of practice", that term and the way it's applied, as you have just said, is bandied around differently in different conversations, and often people think they're all talking about the same thing and they're not.

So, for example, one profession might talk about advanced scope; another profession might talk about top of

scope; another profession may talk about extended scope. Often they think they're all talking about the same thing or they're all talking about different things and sometimes it's hard to tell.

For this Inquiry, we did prepare some briefings to try and simplify the use of those terms, and that's one of the things that our unit is doing in our engagement with stakeholders, so we can have meaningful conversations. Because it's like speaking five different languages, and I feel like I've moved to Switzerland in this job at times, to try and have a conversation with people that come from very different frames of reference, and even at the national level in my engagement with AHPRA, it's something that's acknowledged that different boards and professions will categorise things differently and apply it to how their professions have evolved over time, yes.

Q. So that we make sure we are understanding each other, when you use "top of scope", what do you mean?
A. So if we look at scope, which broadly would be things like the training someone's done, the registration they need to have, the legislation or licences they need to operate with or within, and then the context of where they work - so those are the kind of, just roughly, things that would make up a scope of practice.

When we talk about "within scope", it means that that professional person might have a broader range of things that they could do, but in the context of this role or our discussion, we're talking about things that are within scope. If we're talking about "full scope", which is also a term that's used a lot, that means the person can or is operating across the entire spectrum of what they're able to do in that context, and that might be, for example, someone working in a rural area or in a generalist role where they need to do all the bottom and top end of that job because they don't have other people to do it or that's just the way it's designed.

"Top of scope" is where everyone wants to be, which is as a health professional, I have been trained to do lots of things, but I really like to do what I'm really good at, what I'm really expert at and what the patients really need, and that's where you move up into the top of scope, but this bit in the bottom may be where an assistant or a piece of technology or a decision-making framework or

something else has been put into place to take that, let's call it, lower-value work or work that doesn't require that higher level expertise; or it could be that, in that context, you have multiple professions working together, there's an overlap in what is at that bottom, but by recognising that and not duplicating that work, you're allowing people to push their effort to the top of scope in that model.

Then, finally, if we're looking at what's "out of scope" or what we're trying to look at, whether it's advancing or extending, but I'll use the term "out of scope", that's where there's the opportunities to go: is there some low-hanging fruit there because of some kind of regulatory licensing, training, whatever issue it might be, it's not currently in scope, but if we do something, we can put it in there; like, it's not unachievable.

Q. And if a plan referred to "examining opportunities to extend scope", would that be in that third category that you have just described?
A. Yes, so I've probably - again, I've fallen into that trap, used that word. "Extended scope" is probably a word a probably need to stay away from. But really, it's about at a foundational basis, top of scope, out of scope, and then different professions will use those terms as it applies to their individual practice. So as an OT, you know, my normal scope is this, but as a profession, the profession might be looking at how they could advance or extend the scope of the profession. Does that make sense?

Q. Yes. In an earlier answer you said that everybody wants to be at top of scope?
A. Mmm-hmm.

Q. Why?
A. Anecdotally from engagement?

Q. Your understanding and experience?
A. From my understanding? That provides a higher level of satisfaction for clinicians. They enjoy being well utilised. They're highly trained people. Generally they come into health care because they want to help people, they want to do the best that they can and it allows them to operate in a more autonomous way, where they feel like they're using all their muscles and their capability on a daily basis, and therefore feel more valued.

Q. Accepting that those principles are important from a system perspective, are there other system advantages to having clinicians operate at the top of scope?
A. Yes. So I think it's minimising duplication and maximising your bang for buck. So if you're paying for someone who has a higher level of capability than you're using then you are not getting value for money in what you're asking that person to do.

Q. In paragraph 44 of your statement you tell us that there are a number of barriers, however, which impact on the ability of clinicians to operate at their top of scope, and you give some examples. If we just start with the example in paragraph 44(a), "Workplace culture and attitudes of individual clinicians and managers which can prevent collaborative and transdisciplinary working", how might the culture and those attitudes manifest to create a barrier to clinicians operating at top of scope?
A. In many ways. So it could be as simple as people working in a service or a team where there is an individual or a group of individuals that is very comfortable with the way things are working, they don't want to change the way things are working and, therefore, might behave in a manner that is recalcitrant or not collaborative in the efforts of other clinicians and/or leaders, managers, executives, to improve or change a service for the benefit of patients.

You can talk about things like, you know, let's assume that the evidence says it's a good idea that scopes of practice say it's fine that there's no legal impairment, that we can unlock all the red tape, so let's say we can fix all those things. If there's someone who's senior enough, powerful enough and with a loud enough voice that says, "This is unsafe", and they say it repeatedly enough, then people will believe that. And that's one of the things clinicians will often first say when they are uncomfortable, "This is unsafe. This is unsafe." And that happens a lot, or, "No, I don't think that person can do that, I don't think that's in their scope of practice". So where you've got other professions commenting on what another profession is trained to do or capable of doing. And that may be because that's that person's genuine belief or that they're not informed or that they're scared because they don't know what they don't know or there's a genuine safety concern that we're not aware of that hasn't been properly articulated or explained.

Q. How prevalent is culture and attitudes of the kind that you've just described across the system, to your observation?
A. So I would say there are pockets of outstanding excellence, and where you get particularly a senior medical clinician that is really on board, focused on the community and really empowering and valuing the multidisciplinary team they work with - and that is allied health, that is nursing/midwifery - it can be amazing accelerator. It's like magic, it just unlocks all of the barriers and they just focus on the outcome and get it done, and there are pockets of that all over the place.

However, I would say that it is definitely a massive challenge and is quite prevalent across the state, and that makes it difficult for particularly our next generation of clinicians that are coming through, that are coming out of university and are very excited and they're innovative and they've got ideas and they're obviously tech savvy and they want to do amazing things, and that can be a real challenge to come up against when they suddenly enter a system like NSW Health. So - yes, I'll stop there.

Q. I will just pass over 44(b) for the moment and come back to it, but touching on part of the answer you just gave, in 44(c), you raise as one of the potential barriers concerns about patient safety, real or perceived, et cetera.
A. Mmm.

Q. You gave some examples in that last answer. Is there anything further that you would add to that by way of example for these types of concerns operating as a barrier to clinicians operating at top of scope of practice?
A. Yes. I'm just trying to think of which one. Can I just read the paragraph again?

Q. Of course you can. Take your time.
A. Could you just ask me the question again, sorry?

Q. Yes. So in the answer you just gave, you mentioned as part of the description of cultural and attitudinal barriers clinicians raising a concern about patient safety, once a clinician of a particular seniority might raise an issue of patient safety, that spreads through the system and operates as a barrier?

A. Mmm-hmm.

Q. What I was just inviting you to do, in relation to what's in subparagraph (c), are there any other examples of concerns about patient safety, real or perceived, as you've described it, operating as a barrier to or hindering clinicians operating at the top of scope of practice?
A. So again I'll talk about - so real or perceived, so from a cultural perspective - I will just give two different examples, if that's okay.

Q. Of course.
A. So from a perceived perspective, I can talk about a conversation I was perhaps having the other day around governance. So if we're going to put in a new model and we decide that we want to put in a different type of health professional than we've put in before, we need to make sure there's a good governance of that person to make sure that they have good clinical support, they know who their operational manager is and they know who their professional line is.

So with health professions, best practice requires that you have an operational manager so you know who you report to; you might have a clinical line, which is who's responsible for the overarching care of the patients in that setting; and then a professional line, which is someone from your own discipline. The way those three lines behave is different across professional groups.

So, for example, in nursing/midwifery, they're normally all the same person. In medical, there might be a combination of that. In allied health, we're very used to - and I say "we", because my background is occupational therapy - used to working in a matrix structure. So if we're putting someone into a model of care that is an autonomous clinician that can work really well without being, you know, high degrees of supervision, and another professional group might find that very concerning because the three lines of governance are not aligned to the one person, or they find it difficult to understand that, therefore, they will raise concerns about, "Well, what happens if there's an incident or a root cause analysis or if there's a concern with that person's performance?" So that's an example of perceived.

There are real - we do need to always be concerned

about are there real risks, and so, therefore, the role of my unit, in looking at models we might be trialling at a state level, is involving organisations like the Clinical Excellence Commission, the chief health officers unit, as well as the local clinical governance groups in the district, to make sure that there are not real issues that bee haven't considered in the design of the models, which therefore we can confidently respond to any concerns people might raise, whether they are real or perceived, about safety.

Q. If I just take you ahead on this topic to paragraph 78 of your statement, please, and just invite you briefly to refresh your memory about what you've said in paragraphs 78 through to 81 and just let me know when you've had an opportunity to do that.
A. Mmm. Yes.

Q. Do we understand that in these paragraphs you set out some of the measures that need to be implemented to overcome some of those cultural and attitudinal beliefs?
A. Mmm-hmm. Yes.

Q. And do you perceive any challenges in implementing those responses themselves?
A. Sorry, for all of them? I'm just --

Q. The answer might be different. I'm just trying to do it in a general way, but, for example, you say in paragraph 78 that there's a need to introduce a narrative across New South Wales health system --
A. Mmm.

Q. -- about what is understood, working to the top, et cetera. And then in 79 you go on to tell us about attitudes, professional guarding behaviour between the professions is a major barrier. As part of introducing the narrative and the dialogue to overcome those challenges, will that itself present a challenge to you and your team in rolling that out?
A. Yes.

Q. In what way?
A. Because it's uncomfortable for people and we're at a time where matters around workforce are very highly emotive issues, for good reason, and we're also, in New South Wales, going through a period where there's a lot

of industrial reform and it's for, you know, various reasons, and the roles of unions around ensuring that the are doing what they need to do for their members.

So there's a lot of activity occurring in each of the individual professional groups around matters that are very important to them - whether it's industrial issues or whether it's professional issues or whether it's workforce supply and demand issues - and people have very strong attachment to their identity as a clinician in their professions, for good reason. They've worked hard to develop that. There's, you know, a history around medicine, nursing, midwifery, paramedicine, how that has evolved in Australia.

So in that context where people are really trying to advocate for their individual professional issues, trying to then have a conversation to lift people up and say, "Hang on a minute. What are we doing here? The focus is the patient and the community and that is what we need to, firstly, think about and talk about", when we're analysing what is the service they need, who's got the skills required to deliver that service, and then how do we design a model where there may be overlap in skills and capability, where there may be a need for certain professions to operate at top of scope, and it's about meeting the need of the community not trying to take away people's identity or erode their practice or minimise their role, and that's a genuine fear of people.

So there may be perverse incentives, in some way, from some people. But people do genuinely have that concern about, again, real or perceived: does that mean I won't have a role? Does that mean I won't have a job? Does that mean I'll be less valued than a new person coming in? So they're real concerns. But it is challenging and it continues to be challenging and I recognise that that's a key component of my role in the unit and with our stakeholders, is to have those - start having those conversations, as uncomfortable as they are, yes.

Q. Has work commenced to start having those difficult conversations?
A. Yes.

Q. And how has it gone so far?
A. Interesting. It's robust. I mean, it depends on what

context, but I think, reflecting on just the last 11 months where we've started to have conversations in a variety of forums for different reasons, generally, when you give people the time to ask questions and be curious and you listen to them - and I think that's the key, we've got to listen to people and what their concerns are; however, then have a robust conversation in an evidence-based manner about genuine concerns versus just poor attitude, and then to be able to distil, well, what is it that we need to genuinely address and what is it that's another issue? So - yes. It's robust and it's challenging but people are engaging in the dialogue.

Q. Can I take you back to 44, and this time to subparagraph (b), please, where you tell us that policy and legislative requirements such as regulation of drugs have not kept pace with the changing landscape, et cetera. We heard some evidence earlier in the week about legislation review undertaken in the context of nurse practitioners?
A. Mmm-hmm.

Q. Is there any other work being undertaken in relation to the barrier that you identify in paragraph 44(b)?
A. Yes, I can give a couple of examples.

Q. Please do.
A. So one is, in my portfolio I'm responsible for the Aboriginal health workforce, and that includes Aboriginal health practitioners and growing the number of places that they can work in multidisciplinary teams across the state. So one of the pieces of work is where Aboriginal health practitioners are trained and able to do things like administer intramuscular injections, but because of the way they're employed within NSW Health, they may not necessarily be doing that all the time - sorry, let me just take a step back. This is about Aboriginal health practitioners and enabling them to vaccinate the Aboriginal community.

So with the current legislative framework, that was not possible, so we've worked with the immunisation unit and Western New South Wales, who had raised that they wanted a group of their Aboriginal health practitioners to start vaccinating the community this year with Fluvax - under 5s have a good vaccination rate, over 65s do, but between 5 and 65 the Aboriginal population has a very poor vaccination rate compared to the rest of the population.

So in partnership with the chief health officer and the immunisation unit, they put in place an authorising instrument to enable Aboriginal health practitioners to vaccinate with the flu vaccine and also have a state standing order to administer adrenaline, so that in the case of an anaphylactic reaction they could administer that, and that would mean that they could do that independently without having to get a direction repeatedly from a medical officer. Again, if you don't need to have that person in the team, if there's an instrument that allows you to just get on with it with the appropriate governance in place, that makes it --

Q. So just from that answer, do I understand that there have been some reviews undertaken of a range of legislative barriers to particular clinicians performing particular services, with a view to removing them?
A. Correct.

Q. Can I take you ahead to paragraph 44(d), please. There you tell us that in some cases, employment conditions arising from industrial instruments may be a barrier?
A. Yes.

Q. What work is being done to overcome those barriers?
A. So NSW Health, as well as the industrial associations, are commencing a process of award reform and members of my team are involved in each of the various working parties around medical awards, allied health awards and Aboriginal health practitioner awards, and other awards that may affect our health professional workforces. So that work is occurring. Yes.

Q. So what type of barriers are created by the industrial instruments to permitting clinicians to operate at the top of their scope?
A. Two brief examples. So one that I've mentioned there is the work we're doing with paramedics. Currently, there's no industrial instrument that allows local health districts to employ a paramedic. So even if they wanted to create a role, they can't employ them.

The second example is the health professionals award, which currently encompasses 18 allied health professions, treats things like on-call allowances differently between professions, and then the other five professions are

employed under different awards again, so if you're trying to look at designing a model of care where you're wanting professions to behave in a similar way, it can make it difficult, as a manager, to do that and it may then influence your choices about whether or not you would include certain professions in your service model.

Q. And that's why you tell us in your statement that those instruments are operating as a barrier to the implementation of the innovative model?
A. Correct.

Q. In paragraph 45 you refer to the scope of practice review.
A. Mmm-hmm.

Q. Then in paragraph 46 you tell us that your unit is coordinating the statewide response, and that, in doing so, it has been a significant opportunity for NSW Health to contribute to the process of identifying and addressing barriers experienced by primary health care professionals.
A. Mmm-hmm.

Q. What barriers have you identified to primary health care professionals in operating to their optimum scope of practice?
A. So as far as the review is at, and noting that the outcomes have not been finalised, the barriers that have been identified are very similar - so are things like access to training and education; the existing regulatory policy and legislative requirements. So they operate under, obviously, federal policy, largely, but also state-based policy will be influencing what they can and can't do. The way that work is arranged and funding is applied to particularly professions that are not general practitioners, in being able to deliver care to the community, and that's obviously out of our scope; and technology and the availability and use of technology in being able to deliver care, and particularly whether or not that attracts funding.

So noting that some of those things are out of our scope, however, the principles are also applicable to the work that we do in NSW Health.

Q. In that answer you referred to professions other than general practitioners. Who did you have in mind?

A. Physiotherapists, occupational therapists, speech pathologists, even nursing, midwifery. So people who would be considered as members of the multidisciplinary team that are required to deliver care to populations that have chronic and complex issues, so where the general practitioner might have a short - you know, may coordinate care or identify issues that need to be addressed, the ability of that patient to then be able to go and access things like podiatry, speech pathology, dietetics can be limited by the things that I have just outlined.

Q. In paragraph 47 - and you touched on this in an earlier answer - you tell us that the general findings from that review are expected to be transferrable to the New South Wales public health system and will likely assist in informing ongoing statewide reforms. Why do you hold that view?
A. So looking at the early themes that have come out of that review and through our work in coordinating the responses for New South Wales health system, the items that I just listed around training and education being a barrier or an enabler; policy and regulatory legislative reform, technology; the way that employers use health professions, their practices and work settings, while that might be the themes coming out related to the primary healthcare work force, they're just as relevant to the work that we're doing in NSW Health, and we have the ability to look at those things as part of our response to workforce challenges here.

Q. Could I take you ahead to paragraph 50 of your statement, please. There you --

THE COMMISSIONER: Q. Can I ask just on the scope of practice review you've just mentioned, the second issues paper came out in April this year, which had some options for reform, amongst other matters. Has NSW Health made a submission in relation to that issues paper? I think there was a call for submissions in relation to it.
A. Yes. So we have responded to the latest call for submissions.

Q. You have, right?
A. Which was some early - I think as you said, I think, early request. Yes.

THE COMMISSIONER: I'll need to follow that up later.

Yes.

MR GLOVER: Q. Can I take you ahead to paragraph 50. There you refer to the future health strategy and the NSW Health workforce plan.
A. Mmm-hmm.

Q. In paragraph 51 you identify four key opportunities, and they're the opportunities that are drawn from the NSW Health workforce plan; correct?
A. Correct.

Q. I just want to ask you about a few elements of the plan, and I'm going to do it by reference to the supplementary guide. Are you familiar with that document?
A. I am familiar with it, yes.

MR GLOVER: I will have it brought up on the screen [MOH.0010.0275.0001]. Commissioner, it's H2.36.

Q. We'll go ahead in that document to internal page 19, please. This refers to priority 3 of the plan, empowering staff to work to their full potential around the future health care needs. Do you see that?
A. Yes.

Q. Under 3.1 there are two columns, "Future state" and "Practical applications". I'll just invite you to read what is attributable to the ministry under "Practical applications", and let me know when you have done that.
A. Yes.

Q. So in this context, the supplementary guide uses the phrase "expanded scope of practice". What work, if any, does your team do in furthering this initiative?
A. So 3.1 applies to the work that we're doing related to those seven key priority areas that I mentioned earlier in the submission, around looking at new roles or expansion of existing roles, and whilst it states "expanded scope of practice" there, as I mentioned earlier, the simplification of the terms that we just talked through, such as "within scope", "full scope", "top of scope", or "currently out of scope" potentially could be in - is the language we're currently using on a day-to-day basis.

But the way my team does that, so those seven priority areas include looking at paramedics and the other settings

that they potentially work in outside of ambulance New South Wales. I've talked about Aboriginal health practitioners; looking at allied health and nursing and their role in what's called criteria led discharge, and some of this is in partnership with the Agency for Clinical Innovation; the expansion of well-piloted and evaluated multidisciplinary teams, such as the rapid access intervention and discharge service in the emergency department, which is a multidisciplinary allied health model, and some other models; and then there's the partnered pharmacist medication charting, which the chief allied health officer is leading our --

Q. Just pausing there, are these initiatives those which are set out - I won't take you to it on the screen, but if you've got your hard copy there - from paragraphs 53 and following in your statement?
A. Most of them are set out there, yes, in detail.

Q. In general, in advancing the work for priority 3, are they the pieces of work that your team undertakes to drive priority 3 of the workforce plan?
A. Correct. They're the current priority focus.

Q. Thank you. If I go to internal page 21, please, this relates to priority 4. I want to ask you about, firstly, 4.2 --
A. Mmm-hmm.

Q. -- in particular, the practical application attributable to the ministry, which is "Exploring new and emerging capabilities to support a future-ready workforce and to work with health education providers to support capabilities", and so on. Is that part of the role of your team to advance that initiative?
A. So 4.2?

Q. Yes.
A. Yes, it will be, in partnership with other teams within the branch and in the ministry.

Q. When you say, "will be", is it a piece of work that has commenced as of now?
A. There has been some work that was commenced in that space, particularly looking at capabilities around the virtual care manager role, which is not a specific clinical role but looking at what, if districts are wanting to

establish or modify how they're leading virtual care or in putting that infrastructure in place, there is some work around a standardised position description and a capability document that is in the stage of being finalised, and that will be distributed across the state for local health districts to be able to use.

Q. Can we come to 4.3, "Graduates entering the workforce are appropriately prepared for contemporary health care delivery", and then the supplementary guide tells us that the ministry, and in particular your branch, will play a lead role in implementing programs to support the development of the workforce pipeline. How does your branch do that?
A. So I can partially answer this, but this question would be worth putting to Richard Griffiths when he provides his evidence, because there's other parts of our branch that do this work around pipelines and student pipelines. But as to how my team works, we have an ongoing relationship with the universities and the deans of each of the core groups for medicine, allied health, and in partnership with the nursing and midwifery office, for nursing and midwifery, where we meet with those groups on at least a biannual basis and we have dialogue as required, to have conversations about what are the current challenges we're seeing, what is the work they're doing to improve their work readiness of their graduates, and how we can work together to ensure that what is coming through is fit for purpose with the challenges we've got on the horizon?

Q. And is that work also related to 4.4 on that same page?
A. Yes.

Q. As part of that work in assessing curriculum and training pathways to current and future workforce needs and competencies, is the modelling that you spoke of earlier in your evidence utilised to progress that initiative?
A. Yes. So we do socialise the outcomes of the modelling in those meetings with the deans and have conversations about - hang on, let me just look at that again. Apologies. Yes. So an example of where we're doing that at the moment for radiation therapy, where the modelling showed we do have a critical problem with the supply of radiation therapists, not just in New South Wales but nationally, part of that has been due to the closure of courses, so we have university representatives on

a time-limited radiation therapy action group to discuss how we're going to address these challenges moving forward and what they're thinking about in how they might be modifying even their existing courses and the impact that that's likely to have on our supply.

Q. Are similar conversations had with the specialist medical colleges?
A. I can't probably answer that question confidently. I think it might be best to ask Richard Griffiths in his --

Q. In that answer you gave earlier, you referred to socialising the workforce modelling data with the universities?
A. Mmm-hmm.

Q. Tell me if you don't know the answer to this question, but is the same process undertaken with the specialist medical colleges?
A. I believe so, because it's - the data is published, so it's available. So it forms part of the conversations, it's one piece of evidence or information that informs what is likely to be needed around training positions or - so I would say yes to that question.

Q. The data that is published in relation to the medical workforce relates to the 2018/19 period, did I understand you earlier?
A. Yes, yes.

Q. So is data post that period being, to use your phrase, "socialised" with the specialist medical colleges?
A. Once it's updated, yes, it will be.

Q. Once it's updated and published on the website, it will be; is that what you mean?
A. Correct, yes.

Q. Jumping ahead, finally, to priority 5 on page 23, please, and 5.1 --
A. Twenty-three?

Q. Sorry, on the screen, not your statement. That was my fault entirely. The supplementary guide, internal page 23, 5.1, the guide tells us that the ministry will "play a lead role in progressing the availability, quality and usability of the workforce data"; do you see that?

A. Yes.

Q. Is there a need to improve the availability, quality and usability of the workforce data, in your view?
A. I think that's been - in my view, personally?

Q. Mmm.
A. I think that when we have access to information and accurate information, it informs what we do as a result of that information, and I think it's been recognised within the health professional workforce plan as one of those four key unlockers around workforce data transparency, access and utilisation. So yes, I think that's an important enabler to the work that we're doing to improve workforce development across the state.

Q. Are you aware of concerns expressed by, for example, the specialist medical colleges about a lack of access to up-to-date workforce data?
A. I'm not specifically. Yes.

Q. Are you aware of concerns expressed within different arms of NSW Health about lack of availability of up-to-date workforce data?
A. So from the previous submissions or the hearings that I've watched, I have seen some reference to that, yes.

Q. And would you accept that there's a need to improve the availability, quality and usability of workforce data in general terms?
A. Yes, in general terms.

Q. That then feeds in to point 5.2, in which your branch will develop an organised and strategic approach to monitoring workforce trends and data-driven decision-making. Do you see that?
A. Sorry, I keep getting confused between - there's a 5.2 on the left and a 5.2 on the right. But there are two different - for each one there are two different --

Q. I'm using the columns, not the yellow. I'm Sorry, I should have made that clear to you.
A. Thank you. Yes.

Q. What work is being done by your branch to achieve that aim?
A. Aside from the information I've already provided

you about modelling, I can't answer that question. Richard Griffiths, though, would be able to answer that for.
You.

Q. And if we just go over the page to internal page 24, this is in relation to priority 6, and do you see the right-hand column, there are four bullet points. I just want to ask you about the second one:

> *Updating award structures to reflect modern operational situations ...*

You referred to this in your earlier evidence. I'm just going to invite you to review that dot point and let me know if there's anything else you would wish to add in relation to the work being done to further that aim?
A. No, I think I've covered that.

MR GLOVER: Thank you.

Thank you, Commissioner. Those are all the questions I have.

THE COMMISSIONER: Do you have any questions, Mr Cheney?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: Thank you very much for your time. We're very grateful.

THE WITNESS: Thank you.

THE COMMISSIONER: You are excused. We'll adjourn until 2 o'clock.

<THE WITNESS WITHDREW

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes, good afternoon.

MR FULLER: Good afternoon, Commissioner. I call Duane Findley of the Royal Australian and New Zealand College of Radiologists, who is on the screen.

<DUANE FINDLEY, sworn: [2.00pm]

<EXAMINATION BY MR FULLER:

MR FULLER: Q. Mr Findley, my name is Dan Fuller, I'm one of the counsel assisting the Commission. I'm going to be asking you some questions this afternoon. Firstly, am I right in thinking you are not a medical doctor?
A. No, I'm not, I am a CEO, yes.

Q. So you're the CEO of the Royal Australian and New Zealand College of Radiologists; that's right?
A. That's correct, yes.

Q. You've assisted the Commission by providing a statement. Do you have a copy of that there with you?
A. Yes, I do.

Q. It's dated 15 July 2024; that's right?
A. Well, I believe so.

Q. It's on the last page. And have you had the opportunity to read over that statement recently?
A. Yes, I have.

Q. Is everything in the statement true and correct, to the best of your knowledge and belief?
A. Yes, it is.

Q. Mr Findley, can you describe your role as CEO of the college, please?
A. Certainly. My role, in a nutshell, is to ensure the long-term financial viability of the college, so that it exists well into the future; to ensure that the training and education of our trainees and our fellows is conducted to an appropriately high standard; to run our policy and advocacy program for the benefit of our members; and to otherwise be a home for our members the same as any other normal member association would be.

Q. You've been in that role since September 2021; is that right?
A. Correct.

Q. Did you hold any role in the college before that time?
A. No, but I was interim CEO of the Royal Australasian College of Physicians, I think it was 2019, 2020, around there. So that was a period of about 12 or 15 months.

Q. In around 2019 and 2020; is that your memory of it?
A. Yes, I finished just as the COVID pandemic hit, so --

Q. The only way to become a specialist radiologist in Australia, if you want to complete your training in Australia, is to complete one of your college's training programs; is that right?
A. That's my understanding, yes.

Q. And your college has two training programs, one in clinical radiology and one in radiation oncology; is that right?
A. That's correct.

Q. As a consequence, you would agree there's no competition between your college and any other training provider for specialist radiology training in Australia?
A. I'd say that's a fair call, yes.

Q. And you would agree that the lack of competition makes it important for colleges such as yours to have fair, effective and transparent processes for the governance and administration of their training programs?
A. Yes.

Q. Am I right in understanding that your college accredits sites?
A. For the accreditation program for our trainees, yes, we do.

Q. Does it also accredit individual positions or training places?
A. Not to my knowledge. We only accredit sites.

Q. We also understand that the college accredits at various levels, A to D; is that correct?
A. Under the current program which we're about to change - there will be a new program that starts on 1 January 2025. Under the current program, the assessment, when it's first carried out, is an assessment: is the site acceptable for accreditation? When it's reviewed, it is given a rating of A through to D.

Q. I see. And what does that rating mean?
A. Essentially it's a quality rating as to whether they're across all the accreditation standards we have set,

all the way down to they're an unacceptable standard at the moment and they need to improve substantially.

Q. So D is effectively a fail rating; is that right?
A. D means that you are an unacceptable level at the moment and we need to work with you to try and improve where you are.

Q. And if a college is either - is rated or downgraded to a D rating, that may have a future consequence that its accreditation is withdrawn? Would that be correct?
A. That's a potential, unless they take steps to move themselves back up again, yes.

Q. Are you able to help us with whether there's a particular reason for your college taking the approach of accrediting sites rather than individual training positions?
A. I will have to take it on notice. I'm not, I'm afraid.

Q. Can you just describe to us what your role, if any, in the accreditation process is?
A. I take a very small role in the accreditation process. It is handled mainly by clinicians, so it's designed by the clinicians for clinicians. They also run the accreditation scheme with support from our training unit. My role, where I do get involved in the accreditation, is primarily as a review role, if they're saying that a site's coming down to a D, they may talk to me about what they're seeing is the issue.

Within the college, if they are looking to withdraw accreditation, it needs to go through the faculty council and also to the board, so I become involved in that piece to make sure that the information going to the board is correct. And if the department is showing some sort of - or the site is showing some sort of reluctance to engage in a rehabilitation scheme, they may call me in to try and negotiate with those groups at a higher level. As far as --

Q. And that's - I'm sorry, you finish.
A. As far as the mechanics and the actual understanding of the scheme itself, I don't become involved in that.

Q. So what you've just told us would explain why we see

some letters with your name on them relating to situations where the college has either withdrawn accreditation or downgraded accreditation; is that right?
A. Correct.

Q. In those circumstances, can you just explain what your role is as CEO?
A. It depends on the site. For many sites around Australia, if we go to a D level, the site will, of its own, wish to be rehabilitated and work with our team. I don't get involved in those at all. I'm only told that such and such a site is at a D level and I'll say, "Just keep me informed to where we're going with it." Soon you'll hear they're back up to a B or C or even an A, and that's not a problem.

It's where the site goes down to a D level and it continues at D level and they start to warn me that it's a longer period of time, they're not showing any signs of coming up, they're resisting, they want to argue about the piece, I come - I get involved then to find out what their issues are and why they're resisting, try and talk a way through that, and then also preparing that for the board level as well so if we need to go to the board I can say, "This is where the process has gotten to."

Q. So it is commonly, if issues are raised with the process of either downgrading or withdrawing accreditation, then that's the sort of situation where you'll become involved as CEO; is that right?
A. Yes, and again, when the site is fairly actively resisting the process.

Q. Tell me if you don't know the answer to these questions, but as we understand it, radiology training in both clinical radiology and radiation oncology is delivered in a network structure in New South Wales?
A. That's my understanding, yes.

Q. Do you understand there to be three what are called local area networks in New South Wales?
A. I can't answer that, I'm sorry.

Q. Are we right in understanding that the networks include both metropolitan and non-metropolitan sites?
A. Yes, that's my understanding.

Q. Do you know whether the college either has had or continues to have any involvement in developing that network structure?
A. I do know that we are trying to develop a regional network structure, and there is a case study in the witness statement around Dubbo and what we were trying to do with Dubbo. So we are doing that.

Usually we are looking at expanding sites out, so we will look at trying to work with regional, we'll talk to the private sector about trying to get private and public together as well. Usually with the metropolitan area, we don't.

Q. Just taking Dubbo as an example while we're on it, do you know whether that was an initiative of Dubbo or the LHD or, on the other hand, an initiative of the college to try to develop a network or an accredited site with Dubbo?
A. I'm not certain. I believe it was RANZCR that started that up.

Q. Sorry, I just missed that.
A. I'm not certain but I believe it was RANZCR that started the discussion around that.

A. RANZCR, okay.
A. Yes, apologies.

Q. And ultimately that didn't proceed; is that right?
A. That's correct.

Q. Can I just take you to paragraph 155 of your statement on page 22. You've described some what you describe as "bureaucratic hurdles" in that paragraph. Are you able to elaborate for us on what specifically those hurdles were from the college's perspective?
A. Yes. As we've put into the witness statement, there were issues around insurances, superannuation, length of service - pardon me. I must apologise, I've got a bit of a sore throat so occasionally I will clear my throat. I do apologise.

So there were a range of employment-type issues that our team were trying to move forward and it seemed to be too hard for the NSW Health department to get over some of these hurdles.

Q. So when you say, for example, "employment-type issues", you've identified some issues here around --

THE COMMISSIONER: Q. Yes, what was the issue, for example, whether the trainee was employed by NSW Health or the individual hospital or the LHD?
A. I'll have to take that question on notice. I didn't get down to that level of detail. I was being reported up to that these were the issues they were facing.

Q. Okay. And the other complications that you've mentioned, leave allowances, super, salary packaging, et cetera, what was the detail of the difficulty there?
A. Again, I was only getting a report up to me, so I didn't actually get involved in the negotiations of that.

THE COMMISSIONER: We might need to follow that up to make sense of that paragraph, I think.

MR FULLER: Q. Mr Findley, do you have any observations about the advantages or disadvantages of radiology training being delivered in a network structure generally?
A. What we find is that rarely any one site will give a trainee the full spectrum of skills and experiences that they require to be, frankly, one of the best trained radiologists in the world when they come out and a good general radiologist.

We also wish them to have more than one hospital experience as well. So even in the best hospitals, I think it's four years' maximum in one hospital site we have, we find that when you have different experiences and different circumstances, different population areas, you gain more, you learn more, you learn different things. So it's a core part of our development that they do experience different areas.

Q. Would we be right in understanding that the network structure is actually a requirement that your college has; in other words, it's not just, in the case of your college, something that's being implemented at the NSW Health level, but you actually require radiology training to be completed within a network; is that right?
A. I'm not certain that that's always the case. I know that we have people inside networks, occasionally they will leave and get jobs elsewhere or they'll move, and they'll move networks. Does that answer your question? I'm not

sure I got it all.

Q. Sure. Do you know whether radiology training is delivered in networks outside of New South Wales?
A. Yes, it is.

Q. Can you have a look, please, at paragraph 62 of your statement, which is on page 11.
A. I'm just getting there. Yes, 62, yes.

Q. In the first sentence of that paragraph you say:

Traditionally RANZCR trainees were selected by the local network with no involvement by RANZCR.

Then you go on to describe RANZCR introducing a selection into training program. Are you able to elaborate on what that program is?
A. Certainly. This is something that traditionally we didn't have a selection into training program managed centrally across the country by the college, and the Australian Medical Council, the AMC, who are the regulators of our college, insisted as one of our conditions, or one of our standards and conditions, that we introduce a selection into training.

So what we have done, starting this year, is we are doing a - we're building a program where the college takes the first step and looks at the resumes from the people coming in and grades them, and then sends them back out to the local area network for final interviews and selection. And the AMC wanted that to happen to make sure there was fairness in process and that under-represented groups were being given a fair assessment piece and there were no adverse or unanticipated differences between the various networks.

Q. Do you have a view as to whether it's a positive development that the college is now involved in that part of the selection process?
A. From the point of view of ensuring consistency and ensuring that the very best candidates get through to the interview, yes, I do. I believe that's a good thing, a positive thing.

Q. Do you see any role or reason for the college's role

in selecting trainees to expand in the future?
A. That would be a bit of speculation. I think it's important, at least at the moment, that the networks have a say in who gets selected into their network because they will be the ones that have to work with them for the next five years, develop them, grow them.

Q. Coming now to the accreditation standards, those standards are - so the college's accreditation standards for sites are developed by the college; that's right?
A. Correct.

Q. You've told us in your statement that the college standards need to meet the Australian Medical Council's standards; that's right?
A. Correct.

Q. They aren't approved by the Australian Medical Council; that's correct?
A. The Australian Medical Council provides standards and conditions for us to operate under and then they come and - they're not prescriptive so much, they'll give you a boundary to work within, and then they'll review us on a regular basis. They'll come out and they'll assess it. They'll tell us whether they believe that the accreditation program we're working on and the standards we're setting are an appropriate match with them.

Q. Are we right in understanding that, in effect, your college is, from time to time, accredited by the Australian Medical Council to deliver its training program; is that a fair understanding?
A. That's correct.

Q. And do you know how often that accreditation process at the medical council level happens?
A. It depends on how you are performing as a college. My understanding is they could - the AMC could review you and only give you a six-month leeway before they come back and investigate again. At the moment, RANZCR's been given out to 2027 as an accreditation, and we've been told that if we continue the way we are, we are potentially likely to go out to 2030. The maximum that they can allow between full reviews is 10 years, and that would be our 10 years.

I think it's fair to say we were last investigated - sorry, not investigated, reviewed last year, that was

called a mid-tender review. I say in the witness statement, it's a user-pay system, they charge us about $100,000 for that review, so you can sort of get an idea of how thorough the review was, and that's where we were given approval to continue forward.

Q. And did that review process include the Australian Medical Council reviewing the college's accreditation standards for training sites, do you know?
A. It covers that as well. There's 10 standards in all, and one of those is CPD Homes that they've pulled out, so yes, it includes the whole gamut.

Q. At the moment, the Australian Medical Council doesn't require colleges to follow any particular procedure for developing their own accreditation standards; is that correct?
A. Again, they operate within a framework that they allow - understanding that different colleges operate in different ways and it would be very difficult to get all 16 colleges to operate exactly the same, they allow you the flexibility to produce the standards as best set for your sector and then they will have a look at that and assess it against their standards to make sure it meets.

Q. Are you familiar with the National Health Practitioner Ombudsman report?
A. Yes, I am.

Q. Are you aware that one of the recommendations from that report was that the Australian Medical Council develop a procedure for colleges to develop their own - to follow in developing their own accreditation standards?
A. Yes, I am.

Q. Do you think that's a good idea or not?
A. My understanding of that recommendation is it will not be a prescriptive, "You must follow this", you know, tick box (a), tick box (b), tick box (c). It will still be a framework in which the colleges can develop their standards. I can say we are developing a new accreditation program which will be launched officially on 1 January 2025. We have presented that to the Health Workforce Taskforce and the team under that are implementing the NHPO report. They've had a look at it and they are telling us at the first level that it is entirely acceptable, so they're actually mapping exercises across to it.

Q. If the AMC were to develop a prescriptive procedure for colleges to prepare their own accreditation standards, would you think that would be a good idea or not?
A. I think it would be an idea fraught with danger and it would be a very difficult thing to implement. I believe you're better off with your - any accreditation program, of looking to be outcomes generated and to allow the flexibility for differences to allow.

Q. At a general level, though, would you agree that consistency in accreditation standards across colleges is desirable?
A. Within the differences that operate within each of the colleges, yes, and that's what the AMC is attempting to achieve with its standards as they currently work.

Q. I think you said a moment ago that you thought accreditation standards should be outcomes based. Did I understand that correctly?
A. Yes, you did.

Q. What do you mean by that?
A. I mean that, again, you can say, for example, "You will enter in the front door, you will paint this wall black and you will paint that wall blue and that will be everything you need." It may not give you the outcome you need. If you say that the outcome is that the trainees in a site are learning and they're growing and their surveys back to us are high quality and we're seeing that the ratios are in place and it's working well, that's more of an outcomes focus. So you can, I believe, become too prescriptive and miss the intent of what you're trying to achieve by trying to tick the boxes.

Q. Just thinking about the idea of ratios for a moment, that's more a process-based measure, isn't it, rather than an outcomes-based measure?
A. It's set, as I understand it, working with similar colleges around the globe and what they find their training works and how it operates effectively and efficiently, and with a good deal of experience in outcome. I can't go any further than that.

Q. What do you view as being the function of the college's accreditation standards generally?
A. We wish to see very high quality radiation oncologists

and clinical radiologists trained and graduated to basically serve the population of the country that they're serving in, and what we want is great outcomes for all of the local health of the nation and so we put a lot of time and effort into making sure our people are amongst the best in the world at that, and I should say, they're also generalists when they come out.

Q. Do you view the accreditation standards or accreditation process as a way of establishing and upholding more general professional standards for the practice of radiology going beyond the delivery of training programs?
A. I'm sorry, could you say that again? Something just dropped out.

Q. Do you view the accreditation standards or process as a way of establishing and upholding more general professional standards for the practice of radiology going beyond the delivery of training programs?
A. I would say that when we're looking at the accreditation standards, we wish to make sure that the sites that the trainees are in are operating to an acceptable standard for them to experience what they need to become top-class graduates. I think that answers your question, sorry.

Q. Thank you. Do you view it being any function of the accreditation process for the college to try to achieve better working conditions for its fellows?
A. The college doesn't get involved in industrial relations matters. That tends to be the remit of the AMA or of groups of the fellows on their own. So we don't advocate for pay and conditions.

Q. Are you aware that one of the accreditation standards for clinical radiology is a maximum number of examinations per consultant?
A. Do you mean exam attempts or --

Q. No. Let me show you the document. It's not in the tender bundle. The document number is [COR.0002.0006.0001]. Mr Findley, you will see it come up on the screen shortly. Can we scroll to page 0021, page 21, I think.

Mr Findley, I'm referring to about halfway down the

page, criterion 2.2.6. Can you read that at all?
A. Yes, slowly.

Q. Just let me know when you have --
A. Yes, I can see it now. I mentioned to Elizabeth from your team, she told me that you may be referring to this document today. I told her before the meeting, I've never seen this document before or read this document before, anything in the document I'd have to take on notice.

Q. That's fine. Just looking at it now, though - and tell me if you can't answer this, sitting here now - a criterion about the maximum number of examinations per consultant that's really about achieving what the college regards as an appropriate workload for its fellows, isn't it?
A. I don't believe I can answer that at the moment. I may need to take that on notice and come back to you.

Q. All right. Thank you. That document can be taken down.

Mr Findley, can you go to paragraph 76 of your statement.
A. Sure.

Q. You see in that paragraph you've told us that the college has required ratios of consultants to trainees. Have I understood that correctly?
A. That's correct.

Q. Do you accept that this will have the practical consequence of limiting the number of trainees who may be engaged at a given site?
A. It could be seen that way, yes.

Q. In that way, it would be right to say that the college does have a practical influence on trainee and consultant numbers - that's not being critical, but just as a matter of practical reality?
A. No, I would disagree with that. What I would say is our interest is in having trainees put into a site where they've got a great chance of learning and being able to complete their course. So what we say is, "If you've got those conditions, these are the numbers that we believe you'll have that will enable you to train them properly to get them out the other end." Any more trainees than that,

you risk potentially losing all of them.

Q. Accepting that rationale, but just as a matter of practical reality, the ratio will limit the number of trainees who can be trained at a given site, assuming there are a given number of consultants at that site; that's right, isn't it?
A. If the site chooses to only put one consultant on, then the trainees - yes, it will be a function of the choices they make, yes.

Q. So there are two ways that a site might achieve the ratio that the college requires. One is by increasing the number of consultants; that's right?
A. Certainly.

Q. And the other is by reducing the number of training positions at the site?
A. That's correct.

Q. Do you also accept that - or do you accept that rural and regional sites might find it harder to meet the college's accreditation standards than metropolitan sites?
A. There will be sites where it will be tougher to take the numbers - yes, you're right. I mean, a huge hospital, teaching hospital site, in central Sydney, it is going to have the resources, the departments, the people on call. It's one of the reasons we try to use networks is to give the trainees an optional round, and so if we could have broader networks, networks covering private/public, networks covering interstate, that would help.

Q. Tell me if you can't answer this, but would we be right in thinking that Dubbo is an example of a site that was not able to meet the college's accreditation standards as they stood?
A. My understanding was it was more issues to do with the employment conditions rather than the clinical side that precluded Dubbo moving forward, was my understanding.

Q. And is that employment conditions in the sense of the number of supervisors who are available?
A. What we said in the case study was things like superannuation, length of service, yeah, those sorts of - the employment pieces underneath. The clinical - it was a different priority, different --

THE COMMISSIONER: The answer the witness just gave relates to employment conditions for the particular employee. You were asking about accreditation standards, which I think are different. Was there an accreditation standard you had in mind that it was difficult for Dubbo to achieve or meet?

MR FULLER: Maybe I'll try to approach it in a different way, if I might, Commissioner.

THE COMMISSIONER: Yes.

MR FULLER: Q. Mr Findley, is it the case that Dubbo was a site seeking to be accredited with the college but not --
A. I can't answer whether they stood to be accredited or we started that process. I don't have that information.

Q. But either way, they're a site that is not currently accredited by the college and, by some mechanism, the college was considering whether or not they should be accredited; is that right?
A. That's correct.

Q. And then it was in that context that the college and management at the Dubbo site were communicating about whether the Dubbo site was able to be accredited; is that the effect of what was happening?
A. That's correct. The information I have is it was the employment conditions that precluded that moving ahead.

THE COMMISSIONER: Q. The statement tells us that RANZCR faced challenges in setting up Dubbo, which, to me, I read that as they wanted to do it but they had challenges, and that the Commonwealth had provided funding for it to be done. That's in 154 I'm reading from?
A. Yes, that's --

Q. And then 155, which you've already been taken to, sets out, without perhaps all the detail which you said you'd want to take on notice, the employment conditions.
A. Sure.

Q. I mean, I'm not criticising anyone, but that doesn't tell me what the accreditation issue might have been prior to this, before this funding. To try and get a - and I don't even know whether it is important, either.
A. Yes, I will have to come back to you, if you like, and

take it on notice about whether the clinical side was appropriate.

Q. Yes, okay.
A. Yes, I would say if they're in negotiations with Dubbo, then the clinical side is likely not to have been the issue, if it was people's employment condition had stopped it. So we'll come back and we'll confirm that for you.

MR FULLER: Q. Can I just ask you this today, and again tell me if you can't answer it, but setting up Dubbo as a regional and rural training program site, even if that was funded by the Commonwealth, your college still had to accredit Dubbo in order for it to deliver the training; isn't that right?
A. That's correct.

Q. And that was where the issue arose?
A. The issue wasn't us accrediting; it was whether they met the standards that needed to be met.

Q. The college's accreditation standards, that is?
A. Sure.

Q. Perhaps you can come back to us on that. I'll just leave it for the moment.
A. Okay.

Q. Would we be right in understanding that, from time to time, trainees and fellows of the college might raise concerns with the college about their working conditions?
A. That's correct.

Q. Those might include concerns about matters such as staffing levels?
A. I haven't directly heard it but I would assume that they would be amongst what they've - they could complain about, yeah.

Q. Have you heard of trainees or fellows raising concerns about workload with the college?
A. I haven't directly but me team may have.

Q. But you're personally not aware of that?
A. I can't point to an example. Again, I tend not to hear about things until they're escalated up, so if the

survey is coming back and saying, "We're not happy about this", "Not happy about" - oh, sorry, I should say, can I modify that answer? There was one I'm aware of, there was one hospital in Sydney. Where NSW Health were pushing back on the accreditation piece and saying they had a different model of operating and we had told them that they were without a consultant on a number of days but I don't know whether that was the trainees complaining about that or we had assessed that ourselves.

Q. I think this is one of the case studies that you have told --
A. It's in one of the case studies.

Q. -- us about. Perhaps if you have a look at paragraph 167 on page 23.

THE COMMISSIONER: Which paragraph, sorry?

MR FINDLEY: I'm sorry, 167 on page 23.

THE WITNESS: Mmm-hmm.

MR FULLER: Q. Perhaps just familiarise yourself with that paragraph, and then read, please, 169.
A. Yes.

Q. Is that the example you were referring to?
A. Yes, it was. Paragraph 170 talks about no consultants on sites for different periods and only one consultant on site for other periods. This was a debate about the ratio of consultants to trainees. The hospital site was saying "Well, we had a backlog. We had people working on the backlog. They're still consultants and you should be more flexible in your model because they're out there." But they were basically ploughing through the backlog of images to get those through rather than helping trainees and being available to help trainees and work with trainees.

Q. Is that one of the situations where you became involved as the CEO?
A. Yes.

Q. Are you aware of situations where trainees or fellows of the college have raised concerns with the college about matters of bullying or harassment or broader cultural issues at the site?

A. Yes, I am.

Q. If the trainee or fellow raises those kinds of issues with the college, are we right in thinking that the college will generally take up those issues on behalf of the trainee or fellow with the relevant health organisation?
A. What the college would do is, depending on how the issue is raised with us, if it's a survey, if it's an anonymous complaint, if it - that's one way. If it's a trainee that has complained to one of our people, we will actually advise the trainee on the processes that are available to them, which may be the EAP, it may be internal systems in NSW Health as the employer, that they should follow. We will raise it with the site itself and it will feed its way into the accreditation at some point in time, and particularly if it's multiple complaints and over a period of time.

Q. And in terms of feeding in to the accreditation, it's the case that, from time to time, the college will rely on those sorts of bullying or harassment or cultural issues raised by trainees or fellows as a basis for either withdrawing accreditation, downgrading accreditation or taking some other action in relation to a site's accreditation?
A. It will form part of the decision.

Q. Do you appreciate that where these sorts of what I'll call cultural issues are raised, that may be in the context of a broader workplace dispute at the particular site?
A. It could potentially be so.

Q. Do you accept that there's a risk that if the college were to make an adverse decision about accreditation based only on the information provided to it by its trainees or fellows, it might, unwittingly, become a participant in a workplace dispute?
A. We rely on a range of factors when we assess a site and accredit a site. There is rarely one thing that would tell us to come down to a D level, and usually it's a range of things that are happening and it's - things like this come from multiple sources. So it's - when you see a site like this, it's usually ratios aren't right, the culture is not right, training outcomes aren't where they need to be - there's a whole range of things. So it forms part of the general pattern.

It's much more sophisticated and complex in the way it's looked at. Rather than a trainee complains or a fellow complains and the college says, "Well, there's a complaint, you're down to a D." Again, it's over a time period as well, and it's a number of complaints as well. And often, when we talk to NSW Health - if it is NSW Health - when we talk to NSW Health about it, they will acknowledge that those issues are there and, in the case study I provided, they acknowledged those issues were there but they said it was our responsibility, not theirs, to resolve.

Q. When you say that the issues may be raised by multiple sources, those sources are usually the college's trainees or fellows, aren't they?
A. Correct. Sometimes, they might be network training directors, they might be directors of training, they could be the consultants on site, they could be the trainees, yes, but they're all RANZCR members or fellows.

Q. Do you agree that to the extent that those sorts of issues are raised with the college, it's important for the college to use its best efforts to verify the allegations, and when I say those sorts of allegations, I'm talking about allegations of bullying, harassment, discrimination or what I've called cultural issues?
A. Certainly, and we work with the site, we inform the site that we're hearing this. I know that on different sites we've actually had - the site has had independent studies done into it which proves or reinforces the bullying allegations.

We don't unilaterally hear a bullying complaint and straightaway drop you down to a D or say we've withdrawn accreditation. We work with the site. We work to see what is happening and what could be improved. Again, it's when the site declines to engage or refuses to engage or resists over a period of time and these complaints continue to come up, and they're usually one of a number of different categories of things that happen, that we start to take a stronger view.

I will also say that we actively fight to not withdraw accreditation, and if you look at some of the case studies, where we should have withdrawn, we continued to try and bring that site back to be on again.

THE COMMISSIONER: Just before your next question, just so it is clear, I think that Mr Findley covered this in his answer, but your question was:

> *Do you agree that to the extent that those sorts of issues --*

the bullying and what not you were talking about --

> *are raised with the college, it's important for the college to use its best efforts to verify the allegations, and when I say those sorts of allegations, I'm talking about allegations of bullying, harassment, discrimination or what I've called cultural issues?*

Your question was in the context of accreditation, was it?

MR FULLER: Yes, I think that's right, Commissioner, yes.

THE COMMISSIONER: Okay. I think the witness answered from the point of view of accreditation.

MR FULLER: Thank you, Commissioner.

THE WITNESS: Thank you, Commissioner.

MR FULLER: Q. Do you also accept, Mr Findley, that in relation to those sorts of cultural issues being raised with the college, it's important for the college to ensure that management at the site has a fair opportunity to respond before the college takes any action adverse to the site's accreditation?
A. Certainly, and we do inform the management of those when we see them.

Q. Does the college have a particular policy or procedure dealing with - a policy or procedure for dealing with those kinds of allegations?
A. I may have to take that on notice. I'm not sure of the exact answer on that one, I apologise.

THE COMMISSIONER: Can I just go back to accreditation generally, just so that it's clear what the college's position is.

Q. Mr Findley, I think in one of your answers to Mr Fuller about the ombudsman's report, you said you didn't view, or the college didn't view, it as being prescriptive in relation to standards and I certainly think that's right. Is it your understanding, firstly, that amongst all of the recommendations the ombudsman made, the first was that there should at least be agreement between the AMC and the various colleges about what the procedure should be for developing standards - that's your understanding, as a first step?
A. Yes. Yes. Yes.

Q. And then perhaps what might be the only prescriptive thing is that when those standards are developed, they have to be - and Mr Fuller has used these words and I think you have agreed. Whatever those standards are, they should be outcome centric and evidence based, which is what the ombudsman's language is?
A. Correct.

Q. That doesn't mean they have to be particular standards, but they have to at least be of the kind that can be said to be outcome centric, which I take to mean those standards will produce well-trained, in your case, radiologists, and that they will be evidence based in the sense that they will be based on some form of proof that those standards produce well-trained fellows; correct?
A. The other thing the NHPO says - and I'm paraphrasing that --

Q. But forgetting that, just before, you --
A. Oh, sorry.

Q. Do you agree that that is a perfectly reasonable recommendation?
A. I believe the outcomes-based recommendations are fine. That's what we would prefer.

Q. And in terms, I think, of how standards are set or what the standards should be, and again, I agree they're not prescriptive and it would be hard to know how they could be, but I think the recommendation is, or the commentary is, there should be minimum standards, like, these are the minimum standards that should be met; then there is what are referred to as normative standards, these are the ones that should be there to ensure we get good training; and then there's the aspirational, this is what

we should work towards to achieve something even better than the minimum or well-trained graduates. Is that a reasonable framework, in your view, as well?
A. The NHPO report talks about - and I'm paraphrasing - it's making the minimum possible standards essentially focused on the outcomes that you need. So what you've just said I think is right, and we believe that is a good way for all the regulators to operate.

THE COMMISSIONER: Okay, great.

MR FULLER: Thank you, Commissioner.

Q. Mr Findley, can you have a look, please, at paragraph 166 of your statement on page 23.
A. Yes.

Q. You've extracted there another recommendation of the NHPO report which relates - and feel free to read it - to developing a framework for managing concerns about accredited specialist training sites and then also dealing in that framework with how to deal with bullying, harassment, racism, discrimination and similar kinds of concerns. Do you see that?
A. Yes, I do.

Q. Do you disagree with that recommendation or do you agree with that recommendation?

THE COMMISSIONER: Q. Well, perhaps, why do you say it was disappointing, in 166? What's disappointing to you and your college about recommendation 13?
A. What was disappointing to me was the meeting we had with NSW Health where they told us it was our responsibility to deal with bullying complaints on one of their sites because they were RANZCR members. We very clearly said to them at the time, "We don't have the power to go on to your site to investigate. We don't have the power to compel people to speak and we can't find against any of those people or put sanctions on."

Q. Pausing there, then, is the disappointment - tell me if I'm wrong - that you wanted the ombudsman to clarify that there's a role for the employer here as well?
A. I was more disappointed that we knew the NSW Health people involved in that conversation had strong input into the NHPO, and then this has come up as a recommendation.

We saw that as within the law, the law is fairly blunt on this one, as much as the law can ever be, about the role --

Q. You mean workplace laws, you're talking about?
A. Workplace law. And that the role of the employer was there. We saw this recommendation as seeking to re-examine that and we just - when you look at the other recommendations of the NHPO report and the quality and the advancement that it takes, we saw this as something that wasn't the same standard as the other pieces.

Q. I have to say from my perspective, I would read the report and that recommendation as not involving any derogation from the employer's duties in relation to any workforce laws, but I at least understand where you're coming from in relation to what you've said there in that paragraph, in any event.
A. Thank you, Commissioner.

MR FULLER: Q. Mr Findley, leaving aside your disappointment about how the recommendation may have come about, do you disagree with the recommendation itself, which is - and tell me if you think I have got this wrong - really about the college developing a framework for how it approaches concerns of bullying and harassment, discrimination and similar matters?
A. I believe that there is a framework that already exists within the workplace law and that the college should follow the workplace law, and I suspect when this is investigated and produced, that's probably what will come out of it.

Q. It's the case, though - tell me if I've misunderstood you but you've told us that from time to time, the college will take accreditation action against a site on the basis of issues of bullying, harassment and other cultural matters that are raised by trainees and fellows? I have understood that correctly?
A. Once we have told the site and asked the site to take action and the site has declined to or it hasn't been able to, for whatever reason, that may form part of the future decision as to their accreditation level, yes.

Q. And I think you agreed with me earlier that the college - it was important for the college to use its best efforts to verify any of those sorts of allegations that it might rely on?

A. We do this by going back through the site and asking the site to conduct their investigation.

Q. And you agree with me, I think, that it's important for the college to ensure that management at the site has a fair opportunity to respond before you take any accreditation action? I think you've told us of the ways that your college does that?
A. That's correct.

Q. Have I understood that correctly?
A. That's correct.

Q. Is there anything wrong, then, with those sorts of steps being reflected in a policy, procedure or other framework developed by the college?
A. I - sorry, could you say that again?

Q. Is there anything wrong with - assuming I have understood, just take it from me that the NHPO recommendation is that the college has a fair and transparent framework for dealing with concerns about bullying, harassment and similar matters that are raised with it. Assume that I'm right about what that means. Is there anything wrong with that?
A. The issue we have with that is it needs to be consistent with current law. So if we see something, we go back to the employer and we ask the employer to investigate. That's the process, if you like.

Q. But if that's the case, in circumstances where, as you say on the college's view, the college can't make determinations about these sorts of bullying and similar issues itself, do you think it's appropriate for the college to rely on those sorts of matters to take accreditation action against a site?
A. Again, it's rarely one thing, almost never one thing that says a site is not performing where it needs to. It tends to be a whole combination of things. This could be one of them.

What we are saying is not that, "If we hear an allegation of bullying we will withdraw your accreditation"; what we are saying to the sites is "We are hearing credible statements from your people that there's some sort of cultural issues on your site. You need to address those and tell us how you're addressing those and

make sure that they're being proved for your site to lift its accreditation standard beyond the D". So they have the opportunity to rectify, they have the opportunity to come back and talk to us, they have an opportunity to show how they are addressing those issues.

Q. Is it the case that the college will always wait for the employer to have investigated and resolved those issues at the employer level before it takes any accreditation action against the site?
A. My understanding in my time, at least, we've never taken immediate accreditation withdrawal on a site.

Q. In circumstances where, as I understand your evidence, you say the college isn't in a position to investigate or take action in relation to these sorts of bullying and similar allegations, do you think it's appropriate for the college to wait for the employer to deal with those matters before taking any accreditation action in reliance on those matters, perhaps, among other things?
A. The college will always reserve its right on withdrawal of accreditation. I can't think of an incident at the moment, but if we ever came across an incident that, for the safety of our trainees, meant we had to withdraw accreditation immediately, we would do so. I cannot think of a time that we would, and we haven't. So we always try and work with the jurisdiction to try and improve and to work and to bring them back up again. It really is not in our interest to withdraw accreditation on a site.

Q. Would you agree that it would, at least leaving aside circumstances of urgency, not be appropriate for the college to withdraw or downgrade accreditation on the basis of bullying or similar allegations that have not been fully investigated and dealt with at the site level?
A. No, I wouldn't say that. Two things. There is a difference between "downgrade" and "withdraw" - a very big difference. And again, if a site refuses to investigate and we continually ask them and we continually hear that there's something going on and the site tells us, "There's nothing wrong, we're fine. No, we don't need to investigate", we may decide to - as a package of a whole range of things probably going on, we could potentially withdraw after a period of time. So we reserve that right.

Q. If, for example, on the other hand, the college saw that the site was investigating the allegations, even

though they hadn't yet finished that investigation, would the college give them the opportunity to do that before taking action?
A. The college has and does work with sites that have done that and we do work with them where we hear they're trying to make changes. I think I mentioned before, there is normally a limited period of time they can sit on a D level before they lose accreditation. We have extended that because we have seen that they are making efforts to try to improve, so we work with them.

Q. You have provided several case studies from paragraph 154 of your statement, which you've mentioned earlier. You see those? You know what I'm talking about there?
A. Yes.

Q. Without getting into the details of those case studies, is it fair to say that these are situations where the relationship between the college and the district or the ministry, as the case may be, became strained?
A. I think they're at a point where there has been some discord or there's been some debate about whether the accreditation process has been where it needed to be or whether they're trying something different and they should be given credit of it. It's often not a - it's not a breakdown of a relationship, it's a testing of different viewpoints oftentimes.

Q. Would it be right to say it's a robust dialogue between the college and individuals in the relevant health organisation from time to time?
A. I would say that would be correct, yes.

Q. Several of the case studies you've identified were situations where the college became - well, it took action on the basis of matters including bullying, harassment and similar cultural issues; would you agree with that?
A. Yes.

Q. And tell me if you don't know, but they include, don't they, occasions where the college at least downgraded accreditation without itself having been able to verify allegations that had been made by trainees?
A. I can't give you the reasons why downgrades happen.

Q. Were there any - are you aware of this - situations

where the college withdrew accreditation on the basis of allegations that it had not been able to verify?
A. No, if you're talking about the case study where we said that continued cultural issues were happening inside the site and then it was withdrawn, there were more things happening than that, and it was including trainee outcomes were not where they needed to be. It's where - and I will say, too, if we believe trainees are in danger, we have an overriding obligation for the safety of those trainees under the AMC and that is one area we would withdraw accreditation, so - but again, it tends to be a mixture of things rather than one single issue.

Q. Do you think anything could have been done at a systems level to avoid or mitigate the, as you have described it, discord in the relationship that occurred in these situations?
A. Maybe if I put it to you this way: we operate across Australia and New Zealand. I'm brought in only when things get difficult. In my three years here, I've had one situation in Adelaide, which was resolved with one meeting; one situation in Victoria, which was resolved with one phone call; and the rest are all New South Wales.

Q. And how many would "the rest" be?
A. Well, the ones I've given you.

THE COMMISSIONER: The case studies.

MR FULLER: So six case studies.

THE WITNESS: The case studies. Well, sorry, some of those case studies refer to the same site, different people coming at us about the same site, so --

MR FULLER: Q. Do you have any reflections on why the college has experienced that different situation in New South Wales?
A. This is not a formal RANZCR position, this is a personal CEO position. We tend to find most other sites want to work with us to try and resolve the issue and when we approach them they say, "What can we do? How can we do this." "This is a problem we can't resolve, we're not sure how to." And we will work with them on a fairly intensive basis to try and bring them across.

Even within New South Wales, I should say, we had

a meeting with St George Hospital on Monday and they've got a new CEO there, Graeme Loy, and the meeting with him was just a joy, and I've worked with Graeme, against Graeme, if you like, on some very tense times in the past, and one of the things he said was, "Look, we're getting better now. We've addressed 10 of your 14 conditions. What else can we do to help you as a college?" We walked away from the meeting going, "We can work with him. This is fantastic. How wonderful is this." We're confident now that that hospital will move up.

So it tends to be the attitude of the person there or the people in there, and if they're willing to help - again, we don't want to shut anyone down, we don't want to withdraw accreditation, we want our trainees to have a great experience, we want the health population of New South Wales to have proper health care. We try everything we can to continue that on. So I'm on my soapbox a little bit there, I'm sorry about it, but did that answer your question?

Q. Can you just tell us, since you've mentioned it, St George, is that one of the case studies you've provided?
A. Yes, it is.

Q. Are you able to identify which one it is?
A. Yes, case study 3 and it was also case study 4.

Q. Do you have any reflections on things, just sitting here now and looking back on these case studies, on things that the college might have done differently in managing those situations?
A. Look, I'll say up-front, this is rarely one side - all fault sits on one side. There are things that we can do and will do better, and whenever we have one of these situations we have an internal discussion and decide what we could have done differently, what we could have done better. We are very much an organisation with that continual learning piece and we really do sit down and do that. We do talk about the personalities that we may face in these areas and how we best can connect with them to try and get them over the line. So we do reflect on that.

With the St George situation, and now I'll name it, there were some accusations made against our visitation team. We actually brought our visitation team in. We talked to them about it. We put those to them. We worked

through what they said and how they said it. We acknowledged that there may have been different ways to say what we had said, and we will improve in the future. So we do that on a regular basis.

Q. Is there any systematic process within the college for reviewing these sorts of situations and trying to take on board lessons from them?
A. I just described what we did.

Q. Do you have any policy or procedure for dealing with that or it's something that you do when you recognise that a situation perhaps deteriorated in a way that it might not have?
A. Whenever we have a difficult - if it's a great situation and there's no outcomes, we don't really have any debrief session on it. It's where there's an issue, where things may not have gone the way we wanted them to and we talk through that to make sure that we are trying to operate as best we can be, recognising again that no-one's perfect. We do make mistakes. We have a saying inside our organisation that mistakes shouldn't define you, it's the way you address your mistakes.

Q. Just one other thing on the case studies, Mr Findley, are you aware that you referred to some handwritten notes in the statement?
A. Yes, I do.

Q. Whose notes are those?
A. They're mine.

Q. What, if anything, would be wrong with a system where the college is responsible for developing curriculum, training standards and administering examinations, but the accreditation function was instead performed by a separate central body on expert advice?
A. That is another valid model.

Q. But do you have any other comments about that, whether it is a good or a bad - whether it would be a good or a bad model?
A. Oh, that's speculation. I would have to see the model. I would have to see what it looks like. It probably has advantages and disadvantages. You would need to look at things like cost, who you were using to do it. As I say, the state - NSW Health at the moment is provided

the accreditation process for free. It costs us about $700,000 a year across all states and New Zealand to provide that for the states. A central body is probably going to have to be costed somewhere else. We also use a lot of volunteer members for our services. I doubt they would go for a central body. It's another model.

THE COMMISSIONER: Q. Any central body, I take it you would agree, would need to have people appointed to it that weren't just nominees, for example, of the ministry but also there was a capacity for nominees from the various colleges to have that sort of expert input into it as well?
A. I do believe that in that model you would need experienced clinicians trained in accreditation who can look at a site and know and understand what was going on inside that site.

THE COMMISSIONER: Yes.

MR FULLER: Q. Mr Findley, can you have a look, please, at paragraph 13 of your statement on page 3.
A. Yes.

Q. In that paragraph you say that the capacity of clinical radiologists and radiation oncologists faces significant challenges and limitations, some of which you go on to describe. You refer then about a third of the way down the paragraph to surge in demand for services. Do you see that?
A. Yes, I do.

Q. When you're referring to "a surge", over what period have you observed that occurring?
A. We are seeing, over the last few years, demand for radiology or diagnostic imaging services lifting by about 12 to 14 per cent per annum, and that tends to be a First-World-wide phenomenon, and our workforce is growing by about 1 per cent a year, and so - when I say "surge", I mean, you know, the surge is a trend.

Q. Those figures that you have given, where do they come from?
A. They're comments that we've talked to when we go to the Americans, RSNA, people like that, they will talk about those sorts of numbers and that seems to be where the global is. I don't have a written quote in front of me.

Q. Sorry, I just missed it, who do you say it came from?
A. Sorry, when we talk to the sister colleges around the globe, when we meet with those, that tends to be the figure that's discussed around that area. I don't have --

Q. Sorry, please finish. Please finish?
A. No, it is all right. Sorry, there is a bit of a lag, my apologies. I don't have a number in front of me at the moment.

Q. Those figures you've mentioned are global figures, as in around-the-world figures?
A. Tend to be First World.

Q. For the First World, did you say?
A. Yes. We talk to the Americans, the Canadians, the English, the Europeans, that's the sort of numbers they're talking about.

Q. Does the college have data about demand in New South Wales?
A. I don't believe we do, not a coordinated data in New South Wales, no.

Q. To what extent does the college have access to data about the supply - the number and distribution of radiologists in New South Wales?
A. We know where the radiologists are on the accredited sites because we see those. We don't have data on the rest of those.

Q. Is that data that it would assist the college to have visibility of?
A. It would be nice to have data. We would certainly like that data, and, yes, it - yes, I'll leave it there, but it would be good data to have.

THE COMMISSIONER: Q. Can I just ask, do you know, the lifting by about 12 to 14 per cent per annum that you mentioned, of the demand for radiology and medical imaging services, do you know what's driving that increased demand?
A. Yes, certainly. There's a number of factors. There is more of a drive towards preventative health and screening programs. There is an increasing tendency in the First World countries for people to want to be seen earlier and quicker. There are new technologies which are making imaging things you couldn't image clearly 10 years ago, you

can now. Contrast dyes, things like that, and interventional work as well. So this sector is the highest technology impact sector of any of the medical professions. So yes, that explodes.

Q. For all those reasons. Yes, okay.
A. Yes.

MR FULLER: Q. Is the college's perception that there's a shortage of radiologists in the New South Wales public system?
A. The New South Wales public health people tell me there are, and when we talk to them about the numbers, and particularly where they might have more trainees than they have people to supervise them, we've heard complaints from them before where they're saying, "Well, we train them, and then the private sector take them as soon as we've gone, we can't get them."

We understand that the rate of pay for New South Wales radiologists and radiation oncologists is less than other state systems, most other state systems, and definitely less than the private, and I do also say in our witness statement, we do recognise NSW Health - they've got a dreadful job, we wouldn't want to do it, and they're putting all the money, and all the time and all the effort into the training. So at the end of the training, they're open slather for the private sector, public sector, interstate, overseas. So, yeah.

Q. You mentioned lower - your understanding of lower pay. Does the college have a position on whether that and anything else are reasons for the shortage of radiologists in the public system?
A. Anecdotally our members sometimes say that, for instance, being put on to call on the Saturday night, you may not get that with the private sector, and so the lifestyle is a bit different. They may get better conditions that suit them better around lifestyle and travel and other things, so that it's seen as not only a significant increase in the remuneration but there are other conditions that I'm being told can attach to the private sector as well that the public can't match.

Q. Are there any other things that you're aware of that may be reasons for there being a shortfall of radiologists in the public system in New South Wales?

A. I think there's two things. There's the overall number in the public service, but there's also the mix between regional and rural and the metropolitan systems as well, and they are two different areas to look at. Again, what I understand is the remuneration and conditions tend to bring in people into the private sector. Definitely it would be pay, if they were moving interstate to another public sector. But there is also - we witness, even with IMGs, international medical graduates, coming into the country, they tend to do their time in an area of need and then they tend to gravitate towards the big cities, and we believe, from the anecdotal evidence we have, that there are a number of factors there. One is being closer to their own community, if there's a number of their own community; another one is the opportunity to learn, to develop their careers, to be at the cutting edge of what they're doing, and you can really only get that in the big cities, and to really explore if they are generalists and they want to specialise, to come up and specialise in an area.

THE COMMISSIONER: Q. Are the things you've just mentioned, including pay, lifestyle, wanting to be in the city for certain kinds of career progression, et cetera - are they similar reasons in relation to the maldistribution that you've talked about in paragraph 133 of the statement?
A. Let me look at 133.

Q. You talked about a significant issue of "maldistribution of clinical radiology resources extends beyond the urban areas", et cetera, and you expand on that, 134, 135. What are the issues that are causing that maldistribution, as far as you are aware?
A. I do believe, from the anecdotal evidence we have, that there is a remuneration element to it, certainly. If you're an IMG, an international medical graduate, you would tend to want to move closer to where more of your own cultural group are, because, you know, we would all want that, I would imagine, and then there are opportunities to specialise, to do more interesting things, to do different things.

A lot of that sort of information is contained in our census data that we put in as one of the packets as well. It's a difficult one. We also suggest, I believe, in the census data, that people who come from the region and are trained in their region are more likely to stay in their

region. So that's one of the reasons that we would like to see more regional networks actually operational.

MR FULLER: Q. In terms of the census data that you just mentioned, Mr Findley, we're right in thinking that the last - firstly, that's a census conducted by the college; is that right?
A. Mmm-hmm.

Q. Of its fellows?
A. That's my understanding, yes.

Q. The last one was conducted in 2020?
A. That's my understanding, yes.

Q. Do you know whether another census is going to be conducted this year?
A. I don't have that information I'm afraid, I'm sorry.

Q. In paragraph 63 - I'm sorry to jump you around your statement - on page 11 --
A. Yes.

Q. -- you say there that RANZCR typically has more qualified candidates than available trainee positions. So there is an oversupply of candidates; is that right?
A. That's correct.

Q. And so, from the college's perspective, the issue is whether there are available positions?
A. That's correct.

Q. Available training positions, that is?
A. Yes. That's absolutely correct. If we had more positions, we'd gladly fill them.

Q. Are you able to comment on whether - you say that you'd gladly fill them, but whether there is sufficient supervision available throughout New South Wales to meet the college's ratios?
A. Anywhere where there is suitable conditions for a trainee to be placed, we would be glad to place them. If NSW Health magically tomorrow had another 200 radiologists and they opened up another 100 spots for us, we would race to fill those.

Q. Do you know, sitting here now, whether there is any

sort of gap or flex in the system as it is at the moment with the number of consultants who could supervise trainees in New South Wales in radiology?
A. I'm not certain. I don't believe so in the public system.

Q. Finally, in paragraph 80, if you can have a look at that on page 14, please?
A. Yes.

Q. In that paragraph you say that a significant influence on the accreditation is the availability of consultants, and then you go on to contrast salaried radiologists with visiting medical officers or VMOs. Can you just explain the issue you're identifying there with VMOs?
A. Certainly. In some sites, we've found in the past, when a visiting medical officer turns up there, they're there at a higher rate for, say, two days a week or three days a week and the hospital is very - or the site is very keen on getting the most out of that expensive resource as it can while they're there, and even though the site will say, "I have a VMO here for two days a week", when the trainees approach to talk to them or try and get some information out of them or some assistance, they will say things like, "The site's got me doing this, this, this today. I haven't got time for you, I'm sorry. I've got to get this out because they're using me to the most of my ability"; whereas a salaried radiologist has that time built into their program that they can actually help the trainees and work with the trainees through the week. So it's not in every site, but we do see sites where they may be under pressure where the VMOs are tending to be pushed very much for an output that may preclude great training of trainees.

Q. So the issue with VMOs, from your perspective, is not with the idea or principle of there being VMOs but whether the VMOs who are in the system have sufficient time available to supervise trainees; is that right?
A. Yes, correct. RANZCR current care whether they are a VMO or a salaried person that's doing the training as long as the trainee is receiving the appropriate training for what they do.

MR FULLER: Thank you, Mr Findley. Those are my questions for this witness.

THE COMMISSIONER: Q. Can I just ask a question about 152 on page 21, where you say:

> *RANZCR is concerned with the proliferation of unaccredited training positions ...*

et cetera. Do you have data about what the numbers are for unaccredited training positions?
A. No, I don't, I'm sorry.

THE COMMISSIONER: All right. That's the answer to that;

Do you - sorry, I'm now talking to Mr Cheney. Mr Cheney, do you still have the difficulty you mentioned yesterday?

MR CHENEY: I do, Commissioner, if I could renew that request.

THE COMMISSIONER: All right.

Mr Findley, Mr Cheney, who is the senior counsel for NSW Health, has told me he hasn't had full time to get complete instructions on your outline, and it was a fairly short time frame, so I've agreed to give him some further time. As I understand it, a time of Tuesday, 6 August at 2pm, has been agreed for you to come back.

THE WITNESS: No.

THE COMMISSIONER: It hasn't?

THE WITNESS: No.

THE COMMISSIONER: That's what I've been told.

THE WITNESS: If I can say, Commissioner, this has been a really difficult process of "last-minutism" and changing of dates and times and I've had to rearrange my diary a number of times on this, and I even had an offsider that could have answered some of your questions today but he was required and he wasn't required, then he had somewhere else to go today. It's been very difficult, and we usually plan our diaries six to eight weeks out.

THE COMMISSIONER: I am completely sympathetic to what you have just said to me. There's also, of course, a whole

range of clinicians that are giving evidence at this Inquiry that have very busy diaries and have to treat patients and - but we manage. What I'm going to have to say to you, though, is, first of all, we're very grateful for your statement and for your time today. I can't release you from your summons yet, though, because in fairness, I've got to give Mr Cheney some time and an opportunity to ask you some questions, as he sees fit and as I see fit as well. Having obviously been misinformed about that date, though, we'll just adjourn your evidence to a time to be fixed --

THE WITNESS: Sure.

THE COMMISSIONER: -- that we'll make sure is convenient to everyone. Can I just ask, though, Mr Cheney, I obviously don't want a list of your questions, but just to help me, what are the general topics you want to explore with the witness? I can probably guess, but you tell me.

MR CHENEY: There are aspects of the case studies and most of the six case studies. It's a bit hard to go much further than that at the moment because I don't have the --

THE COMMISSIONER: That's in the main, what you want to explore, is it?

MR CHENEY: Yes.

THE COMMISSIONER: All right. That will do. We'll talk after I let the witness go.

For the time being, Mr Findley, we will say goodbye, but you're still under your summons and we'll come back to you to reach a convenient date for you to come back and complete your evidence. For the time being, though, thank you for your time today.

THE WITNESS: Okay, thank you very much.

<THE WITNESS WITHDREW

MR CHENEY: We had not, for what it's worth, heard of 6 August as being the projected date either.

THE COMMISSIONER: I got a message on Teams because I sent a message saying, "Has Mr Findley been advised that he has

to come back?" Unless I misread what I was sent, I thought I was told - well, I was:

Confirmed available 6 Aug from 2pm.

Obviously that's not quite right, based on the witness's surprise. But we'll find another time.

Can I just say this, though, generally, the terms of reference are role and scope of accreditation and education and training generally. Do I have to make findings on these case studies?

MR MUSTON: I don't think so.

THE COMMISSIONER: Do you want to think about that, because if I don't have to make findings, the whole thing would go away. I mean, clearly, there have been some issues that are raised in the case studies where people have points of view. There is some correspondence that is referred to that I haven't seen. The correspondence will speak for itself and it might contain some evidence that you might draw an inference from, but you might not as well, but unless I have to make findings on the case studies, I mean, you know, some of them - the discussion between the director of training at Prince of Wales, et cetera, and whether they made unprofessional comments doesn't seem to me to be something that I have to make a finding about in this Inquiry.

MR MUSTON: It seems quite unlikely. There are potentially two steps. The first is working out what the contest is, and it may well be that once we reach that point and we get one side saying "Unprofessional language was used in a meeting" and the other side saying, "No, it wasn't", it seems most unlikely, in the context of this Inquiry, it will be necessary to work out whether unprofessional language was used.

THE COMMISSIONER: There is an aspect of "who cares" to that, without being flippant about it.

MR MUSTON: But, equally, it might be important at a systemic level just to understand that a personality clash during a meeting where two people walk away with conflicting views, neither of which might be --

THE COMMISSIONER: That's why good frameworks might be important for things like accreditation.

MR MUSTON: That might be enough.

THE COMMISSIONER: Can I suggest this: that counsel explore what it is that, first of all, counsel assisting thinks I should make a finding about, and if a lot of that disappears, in terms of those case studies, that that can be discussed with Mr Cheney. It may well be that Mr Findley doesn't have to come back in those circumstances because I can give an assurance that I'm not going to pay any attention to those aspects that are probably troubling NSW Health about this statement, and that will be one way of dealing with it.

But if you think there are, perhaps, some findings that I should make that are relevant to the terms of reference, then we'll obviously get him back. Does that make sense?

MR CHENEY: Commissioner, I was going to volunteer that the question whether fairness dictated that we put these propositions to Mr Findley could only be determined after we had served the responsive evidence, and if you are not minded to make factual findings about the case studies, then that might bear on whether fairness dictates that he --

THE COMMISSIONER: There would be no need for you to respond.

MR CHENEY: We certainly want to respond.

THE COMMISSIONER: There is a whole lot of procedural fairness issues with some of these people that are identified, too, who aren't here.

MR CHENEY: My client certainly wants to respond to the pejorative allegations against it in respect of those various --

THE COMMISSIONER: You could probably do that by way of a submission unless - look, let's just see how we go with your discussion and then you can come back to me and we'll work out - I will withdraw what I said about "you can probably do that by submission", because I will let you

deal with it in the way you want to, and it might be that you want to put some evidence on.

MR CHENEY: Yes.

THE COMMISSIONER: I will leave it at that for the time being.

MR CHENEY: Thank you, Commissioner.

THE COMMISSIONER: All right. So we adjourn until Tuesday, do we, at 10 o'clock? You are getting a note.

MR MUSTON: Yes. Mr Fuller has just raised with me that I think during the course of Mr Findley's evidence there was a document that needed to be marked for identification, I think it was [COR.0002.0006.0001].

THE COMMISSIONER: What's the title of it though?

MR MUSTON: While that is being discovered, we're up to MFI 15. It is the "RANZCR Accreditation Standards For Education, Training and Supervision of Clinical Radiology Trainees".

THE COMMISSIONER: Does it have a date?

MR MUSTON: As I turn over the page, it looks like "July 2012, amended December 2018".

THE COMMISSIONER: All right. That document, as per those dates, is MFI 15.

MFI #15 RANZCR ACCREDITATION STANDARDS FOR EDUCATION, TRAINING AND SUPERVISION OF CLINICAL RADIOLOGY TRAINEES DATED JULY 2012, AMENDED DECEMBER 2018

THE COMMISSIONER: Thank you. Sorry, does that mean adjourned until Tuesday at 10am?

MR MUSTON: Yes, at 10.

THE COMMISSIONER: All right. We will adjourn until Tuesday at 10am. Thank you.

AT 3.36PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO TUESDAY, 30 JULY 2024 AT 10AM

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