NSW HEALTH AND SPECIALIST MEDICAL COLLEGES – ROUNDTABLE

SUMMARY OF OUTCOMES

11 OCTOBER 2019

NSW GOVERNMENT

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INTRODUCTION

On 11 October 2019, the NSW Health and Specialist Medical Colleges Roundtable was held at the Royal Australasian College of Physicians offices in Sydney.

The purpose of the Roundtable was to reflect on the progress made to improve medical culture since the signing of the *Statement of Agreed Principles on a Respectful Culture in Medicine*, the respective roles and responsibilities of key stakeholders and to look at how accreditation processes could be improved.

There were over 75 participants in attendance with representatives from fourteen medical specialist colleges, the Australian Medical Council, the Australian Medical Association (NSW), local health districts and speciality networks and junior doctors. A list of organisations represented at the Roundtable is provided at Appendix 1.

It was clear stakeholders present were committed to maintaining and developing a world class health system for NSW which focuses on delivering high quality safe and appropriate patient services.

It was acknowledged by participants that this requires a system that recognises and values it medical workforce, provides a supportive environment for the incoming generation of doctors and those undertaking more advanced studies. Equally, that medical supervisors play an intrinsic role in teaching and educating young doctors and the system needs to ensure that supervisors have the capacity and skills to do this work.

What became apparent on the day was not all stakeholders understood each other's roles, responsibilities and limitations. This lack of understanding was the basis of many concerns that were raised in terms of complaints management, training and supervision. Also, it was acknowledged that the accreditation processes needed to be examined to ensure they are a joint process between colleges and hospitals.

The Roundtable was facilitated by Mr Mick Reid and comprised of panels, plenary discussions and tablework. The Roundtable Agenda is at Appendix 2.

The Roundtable was opened and closed by the Hon. Brad Hazzard, Minster for Health and Medical Research.

Four themes emerged from the panel, plenary discussions and tablework which have informed the proposed further work to be undertaken by the NSW Ministry of Health in collaboration with medical colleges. These four streams are outlined below.

1. Accreditation processes

This stream of work will develop agreed processes on how medical colleges interact with health services and the NSW Ministry of Health when there is an issue at a training site that could affect its accreditation status. Work will consider:

- developing a process for early identification and sharing of concerns regarding a training site that could affect its accreditation status
- developing escalation procedures where areas of concern are identified
- developing processes for sharing of information.

2. Complaints management of unacceptable behaviour

This stream of work will develop an agreed complaints management process between medical colleges, health services and the NSW Ministry of Health concerning unacceptable behaviour by a clinician. Work will consider:

- clarifying the roles and responsibilities of employers and medical colleges when managing complaints related to unacceptable behaviour of a clinician
- developing a pathway for managing complaints including notification processes, investigation processes, and sharing of information.

3. Supervisor training and monitoring

This stream of work will consider how employers and medical colleges can better support supervisor training, feedback and monitoring. The work will consider:

- developing an agreed framework of supervisor leadership skills and competencies required to perform their role
- developing processes for sharing supervisor training resources
- developing agreed processes to share information about training undertaken by supervisors
- improving processes to monitor supervisor performance and providing them with timely and regular feedback
- developing agreed mechanisms to share information pertaining to a supervisor performance between hospitals and medical colleges.

4. Promoting diversity and flexibility in the workplace

This stream of work will seek to promote diversity and flexibility in the medical workforce. The work will consider:

- identifying barriers to flexible training
- ensuring recruitment processes do not discriminate against those seeking flexible training
- examining the need for guidelines to assist part-time training and the feasibility of establishing of a central register to identify job-sharing/part-time work opportunities.

The NSW Ministry of Health will seek representation from medical colleges, local health districts, the Australian Medical Council and other key stakeholders to progress actions identified at the Roundtable.

NSW Medical Trainees and the Hon. Brad Hazzard, Minister for Health and Medical Research

Back row: Dr James Lawler, Dr Mirna Hunter, the Hon Brad Hazzard, Dr Hariette Goldman, Dr Lachlan Gordon
Front row: Dr Linda Xu, Dr Mahnoor Mian, Dr Lucy McMullen and Dr Tessa Kennedy

A RESPECTFUL CULTURE IN MEDICINE: PROGRESS TO DATE

Summary of presentations

The first session considered progress achieved against the Statement of Agreed Principles on a Respectful Culture in Medicine. The session included presentations and a panel discussion.

Presentations were made by the NSW Ministry of Health, Australian Medical Association, Council of Doctors in Training, the Royal Australasian College of Surgeons, the Royal Australasian College of Physicians and the Sydney Local Health District.

Each presenter considered from their perspective two to three activities or measures that had worked well to improve workplace culture and processes and also what have been the challenges. Copies of the presentations are at Appendix 3.

STATEMENT OF AGREED PRINCIPLES
ON A RESPECTFUL CULTURE IN MEDICINE

OUR ORGANISATIONS:

A. Are committed to creating a respectful culture in the practice of medicine, fostering a profession that reflects the diversity of our community, and promoting a culturally safe workplace for Indigenous Australians;

B. Agree that places of work, training and education are places where all participants should be treated with dignity and respect, and be free from unacceptable behaviour, including bullying, discrimination, harassment and racism;

C. Recognise that past practices and behaviours have not always met the high standards required to provide a safe, inclusive and respectful environment; and

D. Recognise that each party has a different, but valuable role to play in achieving this goal, as employer, educator, trainer, professional association or member organisation.

OUR ORGANISATIONS AGREE TO:

1. Take active steps to build and promote respect, equity, diversity, fairness and cultural safety within our organisation and in our dealings with students, trainees, supervisors, practitioners, employees, contractors, members and each other.
2. Implement policies that promote diversity and respectful behaviours and clearly describe what is unacceptable and unlawful behaviour.
3. Provide support, education and training to students, trainees, supervisors, practitioners, employees, contractors and members to prevent and eliminate unacceptable behaviours.
4. Ensure complaints about unacceptable or unlawful behaviour or other breaches of policy are dealt with quickly, fairly and transparently. Protect complainants from unwarranted retaliation or victimisation, and ensure that prompt and appropriate action, including sanctions, is taken where breaches are proven.
5. Actively cooperate on policies and initiatives designed to promote diversity and respectful behaviour and discourage unacceptable behaviour.
6. Ensure our leaders model appropriate behaviour and actively promote a respectful culture.
7. Demonstrate transparency and accountability in the organisation's progress towards a respectful culture by means such as feedback, reporting, research, publications and surveys.
8. Review the outcomes of policies, actions and other initiatives at regular intervals in order to assess and improve their effectiveness.

ENDORSED BY:

Key messages

Since 2012 the NSW medical workforce has grown by 30 per cent across all salaried medical officers, including a 30 per cent increase in staff specialists, 25 per cent increase in registrars and a 31 per cent increase in junior medical officers (interns, residents, career medical officers)

Changing culture requires support of all stakeholders on the career pathway. It will not happen in one to two years but more likely five to ten years, but it is achievable and the system is responding with the implementation of innovative practices and programs. The system has modifiable risk factors that impact on junior medical officers and senior doctors' wellbeing which can and are being addressed. Junior doctor wellbeing is connected to the wellbeing of senior doctors.

Areas that can be improved are complaints management, recruitment and accreditation processes.

The way forward is:

- Greater understanding of the respective roles and responsibilities of key stakeholders.
- Basing decisions on evidence.
- Greater sharing of information between colleges and hospitals.
- Identifying duplication in the system.

A RESPECTFUL CULTURE IN MEDICINE: PANEL DISCUSSION

A panel discussion followed the presentations. The panel was facilitated by Mr Mick Reid and included:

- **Mr John Biviano**
  Chief Executive Royal Australasian College of Surgeons
- **Ms Robyn Burley**
  Director of Education, Learning and Assessment Royal Australasian College of Physicians
- **Dr Tessa Kennedy**
  Chair Australian Medical Association Council of Doctors in Training
- **Mr Phil Minns**
  Deputy Secretary People, Culture and Governance NSW Ministry of Health
- **Dr Teresa Anderson**
  Chief Executive Sydney Local Health District

Collaboration and complaints management

Collaboration between a number of colleges is already happening. For example, the Royal Australasian College of Surgeons has Memorandums of Understandings with a number of colleges. This raised the question and discussion that if a complaints management process works for one college it should work for all colleges. Further consideration should be given to the development of a universal approach and agreement at a national level on how colleges address complaints.

From a hospital perspective it is very challenging that different colleges have different processes. Hospitals would welcome the adoption of a universal approach.

One suggestion regarding management of complaints was to have an external body to deal with complaints to counteract issues about future career prospects by trainees if they make a complaint.

Trainees are reluctant to complain due to concerns that it will affect end of term assessment. There is already a Patient Liaison Officer, however it was suggested that there could also be a Complaints Liaison Officer to address these concerns.

It is difficult for medical colleges to investigate complaints as they are membership organisations and can only go so far. The main lever they have for dealing with poor behaviour by a Fellow is through site accreditation.

From a Ministry perspective complaints management is a critical process. Early notification is the key to resolving the issues.

Service and training tension

There is a mismatch between numbers in the trainee and specialist workforces. With the introduction of safer hours rostering there is a need for an increase in the number of doctors to staff rosters. This is resulting in trainee entry and exit block.

Further, there are doctors working in unaccredited training positions. It is important for colleges to collaborate around unaccredited trainees.

Strengthening leadership

Colleges have invested in leadership courses for their fellows, although it was noted that leadership remains a key skill gap for college Fellows and trainees. It was noted that there needs to be opportunity to practice leadership skills, it is not enough to just attend courses. Sydney Local Health District has a number of non-clinical terms for trainees. These terms have been beneficial both to the trainees themselves and also the organisation.

It was also noted that there are a lot of leadership courses and there should be greater collaboration in identifying appropriate courses that could be recognised across all colleges and the health system to reduce duplication.

The attendees questioned whether there is a need to have protocols on sharing of information on what training supervisors have completed. Overall there was agreement that this should occur to reduce duplication. Hospitals do not always know what college training a supervisor has done and vice versa. How, and what level of, information is transferred needs consideration.

Flexible training

There was strong agreement that there needs to be greater flexibility in training. Currently trainees applying for part-time positions are experiencing discrimination. Exacerbating the situation, there is no process when applying to show that an applicant is seeking to work part-time.

Colleges have processes in place that support part-time training but acknowledge that there is a culture where some Fellows still do not understand how they can roster flexibly.

A significant part of improving the wellbeing of trainees is being able to offer part-time training without the trainee feeling like a burden to the team or having a negative impact or perception on their ability to complete their training. Part-time training needs to be normalised, while keeping a balance with delivery of services and other training positions.

CREATING AND SUSTAINING A HEALTHY CULTURE

Tablework

This session examined what is required to create and sustain a healthy culture. To understand the factors, participants were asked, firstly, to clarify the respective roles and responsibilities of stakeholders in relation to supervisors and trainees. Each table considered the following questions.

In addition to the questions each table was provided a Supervisor and Trainee Fact Sheet outlining the results from the *2018 Your Training and Wellbeing Matters Survey*. The Survey results provided context and were not outcomes of the roundtable deliberations.

Question 1

Reflect on the current training provided to supervisors: Is there clarity about who provides training for supervisors? Are supervisors receiving adequate training in areas such as how to give feedback, manage a trainee in distress and manage under performance?

The *2018 Your Training and Wellbeing Matters Survey* showed:

Prior to becoming a supervisor I received formal training for the role

32% Agreed

The *2018 Your Training and Wellbeing Matters Survey* showed:

I feel confident in managing an underperforming Junior Medical Officer who I supervise

67% Agreed

The *2018 Your Training and Wellbeing Matters Survey* showed:

I have received training in how to provide feedback to Junior Medical Officers

36% Agreed

Key points:

The majority of the Roundtable participants agreed that medical colleges are responsible for providing training for supervisors of trainees in accredited positions. The challenge is getting supervisors to complete the training. The Royal Australasian College of Surgeons' approach mandating supervisor training was supported.

Some colleges have mandatory training of supervisors but others do not. There is variability in the content, forms, and structure of training courses, provided by colleges for supervisors.

Supervisors reported difficulty in having time to do training.

There was broad consensus that there would be value in identifying the core skills required by a supervisor in clinical and leadership roles, irrespective of which college they are from and developing a generic training course for all colleges. The training would include how to provide feedback, manage under-performance as well as a trainee in distress. This approach would reduce duplication across colleges, the health system and set a clear benchmark of the level of training expected.

Training of supervisors should be targeted to their needs for their own development to remain engaged.

The different language and terminology used by colleges is a barrier - e.g. different titles for supervisors.

Question 2

How can we further enhance people leadership skills of our supervisors?

There was a commonality in themes that emerged, including:

- Introduction of leadership and management training at medical school. Junior doctors are already supervising other junior doctors.
- Training in leadership and management to be formalised and mandated.
- The need for greater recognition by NSW Health and hospital executives of the importance and value of leadership training of supervisors in shaping the medical workforce, including:
    - Development of non-clinical positions for trainees to help develop supervision skills
    - Dedicated time to undertake training
    - Incentivise development of supervision skills.
- There needs to be greater support from medical colleges in supporting supervisors' wellbeing.

Question 3

Who is responsible for monitoring supervisor performance? Are there challenges in monitoring supervisor performance and giving supervisors feedback? How could the process be improved, to both acknowledge good performance and address areas of poor performance?

The *2018 Your Training and Wellbeing Matters Survey* showed:

In the last 12 months I have received formal feedback about my performance as a supervisor

24% Agreed

The *2018 Your Training and Wellbeing Matters Survey* showed:

In the last 12 months I have received informal feedback about my performance as a supervisor

49% Agreed

This question highlighted the lack of clarity of roles and responsibilities and processes of who monitored supervisors' performance and how it was done.

There was general agreement that there is little or no feedback provided to supervisors on a regular basis about their performance.

The majority of participants were not clear on the medical colleges role as opposed to the employer's role. It was suggested that the employer's role was within the domain of clinical performance and conduct, while the college's responsibility was monitoring the supervisor's performance in the domain of education and training provision.

There was agreement that obtaining feedback from trainees on a supervisor's performance was difficult due to the power imbalance and fear of repercussions for the trainee's future training opportunities if negative feedback was provided. One college indicated it sought feedback from trainees on supervisor performance once the trainee had left the site.

To improve the provision of feedback, the following assessments and ideas were identified as valuable:

- 360-degree feedback (multi-source feedback)
- peer to peer review
- developing smart technology to improve the regularity of trainee feedback. An example was an app developed by the Australian Orthopaedic Association that facilitates high frequency feedback between orthopaedic trainees and supervisors, which is quick and provides a real time assessment
- promoting that feedback is also for recognition of good behaviour to encourage ongoing positive performance
- that all assessments of a supervisor's performance must include feedback from trainees in both accredited and unaccredited training places.

Existing tools to monitor a supervisor's performance, such as Morbidity and Mortality meetings remain valuable if undertaken in a supportive environment.

Where negative feedback or a complaint regarding a supervisor has been received by the colleges or hospitals, a mechanism to share this information with the other party is virtually non-existent. Privacy was cited as one issue preventing sharing of information.

Question 4

How do we ensure more flexibility for trainees in completing their training so we achieve a diverse workforce? What are the benefits of flexibility? Are there any barriers? Consider role of colleges and employers?

There was strong agreement that workplace flexibility increased employee satisfaction, diversity, enhanced security, supported staff retention and the ability to provide safe working hours. Furthermore, organisations that provide a flexible work environment are employers of choice.

Participants identified barriers to flexibility including:

- combating historical norms, stereotypes and culture
- balance between needs of individuals and employers
- short contracts/ not having a length of training contract
- tension between safe hours and what colleges consider training time. Colleges usually only count 'in hours' (8 to 5) as training time. Part-time trainees who do some after-hours work can find it difficult to get required training time hours
- difficulty for trainees to find job share partner

Participants identified clear roles and responsibilities of the employer and colleges. For both parties it was felt that options for flexibility in employment and training should be normalised and not seen as a special or extraordinary arrangement. It was considered that part time positions should be the norm rather than the exception.

Employers

Employers ultimately have the levers to provide flexibility in the workplace. It was identified that relevant industrial awards may need to be reviewed to reflect the changing environment.

Areas requiring examination include:

- transferability of leave entitlements, (includes maternity leave, long service leave, parental leave, sick leave etc.) to other jurisdictions and to the private sector
- length of training contracts to cover the duration of the training program
- increasing the training of generalists, for example "critical care doctor" verses an anaesthetist
- development of guidelines that will assist hospitals to effectively implement flexible work arrangements, part-time, job sharing etc. The guidelines would include assistance on rostering practices and leave entitlements
- investigation of the feasibility of the Ministry hosting a central database to allow trainees to register for those looking for part-time/job share positions.

It was noted that the NSW Ministry of Health is actively progressing transferability of leave entitlements and length of training contracts.

Colleges

- Greater flexibility is required in what is considered a reasonable time to complete training.
- Greater flexibility in exam scheduling, including options for more frequent exams and that exams need not be sequential.

Question 5

Are there opportunities for sharing of information between colleges and employers on a number of matters e.g. supervisor training and performance, trainees struggling, recruitment and selection decisions. What are the benefits? Are there any barriers?

There was largely consensus amongst the participants that this is one area where the health system and colleges need to collaborate to improve. It was noted, from the outset, that there was considerable variation between colleges in processes and even within some colleges application of their own processes, making it difficult for hospitals to navigate.

Participants discussed that there were significant opportunities to share information, which is for the wellbeing of both the trainee and supervisor and ultimately to ensure the delivery of high quality patient care.

Areas to be addressed:

- As a matter of priority the NSW Ministry of Health and colleges are to work together to identify situations where information is required to be exchanged and the process through which such exchanges occur, including the identification of any privacy issues, contact points in the respective organisations and communication protocols.
- Clarification of how complaints are managed. Colleges are unable to investigate complaints and must refer to the responsible site.
- Is there a role for the Royal Australasian College of Medical Administrators to develop links between colleges?
- There are still significant problems regarding inappropriate questions being asked at interviews or pre interviews. The NSW Ministry of Health is working with colleges.

Participants identified a number of current barriers to exchanging information. These include:

- Hospitals don't always know who the supervisors are, particularly with the larger colleges as some run their own training with negligible interaction with JMO Units.
- Trainees are reluctant to make a complaint regarding unacceptable behaviour of a supervisor. This may be exacerbated if they know the information will be exchanged with the college.

Question 6

Are the existing processes and support mechanisms sufficient to ensure that junior doctors are able to raise concerns about unacceptable behaviour. What more could be done by employers and colleges?

And

Question 7

What is the role of the employer and the colleges to address an issue of unacceptable behaviour raised by a trainee?

The *2018 Your Training and Wellbeing Matters Survey* showed:

There is a culture that deals effectively with discrimination, bullying and sexual harassment at my hospital

43% Agreed

The *2018 Your Training and Wellbeing Matters Survey* showed:

In the last 12 months I have witnessed bullying at my work

54% Yes

The *2018 Your Training and Wellbeing Matters Survey* showed:

In the last 12 months I have been subjected to bullying at work

30% Yes

Questions 6 and 7 have been considered together given the interconnectivity of the issues.

Participants considered that there had been an overall improvement in processes and support mechanisms to facilitate JMOs raising concerns regarding unacceptable behaviour, but more needs to be done, particularly around the communication of appropriate processes and communication channels.

There was agreement that the role of the employer, versus the college in addressing a complaint of unacceptable behaviour needs to be more explicit by defining the issues that are in the domain of the college and those of the employer. It was acknowledged the way the organisation addresses the complaint may vary based on the circumstances, however an agreed escalation policy needs to be in place. Having an agreed policy to share information is vital to successfully managing complaints.

It was acknowledged that the JMO Units are often the first contact point for JMOs to raise concerns regarding unacceptable behaviour or other issues concerning their wellbeing. However, it was acknowledged that many JMO Unit staff do not have the right skills or knowledge of escalation processes to adequately assist the JMO seeking help.

A number of participants believed that creating a dedicated JMO Liaison Officer would address this. This Liaison Officer would also have extra training in human resources in relation to medical officer's appointments and training requirements as this area was identified as a major source of stress for JMOs.

Overall participants acknowledged that a lot of JMOs lack trust in the current systems to protect them from recriminations if they were to make a complaint. Both the heath system and colleges need to collaborate to publicly reinforce their commitment to the *Statement of Agreed Principles on a Respectful Culture in Medicine*.

Colleges identified that it is not in their power to investigate and manage complaints regarding unacceptable behaviour, however they are often the recipient of information. This highlighted the strong case to develop pathways to share information.

Question 8

Are there areas where trainees might feel like they are falling through the cracks, e.g. don't know who to go to in respect of which problems.

There was strong agreement that trainees in unaccredited positions, Career Medical Officers and trainees on short term contracts are most at risk of falling through the cracks. Although there are variations between local health districts and colleges, this group are most vulnerable as they don't have college supervisors advocating on their behalf or in some cases providing formal supervision or training.

In the development of any complaints pathway process this group needs to be explicitly included.

ACCREDITATION PANEL DISCUSSION

The final session included a Panel discussion on medical college accreditation of training sites. The panel was facilitated by Mr Mick Reid and included:

- **Mr Brett O'Neill**
  Australasian College of Dermatologists
- **Dr Simon Judkins**
  Australasian College for Emergency Medicine
- **Prof. Trish Davidson**
  Hunter New England Local Health District
- **Dr Jo Karnaghan**
  South Eastern Sydney Local Health District
- **Mr Philip Pigou**
  Australian Medical Council
- **Dr Greg O'Sullivan**
  Australian and New Zealand College of Anaesthetists

Collaboration

A strong theme was that accreditation is a collaboration between service providers and colleges. Accreditation should not be about punishing the hospital or senior clinicians but about making sure the training site provides a quality training experience. It was recognised that it was important to have good working relationships between medical colleges, local health districts and the Ministry to ensure the best possible outcome.

There was agreement that accreditation works well where there are clear standards and good processes and where the hospital engages early with the college if there is a concern or an issue that needs to be addressed.

Withdrawal of accreditation was seen as a sign that the system is not working well and the worst outcome. Withdrawal of accreditation should be seen as the last resort not the first point in identifying issues. It was strongly agreed that there needs to be an escalation strategy when issues at a site are identified so that they can be remediated. Some colleges already use this approach.

It was noted that colleges and employers have the same pool of people – the specialists are working for the local health districts and are Fellows of the college therefore it is important that there is collaboration. It was also noted that the culture that we are trying to achieve is complementary and that providing quality teaching and patient care are not competing priorities.

Trainees in unaccredited positions

Trainees raised the issue that when accreditation is withdrawn from a site the positions are then filled by trainees not in a training program. There is an accreditation gap for doctors working in unaccredited trainee roles and there need to be a set of generic standards for doctors working in unaccredited positions.

Another issue raised was that in many training sites accredited trainees work alongside trainees in unaccredited positions. The work performed by the accredited trainee is recognised by the college towards specialist training but that of the trainee in the unaccredited position is not recognised.

It was noted that as trainees often rotate to different sites they may not be at a site at the time of accreditation to raise issues of concern. It was also noted that medical colleges do things differently, but a number of colleges indicated that they do interview trainees who were previously at the site but not there at the time of accreditation.

Medical Training Survey

It was recognised that currently medical colleges are using different evidence sources and from different time periods to inform the accreditation process. The Medical Board of Australia's Medical Training Survey was considered to be potentially 'game changing' as it will be providing information about training sites to all medical colleges at the same time.

However, it was noted that as the Medical Training Survey will only publish results when 10 or more responses have been received it may be difficult for small colleges with few trainees at a site, to get meaningful data from the survey.

Duplication and variation

Health services raised concerns about the duplication in accreditation that occurred and suggested that there needs to be co-badging and sharing between colleges.

Health service representatives also commented that there is often inconsistency in the application of standards and variations between different college accreditation teams.

Cannot keep doing things the same way

A number of speakers emphasised that the world has changed and that things need to be done differently. The same models of accreditation and training have been in place for twenty years and may need to be more adaptive for the future. For example, medical colleges require that supervisors are from the same specialty as the trainee. However, in future, a Fellow of another college may provide feedback on a different college trainee.

SUMMATION AND NEXT STEPS

Mr Phil Minns, Deputy Secretary, People, Culture and Governance, Ministry of Health provided a summation of the key themes that emerged from the day. A key message from the Roundtable was it's time to tackle some of the big issues openly and in a collegiate environment.

It also emerged that the medical colleges and health services silos remain very much in place. For most of the key themes identified the starting point is understanding each organisation's role and responsibilities.

The outcomes of the Roundtable will guide the four work streams.

To this end the NSW Ministry of Health will establish the following work streams based on the key themes identified:

- **Stream 1:** Accreditation processes
- **Stream 2:** Complaint management of unacceptable behaviour
- **Stream 3:** Supervisor training and monitoring
- **Stream 4:** Promoting diversity and flexibility in the workplace.

Representation on Work Streams

The NSW Ministry of Health will seek representation from medical colleges, local health districts, the Australian Medical Council and other key stakeholders to progress actions identified at the Roundtable.

Thank you to all Roundtable participants for providing your expertise and insights and sharing these in a collaborative and respectful way.

APPENDIX ONE: ROUNDTABLE PARTICIPANTS

Name	Position	Organisation
The Hon. Brad Hazzard	Minister for Health and Medical Research	
Ms Jasmine Morgan	Workforce Advisor	
Medical Specialist Colleges		
Dr Simon Judkins	President	Australasian College for Emergency Medicine
Dr Keng Cheng	Chair of NSW Faculty	Australasian College of Dermatologists
Mr Brett O'Neill	Director of Education Services	Australasian College of Dermatologists
Dr Sharron Flahive	College Fellow	Australasian College of Sport and Exercise Physicians
Dr Rod Martin	NSW College Councilor	Australian College of Rural and Remote Medicine
Miss Angela MaGarry	Chief Executive Officer	Council of Presidents Medical Colleges
A/Professor Leonie Watterson	NSW Council	The Australian and New Zealand College of Anaesthetists
Dr Greg O'Sullivan	Senior Accreditation Officer	The Australian and New Zealand College of Anaesthetists
A/Professor Stuart Lane	Chair, NSW Regional Committee	The College of Intensive Care Medicine of Australia and New Zealand
Ms Robyn Burley	Director of Education, Learning and Assessment	The Royal Australasian College of Physicians
Dr Adrian Lee	Chair NSW/ACT Regional Committee	The Royal Australasian College of Physicians
Mr Tony Sparnon	President	The Royal Australasian College of Surgeons
Mr John Biviano	Chief Executive Officer	The Royal Australasian College of Surgeons
Mr Allan Chapman	Manager, NSW Regional Office	The Royal Australasian College of Surgeons
Dr Anthony Dilley	Paediatric Surgeon	The Royal Australasian College of Surgeons
Dr Tanya Nippita	Fellow	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Ms Vase Jovanoska	Chief Executive	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Mr David Andrews	Chief Executive Officer	The Royal Australian and New Zealand College of Ophthalmologists
Ms Victoria Baker-Smith	Head of Education	The Royal Australian and New Zealand College of Ophthalmologists
Professor Louise Nash	NSW Branch Training Committee	The Royal Australian and New Zealand College of Psychiatrists
Dr Ralf Ilchef	NSW Branch Training Committee	The Royal Australian and New Zealand College of Psychiatrists

Name	Position	Organisation
Ms Chloe Visser	Senior Project Officer	The Royal Australian and New Zealand College of Radiologists
Dr Morgan Schulze	Fellow	The Royal Australian and New Zealand College of Radiologists
Associate Professor Alan Sandford AM	President	The Royal Australian College of Medical Administrators
Ms Melanie Saba	Chief Executive Officer	The Royal Australian College of Medical Administrators
A/Prof Kenneth Lee	Chair of NSW State Committee & Counsellor	The Royal College of Pathologists of Australasia
Dr Wendy Pryor	Director, of Education & Accreditation	The Royal College of Pathologists of Australasia
Australian Medical Council		
Mr Philip Pigou	Chief Executive Officer	Australian Medical Council
Ms Kirsty White	Director, Accreditation and Standards	Australian Medical Council
Ms Juliana Simon	College Accreditation Officer	Australian Medical Council
Australian Medical Association		
Ms Fiona Davies	Chief Executive Officer	Australian Medical Association (NSW)
Dr Tessa Kennedy	Paediatric Trainee / National Chair	Australian Medical Association Council of Doctors in Training
NSW Health System		
Ms Elizabeth Koff	Secretary	NSW Ministry of Health
Dr Anthony Rodrigues	Trainee	Central Coast Local Health District
Dr Mirna Hunter	RACMA Trainee	Health Education and Training Institute
Dr Claire Blizard	Medical Director	Health Education and Training Institute
A/Prof. Annette Solman	Chief Executive	Health Education and Training Institute
Prof Trish Davidson	Executive Director, Medical Services	Hunter New England Local Health District
Dr Mark Bassett	Executive Director Medical Services & Clinical Governance	Illawarra Shoalhaven Local Health District
Ms Yvonne Becarevic	Manager Junior Medical Officer Services, Wellbeing and Medical Education	Illawarra Shoalhaven Local Health District
Dr Leigh Haysom	Director Medical Programs	Justice Health & Forensic Mental Health Network
Dr Yolisha Singh	Director Basic and Advanced Training in Psychiatry	Justice Health & Forensic Mental Health Network
Dr Logan Carroll	Senior Hospitalist Medical Administration	Mid North Coast Local Health District
Dr Pankaj Banga	Director of Medical Services, Wagga Wagga Health Service	Murrumbidgee Local Health District

Name	Position	Organisation
Dr Devesh Thakkar	Basic Physician Trainee	Nepean Blue Mountains Local Health District
Dr Peter Thomas	Director Medical Services	Nepean Blue Mountains Local Health District
Ms Sally Sammut	Junior Medical Workforce Manager	Nepean Blue Mountains Local Health District
Mr Timothy Williams	Executive Director of Medical Services	Northern NSW Local Health District
Dr Tamsin Waterhouse	Medical Executive Director	Northern Sydney Local Health District
Dr Linda Xu	Advanced Trainee	Northern Sydney Local Health District
Dr Michael Whiley	Executive Director of Medical Services and Clinical Streams	NSW Health Pathology
Mr Phil Minns	Deputy Secretary, People, Culture and Governance	NSW Ministry of Health
Mr Richard Griffiths	Executive Director, Workforce Planning and Talent Development (WP&TD)	NSW Ministry of Health
Dr Linda MacPherson	Medical Adviser, WP&TD	NSW Ministry of Health
Ms Deborah Frew	Director, Workforce Strategy and Culture, WP&TD	NSW Ministry of Health
Ms Michelle McNally	Manager, Culture & Diversity, WP&TD	NSW Ministry of Health
Ms Liz Martin	Manager, Medical Workforce Policy, WP&TD	NSW Ministry of Health
Ms Jennifer Chapman	Principle Policy Officer, Workforce Strategy and Culture, WP&TD	NSW Ministry of Health
Ms Sue McGovern	Program Manager, JMO Recruitment Governance Unit	NSW Ministry of Health
Ms Mary Roche	Project Officer, JMO Recruitment Governance Unit	NSW Ministry of Health
Dr Jake Williams	Trainee	South Eastern Sydney Local Health District
Dr Hariette Goldman	General Medicine Trainee	South Eastern Sydney Local Health District
Dr Patricia Griffiths	Post Graduate Year 2	South Eastern Sydney Local Health District
Dr Jo Karnaghan	Director, Clinical Governance and Medical Services	South Eastern Sydney Local Health District
Dr Brett Oliver	Director Medical Services	South Western Sydney Local Health District
Dr Mahnoor Mian	Basic Physician Trainee	South Western Sydney Local Health District
Dr Lachlan Gordon	Medical Administration Registrar	Southern NSW Local Health District
Dr Sarah Michael	Director of Prevocational Education and Training	St Vincent's Health Network
Dr Sarah Michael	Director of Prevocational Education and Training	St Vincent's Health Network
Dr Ash Quadir	Trainee	Sydney Children's Hospitals Network
Dr David Lester-Smith	Associate Director, Clinical Education	Sydney Children's Hospitals Network
Dr Teresa Anderson	Chief Executive	Sydney Local Health District
Dr James Lawler	Advanced Trainee	Western Sydney Local Health District
Dr Peter Hockey	Director of Education, & Research Network	Western Sydney Local Health District
Dr Emma McCahon	Executive Director Medical Services	Western Sydney Local Health District

APPENDIX TWO: AGENDA

NSW GOVERNMENT

health.nsw.gov.au

NSW Health and Specialist Medical Colleges Roundtable

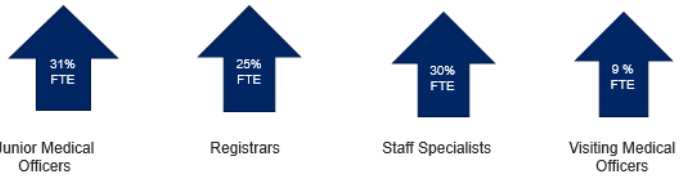
AGENDA

9am – 2.30pm Friday 11 October 2019
Royal Australasian College of Physicians, Governor Macquarie Tower, 1 Farrer Place Sydney

9 AM	REGISTRATION: TEA/COFFEE	
9.30	Welcome and introductions Acknowledgment of Country	Mr Mick Reid Facilitator
9.35	Opening Address	The Hon. Brad Hazzard
9.45	A respectful culture in medicine: progress to date • AMA Council of Doctors in Training • NSW Health • Royal Australasian College of Surgeons • Sydney Local Health District • Royal Australasian College of Physicians	• Dr Tessa Kennedy • Mr Phil Minns • Mr Tony Sparnon • Dr Teresa Anderson • Ms Robyn Burley Panel discussion
11.00	Creating and sustaining a healthy culture Clarifying the respective roles and responsibilities of stakeholders • Supervisors • Trainees • Session Report	Tablework Plenary
12.30	Lunch	
1.15	Issues and priorties from the morning session	Mr Mick Reid
1.30	Accreditation • Australasian College of Dermatologists: Mr Brett O'Neill • Australasian College for Emergency Medicine: Dr Simon Judkins • Hunter New England Local Health District: Prof. Trish Davidson • South Eastern Sydney Local Health District: Dr Jo Karnaghan • Australian Medical Council: Mr Philip Pigou • Australian and New Zealand College of Anaesthetists: Dr Greg O'Sullivan	Panel discussion
2.15	Summation and next steps	Mr Mick Reid
2.30	Close	

APPENDIX THREE: PRESENTATIONS

Increase in Medical Workforce in NSW – Between 2012 and 2019



	FTE				Medical per 100,000 population			
	2012	2019	Variation #	*Variation %*	2012	2019	Variation #	*Variation %*
Medical FTE	9,696.2	12,503.3	2889.1	30.1	132.4	157.0	24.6	18.6
Junior Medical Officers (Interns, RMO +CMO)	3,545.5	4,648.2	1,102.7	31.1	48.4	58.4	10	20.7
Registrars	3,268.8	4100.3	610.5	25.4	44.6	51.5	6.9	15.5
Staff Specialists	2,881.9	3,754.7	869.8	30.2	39.3	47.1	7.8	19.8
Visiting Medical Officers (Headcount)	5,267*	6,142	875	16.6	71.9	77.1	5.2	7.2

Note:
* 2013 data
- Inclusive of Productive and non-productive FTE
- VMO and Medical totals impacted by movement of medical specialists between Staff Specialists and Visiting Medical Officers by some LHDs.
- The other staff groups working in LHDs have been impacted by staff movements to HealthShare & Pathology NSW and excluded from this report

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NSW Health – Progress to date

2018 – Working on Safe Hours Initiatives

A new standard was introduced at the beginning of the 2018 clinical year where medical officers may not be rostered for more than 14 consecutive hours and there must be a 10 hour minimum break between shift periods

2018 – A Framework for Rostering in NSW Health 2018-2023

Improvements to medical rostering are a key focus in the Framework and are supported by the state-wide rostering system, HealthRoster, and the Rostering Capability Framework.

2018 – Forum for JMO Workforce Management

The 2018 inaugural Forum for JMO Workforce Management was held, a whole day event for staff who support and manage the JMO workforce, focussed on their health and wellbeing ("supporting the supporters").

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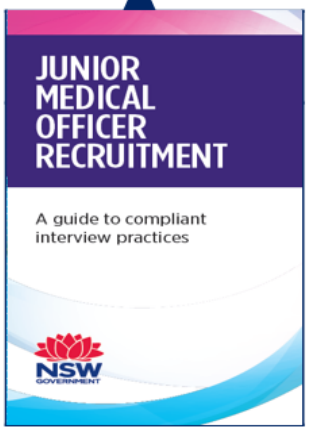
NSW Health – Progress to date

2019



2019

Shift - App

The **Black Dog Institute has developed a smartphone app** currently in pilot to support the mental health and wellbeing of NSW Health JMOs. The app will be subjected to a randomised controlled trial in to study its effectiveness in improving JMO wellbeing.

2019

JMO Be Well Program

The **JMO Be Well Program** has been established to support local workforce projects that contribute towards improving JMO wellbeing, training and supervision. Over one million dollars in funding has been allocated to the Program and eight projects have been awarded funding.

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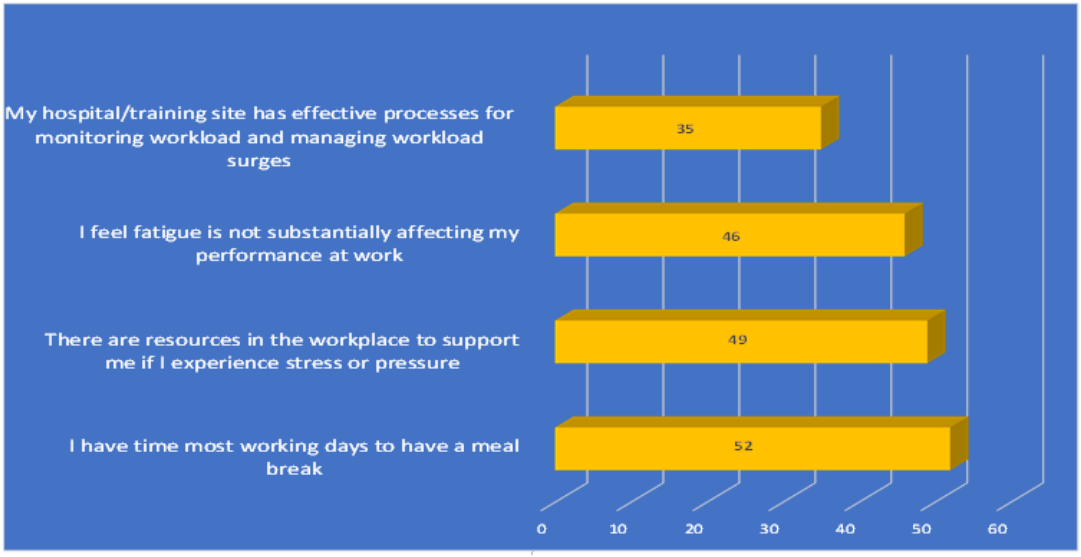
Areas to improve

% Agree or strongly agree



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Your Training and Wellbeing Matters Survey – 2018 - JMO Indices

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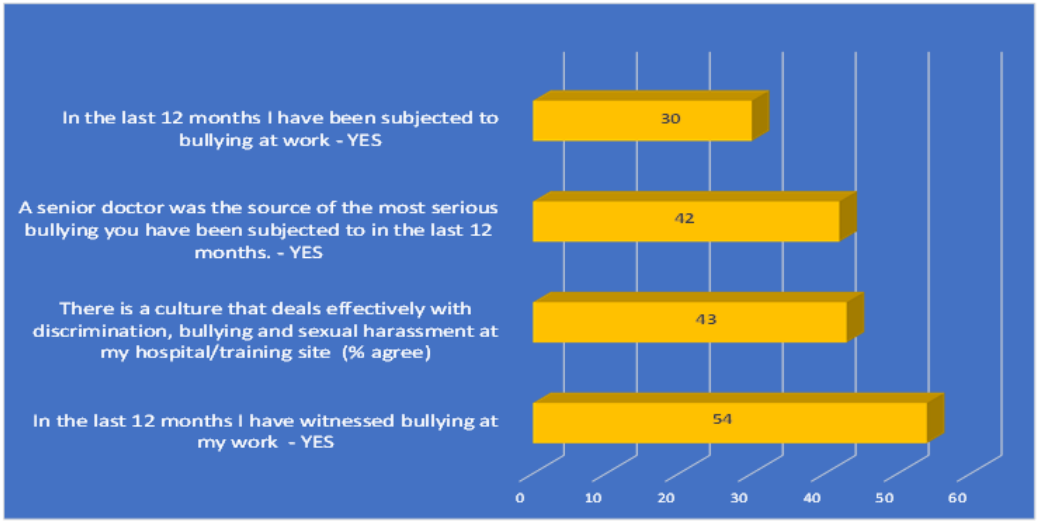
Areas to improve

% responded YES



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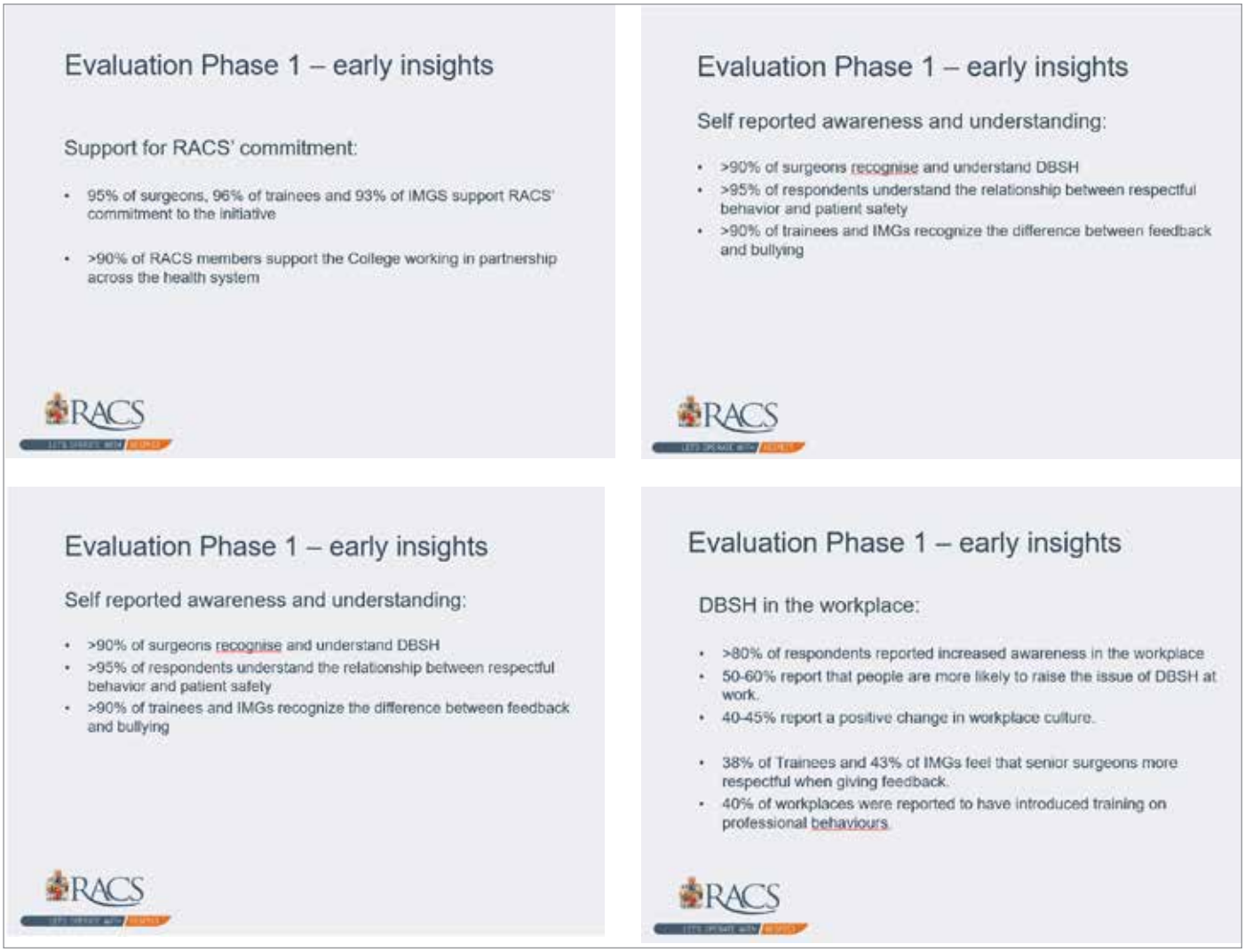
NSW GOVERNMENT


Building Respect Improving Patient Safety,
October 2019
Towards a culture of respect in the practice of surgery
RACS
LET'S OPERATE WITH RESPECT
About RACS
The Royal Australasian College of Surgeons (RACS), formed in 1927, is a non-profit organisation training surgeons and maintaining surgical standards in Australia and New Zealand.
RACS represents more than 7000 surgeons and 1300 surgical trainees and International medical graduates
RACS is the leading advocate for surgical standards, professionalism and surgical education in Australia and New Zealand.
Building Respect, Improving Patient Safety:
The Journey So Far
Expert Advisory Group, RACS Action plan, November 2015:
a multi year program of work, requiring sustained, college-wide focus
an evidence-informed mix of complementary strategies to address culture and behaviour change in the practice of surgery
Expert Advisory Group - reconvened November 2017
to audit progress
to learn from EAG member's experiences in other settings
to gauge their feedback on our progress to date
Phase 1 Building Respect evaluation - complete at end of year 3
Three Strategic Pillars
1 Cultural change and leadership
Partnerships (employers, health jurisdictions, medical colleges, university medical schools)
Communication campaign
Surgical Leadership
Diversity and Inclusion
2 Surgical education
Operating with Respect online
Foundation Skills for Surgical Education
Operating with Respect face to face course
3 Complaints management
Focus on timeliness, procedural fairness and transparency


Evaluation Phase 1 – early insights
Support for RACS' commitment:
95% of surgeons, 96% of trainees and 93% of IMGS support RACS' commitment to the initiative
>90% of RACS members support the College working in partnership across the health system
RACS
Evaluation Phase 1 – early insights
Self reported awareness and understanding:
>90% of surgeons recognise and understand DBSH
>95% of respondents understand the relationship between respectful behavior and patient safety
>90% of trainees and IMGs recognize the difference between feedback and bullying
RACS
Evaluation Phase 1 – early insights
Self reported awareness and understanding:
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>90% of trainees and IMGs recognize the difference between feedback and bullying
RACS
Evaluation Phase 1 – early insights
DBSH in the workplace:
>80% of respondents reported increased awareness in the workplace
50-60% report that people are more likely to raise the issue of DBSH at work.
40-45% report a positive change in workplace culture.
38% of Trainees and 43% of IMGs feel that senior surgeons more respectful when giving feedback.
40% of workplaces were reported to have introduced training on professional behaviours.
RACS


Most effective* program elements
• Communication campaigns, agenda setting, awareness raising:
• >70% of respondents considered RACS communication to be relevant and highly professional
• Mandated training and skills development:
• some cynicism about "learning how to behave"
• >80% agreed that improving surgical education is an important way to address DBSH
• Collaboration, working in partnership:
• >90% of members indicated support for RACS working in partnership to achieve system-wide cultural change
RACS
What have been the challenges?...
• Initial resistance from some groups, regarding mandatory training (now shown to be highly supported)
• Some questioning of the appropriateness of a College tackling these issues (now demonstrated to have exceptional levels of support)
• Managing unprofessional conduct in the workplace training environment give our duty of care to trainees, but our limited powers as a College
What have we learnt?
RACS
What have been the challenges?...
RACS' complaints process – like others - is not perceived as safe by vulnerable groups:
• 55% of Trainees
• 41% of IMGs
• 37% of women
would not feel safe to formalise a complaint
Compared to:
• 17% of males would not feel safe
• 21% of Fellows would not feel safe.
RACS
What have we learnt?
RACS has no powers to investigate complaints of discrimination, bullying, sexual harassment.
Our ability to enforce is limited, only possible via:
1. Code of conduct
2. Annual membership subscription renewals
3. Training agreements
4. Training post accreditation
Our actions must be bound by rules of procedural fairness and natural justice.
RACS
5

The shared endeavour

Others have legislated powers:

- Employers have industrial relations legislation that guide workplace investigations and disciplinary actions
- Regulators have powers through specific legislation

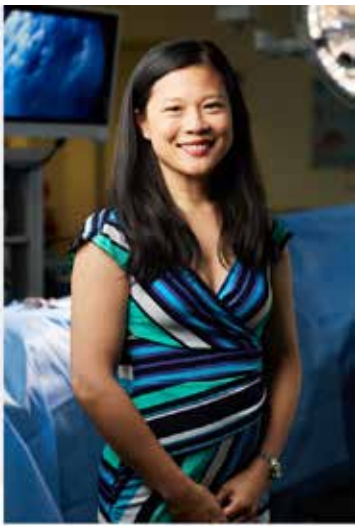
Everyone has a role to play – Individual fellows, employers, medical colleges, regulators

Cultural change over the long term….

- No magic bullet
- Requires a mix of evidence-informed complementary interventions (eg policy, awareness, education, partnerships, peer and public support, sanctions)
  - visible support at the highest levels
  - sustained funding and commitment
  - collaboration

"When surgeons behave respectfully, they get the best from their teams and that naturally translates into better patient outcomes."

Dr Christina Lai



6

NSW Health Roundtable

11 October 2019

Robyn Burley, Director, Education, Learning and Assessment

RACP Specialists. Together
EDUCATE ADVOCATE INNOVATE

Our Vision

A stronger community of doctors supported by the RACP. By collaborating with workplaces, we will proactively advance the health and wellbeing of our members and enhance their provision of high quality health care to the community.

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Why?

- There are certain stressors inherent to the practice of medicine
- There are also a range of stressors that are the result of culture in medicine.
- **As leaders and influencers, we can support a safe, healthy, engaged and productive workforce.**

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Our journey to date

- Developed a Doctors Health and Wellbeing **Strategic Roadmap**
- Established a Physician Health and Wellbeing **Reference Group**
- Prioritised health and wellbeing in the **RACP Strategic Plan 2019-2021**
- **Launched** our health and wellbeing Strategy for the next 3 years

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What has worked well

- Accreditation linked to Physician Training Survey and Concerning Responses
- Trainee Support
- Guidance on local selection addressing issues on appropriate practices

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Accreditation

Training Provider Standard 1: Safety & Quality
The environment and culture encourage safety promoting behaviours and support the delivery of high-quality patient and population-centred care.

Training Provider Standard 2: Learning Environment
The environment and culture value learning and support training.

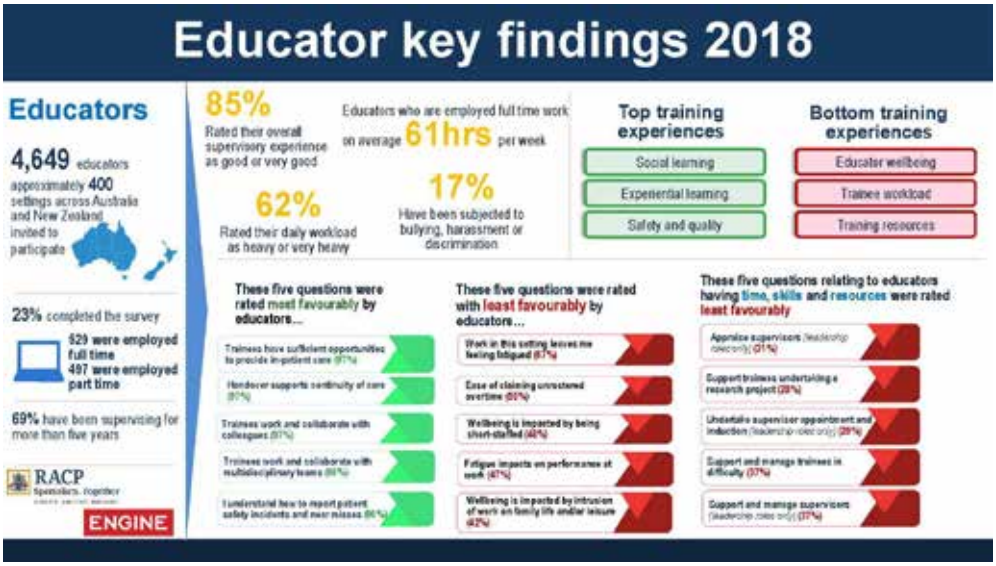
Training Provider Standard 5: Educator Leadership, Support and Wellbeing
Educators are skilled and supported in their teaching and leadership roles.

RACP
Specialists. Together

Proactive feedback approach

- **Identified settings** with concerning responses using the survey data
- **Provided feedback** to accredited settings with more than five responses
- Asked the **setting executive(s) to review the findings and act to improve training**
- **Provide findings to RACP accreditors** to support the Accreditation Program

Physician Training Survey



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Physician Training Surveys

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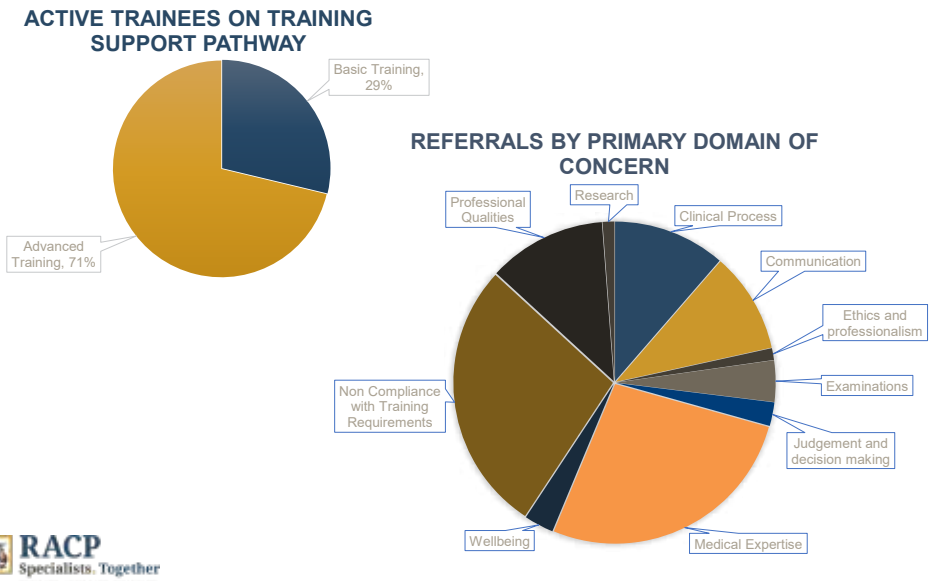
Trainee Support

- **Trainee Support Unit** – **case manage** additional support for trainees together with supervisors
  - 2.4% of trainees are supported on the training support pathway either via supervisor recommendation or via self referral
  - In addition, after any exam failed attempt, trainees are provided with formal exam support

  Member support program facilitated by Converge – confidential counselling, coaching and support for personal and workplace issues
  - Access to services peaks and troughs aligning with key events in the training year e.g. exams
  - Since 2018, there is an increasing trend of health and wellbeing issues raised

- **Regional Offices** provide trainee orientation across various locations (in the office and at the training setting).

Training Support Unit



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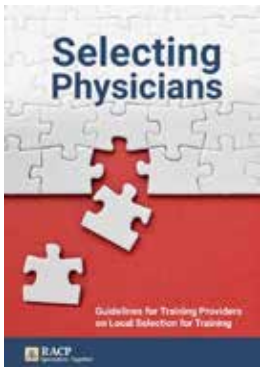
Supporting Local Selection

Whilst the RACP doesn't appoint trainees to positions, it does set and monitor standards for selection, and provides advice on the selection and recruitment of trainee physicians.

The RACP has developed a range of resources to aid in the local selection process.

- ✓ **Web based Guide-** Trainee Selection and Recruitment
- ✓ **PDF Guidelines-** Trainee Selection and Recruitment
- ✓ **Poster-** Local Selection into Training: At a glance



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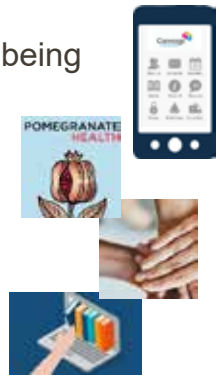
https://www.racp.edu.au/innovation/education-renewal/local-selection

Other

- **eLearning** courses on training support, telesupervision, physician self-care and wellbeing and creating a safe workplace.
- **Podcast** covering of wellbeing topics:

Episode 5: Physician - Heal Thyself
Episode 7: The Art of Supervision
Episode 16: Mind the (Gender) Gap
Episode 22: Transitions to Retirement
Episode 30: Being Human



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Challenges

- Influencing systemic factors that impact on wellbeing
- Balancing workload and training for both trainees and educators
- Addressing ‘unintended consequences’ – changes in employment arrangements that result in reduced contact with trainees
- Developing shared or aligned approaches to managing and supporting wellbeing and cultural change in training settings

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